DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Memorandum

Date JUN 18 2001

From Thomas D. Roslewicz
Deputy Inspector General
for Audit Services

Subject Review of Medicare Outlier Payments at Roger Williams Medical Center for Fiscal Year 1999 (A-01-01-00517)

To Neil Donovan
Director, Audit Liaison Staff
Health Care Financing Administration

This is to alert you to the issuance on Wednesday, June 20, 2001 of our final report entitled, "Review of Medicare Outlier Payments at Roger Williams Medical Center for Fiscal Year 1999." A copy is attached.

We suggest you share this report with the Health Care Financing Administration components involved with program integrity, provider issues, and contractor oversight, particularly the Office of Financial Management, the Center for Beneficiary Services, and the Center for Health Plans and Policy.

The objective of the review was to determine whether hospital outlier payments were reimbursed in accordance with Medicare laws and regulations. Our review focused on outlier payments to Roger Williams Medical Center (RWMC) during Fiscal Year (FY) 1999.

We found that outlier payments to RWMC went from $880,029 in FY 1998 to $4.3 million in FY 1999, an increase of 395 percent. Further, our analysis disclosed that RWMC received significant incorrect outlier payments in FY 1999 because the inpatient operating cost-to-charge ratio used to calculate the payments was incorrect. In this respect, we found a clerical error on the hospital's FY 1996 cost report that was not identified by the hospital or by Blue Cross Blue Shield of Rhode Island, the fiscal intermediary (FI), during its review of the cost report. As a result, the FI calculated an incorrect FY 1999 inpatient operating cost-to-charge ratio, which had a significant impact on the amount of RWMC's outlier payments. Specifically, we estimate that the hospital received a $3.1 million overpayment based on the 260 FY 1999 outlier claims identified in our review period.

We have recommended that RWMC repay the overpayment related to its FY 1999 outlier payments. Further, we recommended that the hospital strengthen its controls to prevent future outlier overpayments. In its response to the draft report, RWMC concurred with our findings and recommendations.

If you have any questions, please contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104 or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE OUTLIER PAYMENTS AT ROGER WILLIAMS MEDICAL CENTER FOR FISCAL YEAR 1999

JUNE 2001
A-01-01-00517

DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services
Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203
(617) 565-2684

CIN: A-01-01-00517

Mr. Robert A. Urciuoli
President and CEO
Roger Williams Medical Center
825 Chalkstone Avenue
Providence, Rhode Island 02908

Dear Mr. Urciuoli:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services (OAS) report entitled, "Review of Medicare Outlier Payments at Roger Williams Medical Center for Fiscal Year 1999." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will made by the HHS action official named below. 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 (Public Law 90-23), OIG, OAS reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR part 5.)

To facilitate identification, please refer to Common Identification Number A-01-01-00517 in all correspondence relating to this report.

Sincerely,

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

George Jacobs
Regional Administrator
Health Care Financing Administration – Region I
U.S. Department of Health and Human Services
Room 2325
J.F.K. Federal Building
Boston, Massachusetts 02203

EXECUTIVE SUMMARY

Background

Under Medicare's prospective payment system, fiscal intermediaries (FI) reimburse hospitals a predetermined amount for inpatient services furnished to program beneficiaries depending on the illness and its classification under a diagnosis related group (DRG). An additional payment is made for atypical cases that generate extremely high costs when compared to most discharges in the same DRG. The charges associated with a discharge are adjusted to cost using a cost-to-charge ratio. The FIs calculate the cost-to-charge ratios using a hospital's latest available settled cost report and charge data for the same period as that covered by the cost report. Cost-to-charge ratios have a major impact on the calculation of a hospital's Medicare outlier payments; the larger a hospital's cost-to-charge ratio, the greater the outlier payment for a qualifying discharge.

Objective

The objective of our review was to determine whether hospital outlier payments were reimbursed in accordance with Medicare laws and regulations. Our review focused on outlier payments to Roger Williams Medical Center (RWMC) during Fiscal Year (FY) 1999.

