DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date MAR 10 1995

From June Gibbs Brown
Inspector General

Subject Review of Hospital Outlier Payments Under the Medicare Program - Blue Cross of Rhode Island (A-01-94-00519)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum alerts you to the issuance on March 14, 1995 of our final audit report. A copy is attached.

BACKGROUND

Under Medicare's prospective payment system, fiscal intermediaries (FI) reimburse hospitals a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a diagnosis related group (DRG). Furthermore, inpatient stays which are extremely long or have extraordinarily high costs are eligible for an additional payment called an outlier payment. Outlier payments are paid using two payment methodologies, day outlier and cost outlier. For day outliers, payment is based on an average per diem amount per DRG. For cost outliers, payment is based on the hospital specific cost of providing care or, under certain circumstances, on average statewide cost data.

OBJECTIVE

The objective of our review was to determine if Blue Cross of Rhode Island, the FI, correctly calculated outlier payments. The period covered by our review is Fiscal Years 1992 through 1994.

RESULTS

The FI properly calculated and reimbursed hospital day outlier payments for qualifying inpatient stays. The FI, however, made cost outlier payments to Rhode Island hospitals using average statewide data when the FI should have used the hospital specific data. Medicare regulations require the use of hospital specific data if reasonable when compared to the Health Care Financing Administration's established parameters. If the hospital specific data is determined to be unreasonable, statewide data may be used. As a result of inappropriately using statewide data, overpayments were made on cost outlier payments.

We conducted a detailed review of 2 Rhode Island hospitals which received approximately 50 percent of the outlier payments made to 12 Rhode Island hospitals. Based on our analysis of all 301 cost outlier payments made to these 2 hospitals for the 3-year period under review, the 2 hospitals were overpaid almost $2 million because the statewide data was used rather than the hospital specific data. These overpayments occurred because the FI misunderstood the Medicare regulations governing cost outlier payments.

In addition, we noted a type of billing error at one Rhode Island hospital which caused certain inpatient claims to inappropriately qualify for an outlier payment. Specifically, the decimal point on the room and board charges was misplaced, i.e., a $525.00 charge became a $52,500.00 charge. In our opinion, the claims processing system should have identified these charges as being unreasonable and suspended these claims. Although the FI manually identified the billing problem and corrected most claims prior to reimbursement, three claims were not detected and resulted in over $660,000 in cost outlier payments to this hospital.

RECOMMENDATIONS

We are recommending that the FI: (1) ensure that the appropriate data is used in determining cost outlier payments; (2) make the necessary adjustments to the cost reports of the two hospitals reviewed in detail to recoup the overpayments (almost $2 million); (3) recoup the overpayments, if cost-effective, at the remaining Rhode Island hospitals; (4) ensure the cost outlier payments associated with three claims are recouped (over $660,000); and (5) consider implementing a system edit to identify unreasonable charges.

In response to the draft report, the FI concurred with the findings. The FI is in the process of reviewing our data for determining the exact amount of the overpayment for the two hospitals. The FI has also indicated that it will review the cost-effectiveness of recouping overpayments at the remaining Rhode Island hospitals. With respect to the incorrect billing problem, the FI indicates that this issue remains unresolved; however, in our meeting with the FI, there was agreement that the three outlier payments need to be recouped.

For further information, contact:

Richard J. Ogden
Regional Inspector General
for Audit Services, Region I
(617) 565-2684

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HOSPITAL OUTLIER PAYMENTS UNDER THE MEDICARE PROGRAM

BLUE CROSS OF RHODE ISLAND

JUNE GIBBS BROWN
Inspector General

MARCH 1995
A-01-94-00519

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

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
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CIN: A-01-94-00519

Mr. Richard Maiorisi
Vice President
Provider Audit Reimbursement
Blue Cross of Rhode Island
444 Westminster Street
Providence, Rhode Island 02903-3279

The purpose of this final report is to provide you with the results of our Review of Outlier Payments. The objective of our review was to determine if Blue Cross of Rhode Island, the fiscal intermediary (FI), correctly calculated outlier payments. The period covered by our review is fiscal years (FY) 1992 through 1994.

