SEP - 9 2005

TO: Herb Kuhn
Director, Center for Medicare Management
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of TrailBlazer Health Enterprises Outlier Payments to Clinic Resources Management, Inc., for Partial Hospitalization Services for the Period August 1, 2000, Through December 31, 2003 (A-07-04-04045)

Attached is an advance copy of our final report on TrailBlazer Health Enterprises (TrailBlazer) outlier payments to Clinic Resources Management, Inc. (Quitman Clinic), for partial hospitalization services for the period August 1, 2000, through December 31, 2003. We will issue this report to TrailBlazer within 5 business days. This is one of a series of reports on Medicare outlier payments to community mental health centers.

Our objective was to determine whether the fiscal intermediary, TrailBlazer, calculated Medicare outlier payments to Quitman Clinic in accordance with Medicare reimbursement requirements.

TrailBlazer correctly calculated Medicare outlier payments to Quitman Clinic during the period May 1 through December 31, 2003. However, for the period August 1, 2000, to May 1, 2003, TrailBlazer did not calculate outlier payments to Quitman Clinic in accordance with Medicare reimbursement requirements. TrailBlazer used an outdated cost-to-charge ratio in computing the outlier payments. TrailBlazer based the cost-to-charge ratio on the tentatively settled fiscal year (FY) 1997 Medicare cost report instead of the final FY 1997 Medicare cost report, contrary to Medicare reimbursement requirements.

The errors occurred because TrailBlazer did not have adequate internal controls to prevent or detect the improper calculation of the cost-to-charge ratio. As a result, TrailBlazer overpaid Quitman Clinic approximately $8.8 million.

We recommend that TrailBlazer recover from Quitman Clinic the improper outlier payments totaling $7,164,566 for services rendered between August 1, 2000, and December 31, 2002. Our previous report (A-07-04-04034) recommended that Quitman Clinic refund overpayments for the same claims for a different reason.

We also recommend that TrailBlazer:

- recover from Quitman Clinic the improper outlier payments totaling $1,638,083 for services rendered between January 1 and December 31, 2003, and

- implement internal controls, such as written policies and procedures, to ensure that future outlier payments are computed with the correct cost-to-charge ratio.

TrailBlazer agreed that it had made an error in calculating the cost-to-charge ratio used to compute outlier payments. TrailBlazer stated that it was unable to extensively review and verify the cost-to-charge ratio because of the limited timeframe for complying with the revised outpatient prospective payment system instructions issued in 2000. TrailBlazer stated that it would calculate the amount of the overpayments related to the outlier payments and seek recovery from Quitman unless the Centers for Medicare & Medicaid Services directed otherwise. TrailBlazer also stated that it had strengthened internal controls to ensure that it used the correct cost-to-charge ratio in computing future outlier payments.

We acknowledge that TrailBlazer has taken corrective actions to strengthen internal controls. However, we believe that additional improvements are needed to ensure compliance with Medicare requirements on calculating outlier payments to community mental health centers.

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 Patrick J. Cogley, Regional Inspector General for Audit Services, Region VII, at (816) 426-3591. Please refer to report number A-07-04-04045 in all correspondence.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Offices of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

Report Number: A-07-04-04045

SEP 14 2005

Mr. Scott J. Manning
Vice President, Audit & Reimbursement
TrailBlazer Health Enterprises, LLC
Audit & Reimbursement Division
Executive Center III
8330 LBJ Freeway
Dallas, Texas 75243-1213

Dear Mr. Manning:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of TrailBlazer Health Enterprises Outlier Payments to Clinic Resources Management, Inc., for Partial Hospitalization Services for the Period August 1, 2000, Through December 31, 2003." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

The HHS action official named below 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. 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 members of the press and general 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-07-04-04045 in all correspondence.

Sincerely,

Patrick J. Cogley
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

James R. Farris, Jr., M.D.
Regional Administrator, Region VI
Centers for Medicare & Medicaid Services
Department of Health and Human Services
1301 Young Street, Suite 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF TRAILBLAZER HEALTH ENTERPRISES OUTLIER PAYMENTS TO CLINIC RESOURCES MANAGEMENT, INC., FOR PARTIAL HOSPITALIZATION SERVICES FOR THE PERIOD AUGUST 1, 2000, THROUGH DECEMBER 31, 2003

Daniel R. Levinson
Inspector General

SEPTEMBER 2005
A-07-04-04045

Office of Inspector General

http://oig.hhs.gov

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

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 nationwide audit of payments to CMHCs.