Results of Review

We found that outlier payments to RWMC went from $880,029 in FY 1998 to $4.3 million in FY 1999, an increase of 395 percent. Further, our analysis disclosed that RWMC received additional outlier payments in FY 1999 because the inpatient operating cost-to-charge ratio used to calculate the payments was incorrect. In this respect, we found a clerical error on the hospital's FY 1996 cost report that was not identified by the hospital or by Blue Cross Blue Shield of Rhode Island, the FI, during its review of the cost report. As a result, the FI calculated an incorrect FY 1999 inpatient operating cost-to-charge ratio, which had a significant impact on RWMC's outlier payments. Specifically, we estimate that the hospital received a $3.1 million overpayment based on the 260 FY 1999 outlier claims identified in our review period.

Recommendations

We have recommended that RWMC repay the overpayment related to its FY 1999 outlier payments. Further, we recommended that the hospital strengthen its controls to prevent future outlier overpayments.

The draft report was issued on April 11, 2001 to RWMC for comment. In response to the draft report, RWMC concurred with our findings and recommendations.

INTRODUCTION

BACKGROUND

The Medicare program, established by Title XVIII of the Social Security Act provides health insurance coverage to people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by the Health Care Financing Administration (HCFA). Under Medicare's prospective payment system, fiscal intermediaries (FI) reimburse hospitals a predetermined amount for inpatient services furnished to program beneficiaries depending on the illness and its classification under a diagnosis related group (DRG).

Section 1886(d)(5)(A) of the Social Security Act requires the Medicare program to pay an additional amount beyond the basic DRG payment for outlier cases. Outliers are those cases that have extraordinarily high costs when compared to most discharges classified in the same DRG. According to 42 CFR 412.80(a)(2), to qualify as a cost outlier, a hospital's charges for a discharge, adjusted to cost, must exceed the payment rate for the DRG by a fixed dollar amount, adjusted for geographic variation in costs. In Fiscal Year (FY) 1999, the fixed dollar amount established by HCFA was $11,100.

Charges are adjusted to cost using a cost-to-charge ratio. The 42 CFR 412.84 requires that FIs base the operating and capital costs of a discharge on the billed charges for covered inpatient services adjusted by the cost-to-charge ratios applicable to operating and capital costs. The operating and capital cost-to-charge ratios are computed by the FIs annually for each hospital based on the latest available settled cost report for that hospital and charge data for the same period as that covered by the cost report.

Thus, the cost-to-charge ratios have a major impact on the calculation of a hospital's Medicare outlier payments. The larger a hospital's cost-to-charge ratio, the greater the costs associated with a discharge. Consequently, the larger the difference between costs and the threshold amounts, the greater the outlier payment for a qualifying discharge.

The Roger Williams Medical Center (RWMC) is an acute care hospital located in Providence, Rhode Island. We found that outlier payments to the hospital went from $880,029 in FY 1998 to $4.3 million in FY 1999, an increase of 395 percent. Outlier payments made to RWMC in FY 1999 were based on cost-to-charge data derived from the hospital's FY 1996 settled cost report.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our review was conducted in accordance with generally accepted government auditing standards. The objective of our review was to determine whether hospital outlier payments were reimbursed in accordance with Medicare laws and regulations. Our review focused on outlier payments to RWMC during FY 1999.

To accomplish our objective, we:

- Used HCFA's National Claims History file to identify outlier payments made to RWMC during FY 1999. In FY 1999, Medicare reimbursed RWMC for 260 outlier claims representing total billed charges of $12.2 million, total payments of $8.3 million, and outlier payments of $4.3 million.

- Analyzed the hospital's inpatient operating cost-to-charge ratios for FYs 1998 through 2001.

- Reviewed the FI's calculation of, and supporting documentation for, the inpatient operating cost-to-charge ratio used to calculate RWMC's FY 1999 outlier payments. Our review of supporting documentation included examination of pertinent worksheets from the hospital's FY 1996 Medicare cost report.

- Analyzed RWMC's Provider Statistical and Reimbursement (PS&R) data for FYs 1995 through 1999.

Our planned approach also included a review of a sample of judgementally selected outlier claims by the Rhode Island peer review organization and the Office of Audit Services. However, because of issues identified during our review of the cost-to-charge ratio, and their impact on FY 1999 outlier payments to RWMC, we limited the scope of our audit work to the calculation of the inpatient operating cost-to-charge ratio.

Our review did not require consideration of the hospital's internal control structure. We determined that our audit could be conducted more efficiently by focusing on our review of the calculation of the hospital's inpatient operating cost-to-charge ratio.