Under Medicare's prospective payment system (PPS), fiscal intermediaries (FI) reimburse hospitals a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a diagnosis related group (DRG). Furthermore, inpatient stays which are extremely long or have extraordinarily high costs are eligible for an additional payment called an outlier payment. Outlier payments are paid using two payment methodologies, day outlier and cost outlier. The methodology which yields the highest payment is used. For cost outliers, Medicare regulations require FIs to use a hospital specific ratio of costs-to-charges (RCC) to adjust hospital charges to cost. A statewide RCC is used only in those instances where the FI calculates a hospital specific RCC which falls outside reasonable parameters.

The FI properly calculated and reimbursed hospitals day outlier payments for qualifying inpatient stays. The FI, however, made cost outlier payments to Rhode Island Hospitals using a statewide RCC when it should have used the hospital specific RCC because the hospital specific RCC fell within reasonable parameters. As a result overpayments were made on cost outlier payments where the hospital specific RCC was less than the statewide RCC.

We conducted a detailed review of two Rhode Island hospitals which received approximately 50 percent of the outlier payments made to 12 Rhode Island hospitals. Based on our analysis of all 301 cost outlier payments made to these two hospitals for the 3-year period under review, the two hospitals were overpaid almost $2 million because the statewide RCC was used opposed to the hospital specific RCC. These overpayments occurred because the FI misunderstood the Medicare regulations governing cost outlier payments.

In addition, we noted a type of billing error at Rhode Island Hospital which caused certain inpatient claims to inappropriately qualify for an outlier payment. Specifically, the decimal point on the room and board charges was misplaced, i.e. a $525.00 charge became a $52,500.00 charge. In our opinion, the claims processing system should have identified these charges as being unreasonable and suspended these claims. Although the FI manually identified the billing problem and corrected most claims prior to reimbursement, three claims were not detected and resulted in over $660,000 in cost outlier payments to this hospital.

We are recommending that the FI: (1) ensure that the appropriate RCC is used in determining cost outlier payments; (2) make the necessary adjustments to the cost reports of Miriam Hospital and Rhode Island Hospital to recoup the overpayments (almost $2 million); (3) recoup the overpayments, if cost effective, at the remaining Rhode Island hospitals; (4) ensure the cost outlier payments associated with three claims are recouped (over $660,000); and (5) consider implementing a system edit to identify unreasonable charges.

In response to the draft report, the FI concurred with the findings relative to the RCC. The FI is in the process of reviewing our data for determining the exact amount of the overpayment for the two hospitals. The FI has also indicated that it will review the cost effectiveness of recouping overpayments at the remaining Rhode Island hospitals. With respect to the incorrect billing problem, the FI indicates that this issue remains unresolved; however, in our meeting with the FI, there was agreement that the three outlier payments need to be recouped.

BACKGROUND

The Social Security Amendments of 1983 provided for the establishment of the PPS for Medicare payment of inpatient hospital services. Under PPS, hospitals are paid a predetermined rate per discharge for inpatient hospital services furnished to Medicare beneficiaries. Each type of Medicare discharge is classified according to a list of DRGs.

The DRGs are a patient classification system which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital. Payment for inpatient hospital services is made on the basis of a rate per discharge that varies according to the DRG to which a beneficiary's stay is assigned. These amounts are, with certain exceptions, payment in full to the hospital for inpatient operating costs.