OBJECTIVE

Our objective was to determine whether the fiscal intermediary, TrailBlazer Health Enterprises (TrailBlazer), calculated Medicare outlier payments to Clinic Resources Management, Inc. (Quitman Clinic), in accordance with Medicare reimbursement requirements. The audit period covered dates of services between August 1, 2000, and December 31, 2003.

SUMMARY OF FINDINGS

TrailBlazer correctly calculated Medicare outlier payments to Quitman Clinic during the period May 1 through December 31, 2003. However, for the period August 1, 2000, to May 1, 2003, TrailBlazer did not calculate outlier payments to Quitman Clinic in accordance with Medicare reimbursement requirements. TrailBlazer used an outdated cost-to-charge ratio in computing the outlier payments. TrailBlazer based the cost-to-charge ratio on the tentatively settled fiscal year (FY) 1997 Medicare cost report instead of the final FY 1997 Medicare cost report, contrary to Medicare reimbursement requirements.

The errors occurred because TrailBlazer did not have adequate internal controls to prevent or detect the improper calculation of the cost-to-charge ratio. As a result, TrailBlazer overpaid Quitman Clinic $8,802,649.

In a previous medical review audit, we recommended that Quitman Clinic refund to the Medicare program $12,491,797 in unallowable payments for 1,714 claims for services provided between August 1, 2000, and December 31, 2002.[1] Of the $8,802,649 in improper payments identified in this review, $7,164,566 was associated with the same 1,714 claims questioned in the medical review audit for services between August 1, 2000, and December 31, 2002. Thus, this report provides an additional basis for recovering the $7,164,566. The remaining $1,638,083

[1] "Medical Review of Quitman Clinic's Partial Hospitalization Services for the Period August 1, 2000, Through December 31, 2002" (A-07-04-04034, issued March 4, 2005).

identified in this review was associated with 330 outlier claims for services between January 1 and December 31, 2003, which were not included in the previous audit.

RECOMMENDATIONS

We recommend that TrailBlazer recover from Quitman Clinic the improper outlier payments totaling $7,164,566 for services rendered between August 1, 2000, and December 31, 2002. Our previous report (A-07-04-04034) recommended that Quitman Clinic refund overpayments for the same claims for a different reason.

We also recommend that TrailBlazer:

- recover from Quitman Clinic the improper outlier payments totaling $1,638,083 for services rendered between January 1 and December 31, 2003, and

- implement internal controls, such as written policies and procedures, to ensure that future outlier payments are computed with the correct cost-to-charge ratio.

AUDITEE'S COMMENTS

TrailBlazer agreed that it had made an error in calculating the cost-to-charge ratio used to compute outlier payments. TrailBlazer stated that it was unable to extensively review and verify the cost-to-charge ratio because of the limited timeframe for complying with the revised OPPS instructions issued in 2000. TrailBlazer stated that it would calculate the amount of the overpayments related to the outlier payments and seek recovery from Quitman unless CMS directed otherwise. TrailBlazer also stated that it had strengthened internal controls to ensure that it used the correct cost-to-charge ratio in computing future outlier payments.

TrailBlazer's response is included in its entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We acknowledge that TrailBlazer has taken corrective actions to strengthen internal controls. However, we believe that additional improvements are needed to ensure compliance with Medicare requirements on calculating outlier payments to CMHCs.

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INTRODUCTION

BACKGROUND

Partial Hospitalization Program

Partial hospitalization is an intensive outpatient program of psychiatric services that hospitals or community mental health centers (CMHCs) may provide to patients in lieu of inpatient psychiatric care. The program is designed to provide patients who have profound and disabling mental health conditions with an individualized, coordinated, comprehensive, and multidisciplinary treatment program involving nurses, psychiatrists, psychologists, and social workers.

Pursuant to the Balanced Budget Act of 1997, Medicare payments for partial hospitalization services provided by CMHCs are made as part of the hospital outpatient prospective payment system (OPPS) that was implemented in August 2000. Under the OPPS, Medicare pays CMHCs a per diem rate for such services. Medicare may also make outlier payments for situations in which the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. Medicare makes these additional outlier payments when the provider's charges for the services, adjusted to cost, exceed a given threshold established by the Centers for Medicare & Medicaid Services (CMS).