We conducted our audit during the period January 2001 through March 2001 at Blue Cross Blue Shield of Rhode Island in Providence, Rhode Island and the Boston regional office of the Inspector General. We also met with hospital officials at Blue Cross Blue Shield of Rhode Island in February 2001.

The draft report was issued to RWMC on April 11, 2001. The RWMC's written comments, dated May 7, 2001, are summarized on page 5 and appended in their entirety to this report (see APPENDIX A).

FINDINGS AND RECOMMENDATIONS

Our review found that RWMC received additional outlier payments of about $3.1 million in FY 1999 because the inpatient operating cost-to-charge ratio used to calculate the payments was incorrect. We found a clerical error on the hospital's FY 1996 cost report that was not identified by the hospital or by Blue Cross Blue Shield of Rhode Island, the FI, during its review of the

cost report. As a result, the FI calculated an incorrect FY 1999 inpatient operating cost-to-charge ratio, which resulted in a significant payment error to the hospital.

Payments to hospitals for cost outlier cases are based on a complex calculation. A hospital's cost-to-charge ratio is a significant factor in the calculation. Below, we discuss our analysis of RWMC's historical cost outlier data, our review of the development of the hospital's FY 1999 inpatient operating cost-to-charge ratio, and the effect of the inpatient operating cost-to-charge ratio on RWMC's FY 1999 outlier claims.

Analysis of Cost Outlier Data

Our analysis of HCFA's payment data showed that outlier payments to RWMC went from $880,029 in FY 1998 to $4.3 million in FY 1999, an increase of 395 percent. Outlier payments made to RWMC in FY 1999 were based on cost-to-charge data derived from the hospital's FY 1996 cost report. Further, analysis of RWMC's inpatient operating cost-to-charge ratio for the last several years found the FY 1999 ratio of 0.993 was significantly higher than the FY 1998 ratio of 0.617, the FY 2000 ratio of 0.616, and the FY 2001 ratio of 0.587.

Development of the Inpatient Operating Cost-to-Charge Ratio

We reviewed the FI's calculation of the inpatient operating cost-to-charge ratio used to calculate RWMC's FY 1999 outlier payments. According to the supporting documentation for the calculation, RWMC reported $151,957 in inpatient routine charges on its FY 1996 cost report. Inpatient routine services are generally those services included by the hospital in a daily service charge--sometimes referred to as the "room and board" charge. The $151,957 inpatient routine charges were used by the FI to calculate a FY 1999 operating cost-to-charge ratio of 0.993. Our review of PS&R data for FYs 1995 through 1999 found that charges for inpatient routine services at RWMC ranged from $16.7 million in FY 1995 to $14.6 million in FY 1999. While we would anticipate differences in charges from year to year, and between charges recorded in the PS&R system and on the cost report (because of timing differences), the $151,957 inpatient routine charges appeared to be an error.

We presented our analyses of the cost-to-charge ratios and inpatient routine charges to Blue Cross Blue Shield of Rhode Island, the FI. According to the FI, inpatient routine charges of $15,452,275 should have been used to calculate RWMC's FY 1999 operating cost-to-charge ratio. Using the correct inpatient routine charges, the FI has recalculated the FY 1999 operating cost-to-charge ratio as 0.588.

	Original Calculation	Revised Calculation	Difference
Total Costs	$22,088,961	$22,088,961	$ 0
Routine Charges	$ 151,957	$15,452,275	$15,300,318
Ancillary Charges	22,102,908	22,102,908	0
Total Charges	$22,254,865	$37,555,183	$15,300,318
Cost-to-Charge Ratio	0.993	0.588	0.405

Effect of Inpatient Operating Cost-to-Charge Ratio

The cost-to-charge ratio has a major impact on a hospital's Medicare outlier payments; the larger the cost-to-charge ratio used to compute the payment, the greater the outlier payment for a qualifying case. Therefore, it is essential that the amounts used to calculate the cost-to-charge ratio in accordance with Medicare regulations, are accurate. For example:

> The hospital received an outlier payment for a FY 1999 discharge involving an inpatient admission for DRG 478 (Other Vascular Procedures). Using the original FY 1999 operating cost-to-charge ratio of 0.993, an outlier payment of $7,765 was made for this discharge. We recalculated the payment using the correct cost-to-charge ratio of 0.588 and found that this discharge no longer qualified as an outlier because costs did not exceed the cost outlier threshold.