One of the main concerns with the PPS recognized by Congress involves the treatment of cases that are extremely long or extraordinarily costly in relation to other cases within a given DRG, because of the severity of an illness or complicating conditions. Congress was concerned that a hospital would not be adequately compensated for treating such cases under

PPS[1]. As such, Section 1886(d)(5)(A) of the Social Security Act (The Act) requires the Health Care Financing Administration (HCFA) to pay an additional amount beyond the basic prospective payment amount for a hospital inpatient case that involves an extremely long length of stay or extraordinarily high costs when compared to other discharges classified in the same DRG. Such cases are referred to as day outliers and cost outliers, respectively. The purpose of the outlier payment is to protect the hospital from significant financial loss in individual cases.

For day outliers, an additional per diem payment is made for each covered day beyond the day outlier threshold, which is set annually by HCFA. The per diem amount is calculated by dividing the applicable DRG payment amount by the average length-of-stay for the same DRG times the marginal cost of care. For cost outliers, the additional payment represents the marginal cost of providing care beyond the cost outlier threshold, which is also established annually by HCFA. Charges for the additional care are adjusted to cost using a RCC. The cost outlier payment is equal to the excess of the cost over the threshold. Cases which qualify as both day and cost outliers are paid under the methodology which yields the higher payment. Outlier payments are determined by the claims processing systems maintained by the Medicare FIs.

Relative to outlier payments, FIs have several responsibilities. Utilizing the GROUPER and PRICER programs supplied by HCFA, FIs process inpatient claims and make outlier payments when appropriate. The FIs are further responsible to ensure that provider specific files used by these programs are accurate. One specific field needed in determining cost outliers is the RCC. The 42 Code of Federal Regulations (CFR) section 412.84(h) requires the FIs to compute the RCC annually for each hospital based on the latest available settled cost report for that hospital and charge data for the same time period as that covered by the cost report. Statewide RCCs are used in those instances in which the FI computes a hospital specific RCC which falls outside reasonable parameters. Whenever data specific to a provider changes that would affect payment, FIs are required to ensure the provider specific file is current.

In the State of Rhode Island, Blue Cross of Rhode Island holds the contract as the FI to process Medicare Part A claims. For FYs 1992 and 1993, Blue Cross of Rhode Island made day and cost outlier payments of approximately $8.6 million and $8.5 million, respectively, to 12 Rhode Island hospitals[2].

We recognize the technical nature of the terminology used. As such, we have added a GLOSSARY to the end of this report.

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[1] As summarized by Commerce Clearing House, Medicare and Medicaid Guide, Section 4253.

[2] The amount of day and cost outlier payments made in FY 1994 was not available.

SCOPE

Our review was made in accordance with generally accepted government auditing standards. The objective of our review was to determine if Blue Cross of Rhode Island (the FI) correctly calculated outlier payments. Initially, our audit covered outlier payments made to Rhode Island hospitals in FYs 1992 and 1993 and was later expanded to include FY 1994. Furthermore, we limited our review to the two Rhode Island hospitals, Miriam Hospital and Rhode Island Hospitals, with day and cost outlier payments of approximately $4.5 million and $8.2 million, respectively, for the period under review. Our review was also limited to determining if the operating portion of the cost outlier payment was correctly calculated by the Medicare contractors.

As part of our examination, we obtained an understanding of the internal control structure surrounding the payment of outlier claims. We concluded, however, that our consideration of the internal control structure could be conducted more efficiently by expanding substantive audit tests, thereby placing limited reliance on the internal control structure.

To accomplish our objective, we:

- identified applicable criteria for outlier payments;
- obtained the Provider Statistical and Reimbursement (PS&R) records for FYs 1992, 1993, and 1994 for Miriam Hospital and Rhode Island Hospital;
- traced the charges from the PS&R to the itemized bills and the medical records for selected day and cost outlier cases;
- reviewed the provider specific files for the two hospitals to identify information used for calculating the cost outlier payments;
- verified the DRG and outlier payment amounts identified on the PS&Rs;
- obtained the Notice of Program Review (NPR) settlement dates for all hospitals in Rhode Island;
- obtained latest available settled cost reports for all PPS hospitals in Rhode Island to determine the hospital specific RCC; and
- recalculated the cost outlier payment amounts using the hospital specific RCC.