Cost-to-Charge Ratio

Providers bill for Medicare claims based on patient charges. To determine whether a claim qualifies for an outlier payment, billed charges must be converted to estimated costs using a cost-to-charge ratio. The use of provider-specific, current cost-to-charge ratios is essential to ensure that outlier payments are made only for cases that have extraordinarily high costs, not merely high charges. The Medicare fiscal intermediaries calculate these ratios by dividing total patient-related costs by total charges as shown on the provider's Medicare cost reports.

Intermediary Responsibilities

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

- processing and paying claims for 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, effective April 30, 2003, based on the most recent cost reports available;

- conducting audits of cost reports submitted by CMHCs; and

- performing medical reviews of claims for 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 acceptance of 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. The final settlement incorporates any audit adjustments that the fiscal intermediary may have made.

Quitman Clinic

Clinic Resources Management, Inc. (Quitman Clinic), a Medicare-certified CMHC in Houston, TX, received Medicare payments totaling $17,774,484 for services rendered from the inception of the OPPS in August 2000 through December 2003. Of the payments, $8,802,649 (approximately 50 percent) was outlier payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the fiscal intermediary, TrailBlazer Health Enterprises (TrailBlazer), calculated Medicare outlier payments to Quitman Clinic in accordance with Medicare reimbursement requirements.

Scope

Our audit covered TrailBlazer's $8,802,649 in outlier payments to Quitman Clinic for services rendered between August 1, 2000, and December 31, 2003. We reviewed the elements of the outlier payment calculation.

We limited our internal control review to the processes that TrailBlazer used in the outlier payment methodology and to Quitman Clinic's internal controls that affected the outlier payment mechanism. We did not perform detailed tests of internal controls because our objective did not require such testing. On behalf of the Office of Inspector General, medical reviewers examined a sample of Quitman Clinic's claims for medical necessity in a separate audit.[1]

We performed fieldwork at Quitman Clinic in Houston, TX, and at TrailBlazer in Dallas, TX.

[1] "Medical Review of Quitman Clinic's Partial Hospitalization Services for the Period August 1, 2000, Through December 31, 2002" (A-07-04-04034, issued March 4, 2005).

Methodology

We reviewed the Balanced Budget Act of 1997, the Balanced Budget Refinement Act of 1999, the Federal Register, program memorandums, the CFR, the Medicare Intermediary Manual, and the Provider Reimbursement Manual as they pertained to outlier payments for partial hospitalization services. We also interviewed officials of TrailBlazer, CMS, and Quitman Clinic.

From TrailBlazer, we obtained (1) cost reports for the FYs that ended between December 31, 1997, and December 31, 2002; (2) documentation detailing the cost-to-charge ratio calculation; (3) information from the online system screen that identified the cost-to-charge ratio effective date; and (4) summaries and details of provider statistical and reimbursement (PS&R) reports. We identified the cost report that was used to establish the cost-to-charge ratio.

We extracted individual detailed claim information from CMS's Standard Analytical File using the Data Extract System for partial hospitalization claims for the period August 1, 2000, to December 31, 2003. We reconciled these data to the PS&R reports from TrailBlazer.

We independently computed all of the outlier payments as they appeared on the PS&R reports. Specifically, we computed the outlier payments on a claim-by-claim basis from a spreadsheet obtained from TrailBlazer and claim data in the Standard Analytical File.

To determine the proper amount of the outlier payments, we recalculated the outlier payments using the cost-to-charge ratio from the final cost report for FY 1997 and compared the amounts with those shown on the PS&R reports.

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

FINDINGS AND RECOMMENDATIONS

For the period August 1, 2000, to May 1, 2003, TrailBlazer did not calculate Medicare outlier payments to Quitman Clinic in accordance with Medicare reimbursement requirements. TrailBlazer used an outdated cost-to-charge ratio in computing outlier payments. TrailBlazer based the ratio on the tentatively settled FY 1997 Medicare cost report instead of the final FY 1997 Medicare cost report, contrary to the requirements of CMS Program Memorandum A-00-63.