> The hospital received an outlier payment for a FY 1999 discharge involving an inpatient admission for DRG 473 (Acute Leukemia). Using the original FY 1999 operating cost-to-charge ratio of 0.993, an outlier payment of $39,021 was made for this discharge. We recalculated the payment using the correct cost-to-charge ratio of 0.588 and found the outlier payment should have been $14,261.

Based on our preliminary analysis and discussions with the FI to date, we believe that RWMC received an overpayment of about $3.1 million based on the 260 FY 1999 outlier claims identified through HCFA's National Claims History file. It is our understanding that HCFA has requested that all of RWMC's outlier claims with dates of discharge in FY 1999 be reprocessed. Therefore, the exact amount of the overpayment may vary once the reprocessing has been completed.

RECOMMENDATIONS

We have recommended that RWMC:

- Repay the overpayment related to its FY 1999 outlier payments (estimated at $3.1 million).
- Establish independent checks and supervisory review of cost reports for clerical and/or input errors and inconsistencies.
- On an annual basis, perform a comparative analysis of provider statistical data (i.e., cost-to-charge ratios) used to determine Medicare payments for the current and prior years and identify any aberrations. Determine the reason for any unusual changes and take corrective action, if necessary.

- Perform a similar analysis for the actual level of Medicare payments (i.e., outlier payments) made to the hospital.

In addition, we recommended that the FI[1]:

- Perform consistency checks to identify clerical and/or input errors when auditing provider's cost reports.

- On an annual basis perform a comparative analysis of provider statistical data (i.e., cost-to-charge ratios) used to calculate Medicare payments for the current and prior years and identify any aberrations. Determine the reason for any unusual changes and take corrective action, if necessary.

- Perform a similar analysis for the actual level of Medicare payments (i.e., outlier payments) made to providers.

RWMC's COMMENTS

The RWMC concurred with our findings and recommendations. In its response, the hospital acknowledged that a comparison of FY 1999's cost-to-charge ratio and outlier payments with those of prior years would have indicated a problem. However, RWMC experienced significant turnover of its financial service staff during FYs 1999 and 2000, resulting in "very little historical perspective of the reasonableness of the outlier payments." The hospital noted that the FI performed an on-site audit of RWMC's FY 1996 cost report, as well as an additional review in connection with the re-opening of the cost report for other issues. Neither of these reviews identified the clerical error on the FY 1996 cost report and the hospital presumed the operating cost-to-charge ratio calculated by the FI was correct. According to the hospital's response, upon receipt of the FY 1999 PS&R data, RWMC's Reimbursement Manager questioned the calculation of outlier payments. The Reimbursement Manager received confirmation from the FI that payments for three sample patients tested were calculated correctly. The full text of RWMC's comments are included as APPENDIX A to this report.

The FI agreed with our recommendations. The full text of their comments are included as APPENDIX B to this report.

[1]Our recommendations to the FI were not included in our draft report. We addressed these recommendations in a separate letter to Blue Cross Blue Shield of Rhode Island.

Roger Williams Medical Center

Roger Williams Hospital

825 Chalkstone Avenue
Providence
Rhode Island 02908-4735
(401) 456-2000

Robert A. Urciuoli
President & CEO

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REGION I

May 7, 2001

Michael J Armstrong
Regional Inspector General for Audit Services
Office of the Inspector General, Office of Audit Services
John F. Kennedy Federal Building, Room 2425
Boston, MA. 02203
Re: CIN: A-01-01-00517

Dear Mr. Armstrong:

After review and discussion with my staff, I am in agreement, in all material respects, with your draft letter addressed to me dated April 11, 2001.

I believe that the following comments are relevant in evaluating and understanding why the error in calculating outlier payments occurred and went undetected.