In completing our review, we established a reasonable assurance on the authenticity and accuracy of the PS&R information. Our audit was not directed towards assessing the completeness of the files from which the data was obtained.

For those items tested, we found no instances of noncompliance except for the matters discussed in the FINDINGS AND RECOMMENDATIONS section of this report. With respect to the items not tested, nothing came to our attention to suggest that untested items at the remaining hospitals in Rhode Island would produce different results.

Our field work was performed from July 1994 through November 1994 at the Boston Regional Office of HCFA, the Boston Regional Office of the Office of Inspector General, Health Care Review, Inc., the PRO for Rhode Island, Miriam Hospital and Rhode Island Hospital in Providence, Rhode Island, and Blue Cross/Blue Shield of Rhode Island in Providence, Rhode Island.

The draft report was issued on December 19, 1994. The FI's response to the draft report, dated January 17, 1995, is appended to this report (see Appendix IV) and is addressed on page 9.

FINDINGS AND RECOMMENDATIONS

With respect to day outlier payments, we found that the FI correctly calculated and reimbursed the hospitals the day outlier amount; however, the FI made cost outlier payments to Rhode Island hospitals using a statewide RCC which was significantly higher than the required hospital specific RCCs. Because of a misinterpretation of the regulations by the FI, overpayments occurred. Our analysis of cost outlier payments made to the two hospitals in Rhode Island which received approximately 50 percent of the outlier payments, Miriam Hospital and Rhode Island Hospital, identified overpayments of $819,443 and $1,153,945, respectively, for FYs 1992 through 1994.

In addition, we noted a type of billing error at Rhode Island Hospital which caused certain inpatient claims to inappropriately qualify for an outlier payment. Specifically, the decimal point on the room and board charges was misplaced, i.e. a $525.00 charge became a $52,500.00 charge. Although the FI manually identified the billing problem and corrected most claims prior to reimbursement, three claims were not detected and resulted in $663,479 in cost outlier payments to this hospital.

OUTLIER PAYMENTS

Inpatient stays which are extremely long or have extraordinarily high costs are eligible for an additional payment called an outlier payment. Outlier payments are paid using two payment methodologies, day outlier and cost outlier. The methodology which yields the highest payment is used. For cost outliers, federal regulations require the use of a hospital specific RCC to adjust hospital charges to cost. A statewide RCC is available for those providers where the hospital specific RCC falls outside reasonable parameters. The 42 CFR Section 412.84(h) requires,

> The operating cost-to-charge ratio and, effective with cost reporting periods beginning on or after October 1, 1991, the capital cost-to-charge ratio used to adjust covered charges are computed annually by the intermediary for each hospital based on the latest available settled cost report for that hospital and charge data for the same time period as that covered by the cost report. Statewide cost-to-charge ratios are used in those instances in which the hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters.

Annually, HCFA, establishes the reasonable upper and lower ratios and the ratio relative to the statewide RCC. For the period of our review, the ratios were:

FY	HCFA ESTABLISHED PARAMETERS		RHODE ISLAND STATEWIDE RCC
	LOWER LIMIT	UPPER LIMIT	
1992	33.2%	125.2%	76.5%
1993	31.1%	128.5%	76.5%
1994	29.6%	128.8%	63.2%

In order to use the statewide RCC, the hospital specific RCC would have to be less than the lower limit or greater than the upper limit; otherwise, the hospital specific RCC is used by the FI for outlier payments.

Once the appropriate RCC is determined through cost settlement, the FI updates the provider specific file to be used by the PRICER program in determining outlier payments. The PRICER program utilizes information from the hospital as well as data developed by the FI in determining outlier payments. Correct payments depend upon the accuracy of information entered into the provider specific file.