The errors occurred because TrailBlazer did not have adequate internal controls to prevent or detect the improper calculation of the cost-to-charge ratio. As a result, TrailBlazer overpaid Quitman Clinic $8,802,649.

ESTABLISHMENT OF COST-TO-CHARGE RATIO

On September 8, 2000, CMS issued to fiscal intermediaries Program Memorandum A-00-63 on how to compute OPPS outlier payments effective August 1, 2000. The memorandum required intermediaries to use FY 1997 cost reports and to calculate a cost-to-charge ratio for each CMHC. For CMHCs that did not have 1997 cost reports, intermediaries were required to use the

most recent cost report available. If, in the judgment of an intermediary, the 1997 cost report did not yield a valid or usable cost-to-charge ratio, the intermediary was allowed to use a more recent cost report.

According to the program memorandum, fiscal intermediaries are required to use facility-specific cost-to-charge ratios in outlier computations to convert providers' billed charges to costs. As part of these computations, fiscal intermediaries compare converted cost figures against a prescribed threshold.

IMPROPER CALCULATION OF OUTLIER PAYMENTS TO QUITMAN CLINIC

TrailBlazer correctly calculated Medicare outlier payments to Quitman Clinic during the period May 1 through December 31, 2003. However, for the period August 1, 2000, to May 1, 2003, TrailBlazer did not calculate outlier payments to Quitman Clinic in accordance with Medicare reimbursement requirements. In computing the payments, TrailBlazer used an outdated cost-to-charge ratio of 0.925 based on the tentatively settled FY 1997 cost report. However, TrailBlazer completed the final settlement of Quitman Clinic's 1997 cost report on September 6, 2000, prior to the implementation of Program Memorandum A-00-63 on September 8, 2000.

During the final settlement process, TrailBlazer determined that the correct cost-to-charge ratio was 0.283 as a result of substantial audit adjustments to Quitman Clinic's 1997 cost report. Because the final 1997 cost report was available when the program memorandum was implemented, TrailBlazer should have used the final cost report, instead of the tentatively settled cost report, to obtain the most recent data. Had it done so, TrailBlazer would have correctly calculated the cost-to-charge ratio as 0.283.

In 2003, CMS issued Program Memorandum A-03-004, which required fiscal intermediaries to revise the cost-to-charge ratio for outlier payment computations using the most recent full-year cost reporting period, whether tentatively settled or final. TrailBlazer correctly calculated the revised cost-to-charge ratio.

INADEQUATE INTERNAL CONTROLS

TrailBlazer's internal controls did not prevent or detect the improper calculation of the cost-to-charge ratio. While TrailBlazer had increased its oversight of CMHCs by conducting more medical reviews and onsite audits to improve Medicare reimbursement accuracy, it had not established written policies and procedures to verify the accuracy of its cost-to-charge ratio computations.

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 TrailBlazer had more carefully reviewed the initial computation of the cost-to-charge ratio, it would have prevented the payment errors. Moreover, given the amount of outlier payments to Quitman Clinic relative to the size of this provider, we believe that more active monitoring of the outlier payment process by TrailBlazer during our 3-year audit period would have detected the errors.

IMPROPER OUTLIER PAYMENTS

As a result of using an incorrect cost-to-charge ratio, TrailBlazer overpaid Quitman Clinic $8,802,649. If TrailBlazer had used the correct ratio of 0.283 instead of 0.925, Quitman Clinic would not have received any outlier payments.

Appendix A demonstrates the impact of using the incorrect cost-to-charge ratio on individual claims.

In our previous medical review audit, we recommended that Quitman Clinic refund to the Medicare program $12,491,797 in unallowable payments for 1,714 claims for services provided between August 1, 2000, and December 31, 2002. Of the $8,802,649 in improper payments identified in this review, $7,164,566 was associated with the same 1,714 claims questioned in the medical review audit for services between August 1, 2000, and December 31, 2002.[2] Thus, this report provides an additional basis for recovering the $7,164,566. The remaining $1,638,083 identified in this review was associated with 330 outlier claims for services between January 1 and December 31, 2003, which were not included in the previous audit.

RECOMMENDATIONS

We recommend that TrailBlazer recover from Quitman Clinic the improper outlier payments totaling $7,164,566 for services rendered between August 1, 2000, and December 31, 2002. Our previous report (A-07-04-04034) recommended that Quitman Clinic refund overpayments for the same claims for a different reason.