- RWMC had undergone an almost complete turnover of its financial service staff during the FY1999/2000. This resulted in very little historical perspective of the reasonableness of the outlier payments.
- The clerical error on the FY1996 cost report went undetected through a full field audit by the FI, RIBCBS, prior to being settled. Also the FI completed an additional review after re-opening the cost report for other issues.
- The Hospital internal coding system used to project outlier payments was based on the incorrect RCC from the base period cost report. Since this information had been audited by the FI it was presumed to be accurate.
- The outlier payments are made on an individual claim basis and the total impact is only reflected on the year-end PS&R report. The PS&R report has been inaccurate at times and often not timely completed.
- Despite the above, the Reimbursement Manager did question the calculation of the outlier payments after receiving the FY 1999 PS&R data. He received back from the FI confirmation that the payments were correct for three sampled patients. Find this correspondence attached.
- The Hospital was unaware of the overpayment until notified by the FI of the OIG's analysis reflecting the significant increase compared to prior years.
- In retrospect an annual comparison of the RCC rates from prior years should have clearly indicated there was a problem with the RCC used in the calculation of the outlier payment. Similarly, a simple comparison of outlier payments on the cost report should have raised issues regarding the reasonableness of the outlier number in fiscal year 1999 as compared to

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other years. Unfortunately, neither the hospital nor the FI made these comparisons and the error went undetected.

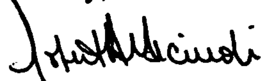
The Hospital will implement the following steps to rectify this situation and to prevent similar problems in the future.

- Based on a schedule of repayments agreed to with the Office of the Inspector General and the local FI, the Hospital will repay the overpayments made for the 1999 outliers.
- The reimbursement manager will complete a quarterly review of patients with outlier payments to validate the actual outlier payment calculation.
- The assistant controller will complete a supervisory review of cost reports for the purpose of identifying any significant errors or inconsistencies in the cost reports. A written report will be provided to the controller summarizing the review and identifying discrepancies if any.
- The reimbursement manager will complete a comparative analysis of statistical data used to determine Medicare payments for the current and prior years and identify any aberrations. The reimbursement manager will identify and resolve any unusual changes. The assistant controller will review these findings and a written report will be provided to the controller summarizing the review and identifying discrepancies if any.
- The assistant controller will review actual payments made to the hospital by Medicare. The assistant controller will identify and resolve any unusual variances in such payments. A written report will be provided to the controller summarizing the review and identifying discrepancies if any.
- The controller will submit a summary report of the review of the cost reports, statistical data, and Medicare payments to the CFO and me within 30 days of the filing of the annual cost report.

I appreciate the professional manner in which your investigation was completed.

If you have any questions, please call, our controller, Joe Hanley, at 401-456-2418 or me at 401-456-2025.

Sincerely,



Robert A. Urciuoli
President

cc: John Schibler
Kim O'Connell
Joe Hanley
George Curtis
BLUE CROSS/BLUE SHIELD

HCFA
Health Care Financing Administration

MEDICARE
Part A Intermediary
Part B Carrier
(401) 459-1000

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REGION I

May 10, 2001

CIN: A-01-01-00517

Mr. Michael J. Armstrong
Office of Audit Services
Regional Inspector General for Audit Services
Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203

Dear Mr. Armstrong:

As a result of your April 11th 2001 draft, regarding the Outlier payment issue at the Roger Williams Medical Center, we have implemented the following corrective action procedures:

1. All of the calculations in the future will have supervisory review focusing on consistency checks on all clerical input data.
2. RCC's will be compared on an annual basis to prior year calculations, and all aberrations will be researched and corrective action taken, if necessary.
3. An annual comparison of Medicare Outlier payments will also be performed by our staff to insure consistency.

Additionally, we have decided to implement the following steps in all of our future Outlier calculations:

1. Insure that all of the testing procedures include Outlier claims. This will highlight any aberrant Outlier payment when compared to the payment under the prior year RCC.
2. Insist on a response from the provider verifying the accuracy of the calculated RCC and Outlier payments identified on the PS&R.

Blue Cross & Blue Shield of Rhode Island
444 Westminster Street • Providence, RI 02903-3279
A HCFA CONTRACTED CARRIER AND INTERMEDIARY

Our expectation is that these corrective measures will prevent a similar situation from occurring in the future.

If you have any further questions or comments on our preventive measures, please contact me at 401-459-1403.

Sincerely,

Henry P. Lourenco
Administrator
Medicare Audit & Reimbursement

HPL/jmc

cc: G. Jacobs, Regional Administrator, Health Care Financing Administration