We also recommend that TrailBlazer:

- recover from Quitman Clinic the improper outlier payments totaling $1,638,083 for services rendered between January 1 and December 31, 2003, and

- implement internal controls, such as written policies and procedures, to ensure that future outlier payments are computed with the correct cost-to-charge ratio.

AUDITEE'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

TrailBlazer's comments on our draft report are summarized below, along with our response. Those comments are included in their entirety as Appendix B.

Establishment of the Cost-to-Charge Ratio and Improper Calculation of Outlier Payments

TrailBlazer's Comments

TrailBlazer agreed that it had made an error in calculating the cost-to-charge ratio used to compute outlier payments because it had not used the latest available ratio. According to

[2]Audited payments for the period August 1, 2000, through December 31, 2002, totaled $12,491,797, including $7,164,566 in outlier payments and $5,327,231 in OPPS per diem payments.

TrailBlazer, it was unable to extensively review and verify the cost-to-charge ratio because of the limited timeframe for complying with the revised OPPS instructions issued in 2000. TrailBlazer suggested that we note the establishment of the correct cost-to-charge ratio as of April 30, 2003.

In addition, TrailBlazer stated that we did not accurately present the improper outlier payments for services provided after CMS changed the payment methodology effective April 1, 2002. TrailBlazer said that our report should also state that the outlier payments were correctly calculated and paid during the period May 1 through December 31, 2003.

TrailBlazer stated that it would calculate the amount of the overpayments related to the outlier payments and seek recovery from Quitman unless CMS directed otherwise.

Office of Inspector General's Response

CMS revised the outlier payment computation from an aggregate claim basis to an individual service basis effective April 1, 2002. We could not recalculate the outlier payments made after April 2002 on an individual service basis because of software limitations. Therefore, we used the aggregate method and compared our recalculated payments with the amounts on the PS&R reports. The difference in the amounts of outlier payments made after April 2002 using the aggregate claim methodology versus the individual service basis was immaterial.

We recalculated the outlier payments using the cost-to-charge ratio from the final cost report for FY 1997. If TrailBlazer had used the proper cost-to-charge ratio, no outlier payments would have been paid. Because the entire amount of outlier payments was improper, we based the questioned costs on the outlier payments from the Standard Analytical File. We discussed our approach with TrailBlazer during the audit and explained how we determined that using one methodology over the other did not have a material impact on the calculation of outlier payments. TrailBlazer did not accept the invitation to recalculate the outlier payments for inclusion in our report.

As TrailBlazer requested, we have amended our final report to acknowledge that TrailBlazer correctly computed outlier payments for the period May 1 through December 31, 2003. Although TrailBlazer stated that we incorrectly used the methodology in effect before April 1, 2002, to determine outlier payments, we used the same methodology (the aggregate claim) to verify that TrailBlazer's outlier payments made between May 1 and December 31, 2003, were correct.

Internal Controls

TrailBlazer's Comments

TrailBlazer stated that internal controls to ensure that future outlier payments are computed with the correct cost-to-charge ratio were already in place. TrailBlazer identified several organizational and operational changes that it had undertaken to improve quality and strengthen internal controls.

TrailBlazer stated that our report should acknowledge the establishment of adequate internal controls by April 2003. According to TrailBlazer, the report did not cite any findings relating to incorrectly calculated cost-to-charge ratios after CMS required the fiscal intermediaries to update the cost-to-charge ratios on an ongoing basis effective April 2003.

Office of Inspector General's Response

We acknowledge that TrailBlazer has taken corrective actions to strengthen internal controls. However, internal control weaknesses related to CMHC outlier payments continue.

This audit is part of a nationwide audit of outlier payments to CMHCs. As part of this nationwide audit, we assessed whether the fiscal intermediaries, including TrailBlazer, adhered to Medicare rules and regulations on calculating outlier payments. Although TrailBlazer is correct that we noted no errors at Quitman for the period April 30 through December 31, 2003, we continue to believe that further internal control improvements are needed for the following reasons:

- TrailBlazer did not update the cost-to-charge ratios subsequent to April 30, 2003, for 3 of 10 providers within the timeframes that CMS required.

- TrailBlazer did not have any written policies and procedures to ensure that the cost-to-charge ratios were updated.

We intend to issue to CMS a report on all of our findings related to the nationwide audit of outlier payments to CMHCs.

APPENDIXES

APPENDIX A

OUTLIER COMPUTATION EXAMPLES

The following table illustrates the impact of using the incorrect cost-to-charge ratio in the outlier payment computation for two claims. Using the correct ratio, we determined that the outlier payments of $6,190.55 and $4,769.77, respectively, should have been zero.

	A	B	C	D	E	F	G
	Billed Charges Per Provider Statistical and Reim-bursement Report (PS&R)	**Cost-to-Charge Ratio**	**Conversion Factor**[1]	**Charges Converted to Cost** (A x B x C)	**Outpatient Prospective Payment System Ambulatory Procedure Classification (APC) Payment** Per PS&R	**Threshold (APC Payment Times Rate)** (E x 2.5^2)	**Outlier Payment (Percentage of Amount Exceeding Threshold)** (0.75^2 x [D - F])
Paid Claim 1 With Dates of Service December 1-28, 2001	$19,300	0.925	0.981956	$17,530.37	$3,710.52	$9,276.30	$6,190.55
Office of Inspector General Calculation	$19,300	0.283	0.981956	$5,363.35	$3,710.52	$9,276.30	$0
Overpayment on Claim 1							**$6,190.55**

						(E x 3.5^3)	(0.50^3 x [D - F])
Paid Claim 2 With Dates of Service September 6-30, 2002	$22,500	0.925	0.981956	$20,436.96	$3,113.55	$10,897.43	$4,769.77
Office of Inspector General Calculation	$22,500	0.283	0.981956	$6,252.61	$3,113.55	$10,897.43	$0
Overpayment on Claim 2							**$4,769.77**

[1]TrailBlazer places a conversion factor of 0.981956 in the outlier calculation in accordance with the Medicare Claims Processing Manual (CMS Publication 100-04), section 50.5.

[2]The threshold rate of 2.5 and outlier payment percentage of 0.75 were in effect for dates of service from December 1 to December 28, 2001, for paid claim 1.

[3]The threshold rate of 3.5 and outlier payment percentage of 0.50 were in effect for dates of service from September 6 to September 30, 2002, for paid claim 2.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE

Part A Intermediary
Part B Carrier

May 13, 2005

Mr. James P. Aasmundstad
Regional Inspector General for Audit Services
Department of Health & Human Services, Region VII
601 East 12th Street, Room 284A
Kansas City, MO 64106

RE: Medicare Intermediary Response to Draft Report Entitled
"Audit of Outlier Payments to Clinic Resources Management, Inc. Community Mental Health Center for Partial Hospitalization Services for the Period of August 1, 2000 through December 31, 2003"
Report Number A-07-04-04045

Dear Mr. Aasmundstad:

In response to the Department of Health and Human Services, Office of Inspector General (OIG), draft report entitled, "Audit of Outlier Payments to Clinic Resources Management, Inc. Community Mental Health Center for Partial Hospitalization Services for the Period of August 1, 2000 through December 31, 2003" (OIG report), we submit the following comments.

Establishment of Cost-to-Charge Ratio

As stated in the OIG report, CMS issued Program Memorandum A-00-63 (Change Request 1310) - "Cost-to-Charge Ratios (CCRs) for Calculating Certain Payments Under the Hospital Outpatient Payment System (OPD PPS)" on September 8, 2000. These instructions were retroactively effective on August 1, 2000 (the effective date of the OPD PPS), and were required to be implemented by September 8, 2000, the same date the instructions were published. In early August 2000, CMS issued a draft of Change Request (CR) 1310 to Medicare contractors for review and comment. However, the distribution of this document was not complete and CMS reissued the draft on August 11, 2000. The draft instructions indicated an effective date of August 1, 2000, and were to be implemented by August 14, 2000. Because of delays in implementing various provisions of OPD PPS, CMS requested emergency clearance of this Change Request in order that Fiscal Intermediaries could properly communicate this critical information to the provider community in a timely manner. The final version of CR 1310 did not change the method for calculating the cost-to-charge ratio for Community Mental Health Centers (CMHCs).

Because of the very short timeframe in which to determine the CCR for all affected providers, including CMHCs, TrailBlazer compiled the necessary data and determined a CCR of 0.925 for Clinic Resources Management, Inc. based on instructions in the draft CR 1310. The draft CR required that fiscal year 1997 cost reports be used to calculate the CCR. We based our determination on the Tentative Settlement issued for the FYE 12/31/97 cost report because this was the most current data available at the time of the calculation.

The OIG report is correct in noting that the final settlement for the FYE 12/31/97 cost report for Clinic Resources Management, Inc. was issued on September 6, 2000, two days before the September 8, 2000 required implementation date of Program Memorandum A-00-63 (CR 1310). The OIG report is also correct in noting that the CCR based on the final settled cost report is 0.283. As previously noted, the

published date and the implementation date of PM A-00-63 (CR 1310) were the same. Because of the requirement to immediately implement this Program Memorandum upon receipt, it was not possible to perform extensive review and verification of the cost-to-charge ratios previously calculated for the approximately 600 hospital and CMHC providers served by TrailBlazer and still meet CMS expectations to implement PM A-00-63 (CR 1310) in a timely manner. As a result, the CCR based on the final settlement of the FYE 12/31/97 cost report was not used for purposes of determining outlier payments.

On January 17, 2003, CMS issued Program Memorandum A-03-004 (CR 2197) – "Calculating Provider-Specific Medicare Outpatient Cost-to-Charge Ratios (CCRs) and Instructions on Cost Report Treatment of Hospital Services Paid on a Reasonable Cost Basis". These instructions require that Fiscal Intermediaries (FIs) recalculate and update the provider's CCR on an ongoing basis, as more recent full year cost reports are available. TrailBlazer implemented the provisions of PM A-03-004 in a timely manner by updating all affected provider CCRs by April 30, 2003. In the case of Clinic Resources Management, Inc., the CCR was changed to 0.292, effective April 30, 2003, based on the final settled cost report for FYE 12/31/98. The CCR has been periodically updated since that time in accordance with CMS instructions. Other than the initial CCR, the OIG report cites no other findings regarding the accuracy of the cost-to-charge ratio.

In order to fully and objectively reflect the results of this audit, which covered the entire August 1, 2000 through December 31, 2003 timeframe, the OIG report should acknowledge appropriate establishment of the CCR effective April 30, 2003. The OIG report should also state the fact that the outlier payments were correctly calculated and paid during the May 1, 2003 through December 31, 2003 timeframe.

Improper Calculation of Outlier Payments

The OIG report states that Clinic Resources Management, Inc. should have received no outlier payments relating to services rendered between August 1, 2000 and December 31, 2003, and that outlier payments of $8,802,649 should be recovered from the provider. Although they recognized the change in methodology for determining outlier payments that were effective April 1, 2002, the OIG recalculation of outlier payments was based on the methodology used prior to this date. CMS published Program Memorandum A-02-026 (CR 2102) – "2002 Update of the Hospital Outpatient Prospective Payment System (OPPS)", on March 28, 2002, changing the manner in which outlier payments are calculated. Based on this program memorandum, effective April 1, 2002, outlier payments are calculated based on each individual Outpatient Prospective Payment System (OPPS) service that appears on a claim. Prior to April 1, 2002, outlier payments were calculated in aggregate for all OPPS services that appeared on the claim. Based on the difference in the method utilized in calculating the outlier payment and correction of the CCR utilized in the OIG report, we believe the improper outlier payments cited in the OIG report are not accurately presented. Additionally, we believe that any outlier payments determined subsequent to the implementation of PM A-03-004 on April 30, 2003 were proper, as the CCR was appropriately updated from that date forward.

In order to fully and objectively reflect the results of this audit, which covered the August 1, 2000 through December 31, 2003 timeframe, the OIG report should state the fact that the outlier payments were correctly calculated and paid during the May 1, 2003 through December 31, 2003 timeframe.

Current CMS instructions do not make provision for retroactive corrections for changes in the CCR due to errors or for any other reason. In Program Memorandum A-00-63, provision is made for adjustments to the cost-to-charge ratio in only very limited situations. According to these instructions, only hospital providers could request a recalculation of their CCR. The instructions state, "When CCRs are recalculated under these criteria, they are to be applied prospectively only." Additionally, in Program Memorandum A-03-004, CMS instructions state "revised CCRs will be applied prospectively for

purposes of calculating outlier payments". Therefore, from the beginning of the OPD OPPS, changes in the CCR have only been applied on a prospective basis. In order to determine the outlier payments Clinic Resources Management, Inc. would receive based on the OIG findings, it will be necessary to reprocess the claims paid for the period between August 1, 2000 and April 30, 2003. However, based on the directive contained in the OIG report, TrailBlazer will calculate the amount of overpayment relating to outlier payments and seek to make recovery from the provider unless CMS directs TrailBlazer to take a different course of action.

Internal Controls

The OIG report recommends that "TrailBlazer implement internal controls to ensure that future outlier payments are computed with the correct cost-to-charge ratio". These internal controls are already in place. As noted previously, the cost-to-charge ratios for Clinic Resources Management, Inc. have been correctly calculated and updated in accordance with PM A-03-004 (CR 2197), and outlier payments have been properly paid for services provided on or after April 30, 2003. The OIG report should acknowledge the establishment of internal controls by April 2003, and should also state that no errors were noted regarding the CCRs calculated during the time period from May 1, 2003 through December 31, 2003.

Evidence of the implementation of these internal controls are supported by actions TrailBlazer has taken since August 2000. Since that time, we have initiated several organizational and operational changes to improve quality and strengthen internal controls. These changes included the following:

1. Beginning in October 2000, the Provider Audit and Reimbursement Division was reorganized, changing from a function-based organizational structure to a provider based organizational structure. This reorganization eliminated function-based departments, such as the Administrative Controls Department responsible for determining the CCRs, and transitioned these functions into Home Office Teams (HOTs). In so doing, the oversight responsibility for functions such as determining CCRs shifted from a single Department Director, to a combination of HOT Directors, Senior Review Specialists, and Reimbursement Support Supervisors. These individuals are responsible for reviewing and verifying the accuracy of the CCR determinations and ensuring the CCR is properly posted to the Fiscal Intermediary Shared System (FISS) to see that claims are properly paid. This increased supervision, oversight and review have assisted in reducing the likelihood that errors will go undetected.

2. Beginning in August 2000, our Training and Quality Support (TQS) Department staff was assigned to re-write and/or develop procedures and policies relating to the functional activities undertaken within the Provider Audit and Reimbursement Division. The Division policies and procedures are available electronically for access by all staff. They are reviewed and updated, as necessary, on an ongoing basis.

3. Since our Division reorganization and revision or development of new Division policies and procedures, extensive staff training has taken place. This training helps ensure that Division policies and procedures are understood and followed.

4. Testing of internal controls has been enhanced. Trailblazer TQS staff perform periodic reviews of the various functional activities performed by the HOTs. Where deficiencies are identified, corrective actions, including further refinement of policies and procedures, are implemented.

5. Division oversight of the CMS Change Management publications has also been assigned to the TQS staff. This includes ensuring that CMS promulgated memoranda, transmittals, and regulations have been properly implemented in a timely and accurate manner.

With the above changes, we believe TrailBlazer currently has adequate internal controls in place to ensure that the CCRs used to determine outlier payments under OPPS are properly made. As evidence of the improvements made, the most recent SAS 70 Audit, covering the period October 1, 2003 to June 4, 2004, resulted in no deficiencies relating to the operating effectiveness of controls in the Provider Audit and Reimbursement Division. Furthermore, the OIG report did not cite any findings relating to incorrectly calculated CCRs subsequent to implementation of Program Memorandum A-03-004, which requires an update of the CCR on an on-going basis.

Other Matters

The OIG report also makes reference to a previous medical review audit involving Clinic Resources Management, Inc. (Quitman Clinic). This OIG audit report, "Medical Review of Quitman Clinic's Partial Hospitalization Services for the Period August 1, 2000 Through December 31, 2002" (A-07-04-04034), issued March 4, 2005, recommends that the provider repay $12,491,797 relating to unallowable services. The recovery amount from the medical review audit includes $7,164,566 of outlier payments. Resolution of both OIG audits and collection of the calculated overpayments will require concurrence from CMS.

Please feel free to contact me regarding any questions or comments associated with our response to the OIG report findings and recommendations.

Sincerely,

Neil Milbrandt

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