Our analysis indicates that the RCCs for all Rhode Island hospitals fell within the upper and lower limits and, therefore, the FI should have used the hospital specific RCC (see Appendix I). However, the FI updated the provider specific file using the statewide RCC. We selected Miriam Hospital and Rhode Island Hospital based on the fact that these two hospitals received approximately 50 percent of the outlier payments in FY 1992 and 1993. Using the latest available settled cost reports (see Appendix II), we determined that at Miriam Hospital and Rhode Island Hospital, the hospitals' RCCs are lower than the statewide RCC, thus, resulting in an overpayment of the outlier amount.

FY	RHODE ISLAND STATEWIDE RCC	MIRIAM HOSPITAL	RHODE ISLAND HOSPITAL
1992	76.5%	62.7%	65.0%
1993	76.5%	62.7% and 51.5%[3]	62.2%
1994	63.2%	51.5%	55.9%

To quantify the effect of using the higher statewide RCC, we utilized the PS&R information for Miriam Hospital and Rhode Island Hospital for FYs 1992 through 1994. We identified 103 cost outlier cases at Miriam hospital and 198 cost outlier cases at Rhode Island Hospital. We then recalculated the outlier payments using the appropriate data, i.e., DRG relative weights, hospital specific RCCs, outlier thresholds, etc., for each FY. By using a lower hospital specific RCC in the calculation, our results showed that 159 cases should have been paid at a lesser cost outlier amount (see Exhibit I for an example of the calculation) and 67 cases no longer qualified for a cost outlier payment (see Exhibit II for an example of the calculation). Furthermore, as discussed in the BACKGROUND section of the report, cases which qualify for both day and cost outlier payments will be paid under the methodology which yields the higher payment. As such, 75 cases should have been paid at the lesser day outlier amount (see Exhibit III for an example of the calculation).

For the 3-year period, overpayments were made on cost outlier cases to Miriam Hospital and Rhode Island Hospital in the amount of $819,443 and $1,153,945, respectively (see Appendix III).

For the remaining hospitals in Rhode Island, overpayments of cost outliers would have occurred in instances where the hospital specific RCC was lower than the statewide RCC. Conversely, in the instances where the statewide RCC is lower than the hospital specific RCC, an underpayment would occur. Without a detail review of the PS&R, we are unable to determine the extent of the overpayments or underpayments at the remaining hospitals.

Through discussions with the FI, we concluded that there was a misunderstanding of the regulations. Specifically, the FI misinterpreted the regulation as to which settled cost report is to be used at the start of a new FY. For Miriam Hospital, the FI settled the FY 1991 cost report in July of 1993. As such, the FI used a RCC based on this settled cost report to properly calculate outlier payments made in the last three months of FY 1993.

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[3] The RCC from the 1990 cost report was available for the first 9 months of FY 1993. The RCC from the 1991 cost report was available for the last 3 months of FY 1993.

BILLING ERROR

As noted in the OTHER MATTERS section of the draft report, we noted a billing problem at Rhode Island Hospital with respect to room and board charges. An error in the hospital's billing system caused all room and board charges to be overstated. Specifically, the decimal point on the charges was misplaced, i.e. a $525.00 charge was submitted as $52,500.00. Because the charges for the inpatient services were grossly overstated, these claims inappropriately qualified for cost outlier payments.

The FI identified this error after the claims were processed but prior to reimbursing the hospital. This discovery was made primarily because of the amount due the hospital on a particular settlement date (over $27 million). Normally, the amount due this particular hospital on a settlement date is approximately $1 million. In our opinion, the claims processing system should have identified these charges as being unreasonable and suspended these claims. The FI withheld payment on all inpatient claims and proceeded to manually identify the inpatient claims with the billing problem. Most of the claims were identified and adjustments were made. However, our review showed that three claims remain outstanding.

Subsequent to the issuance of the draft report, we met with the Manager of the Part A Medicare Claims Department and the Supervisor of the Cash Disbursement Department to resolve the issue. After reviewing the PS&R, remittance advices, and reconciliation schedules, it was agreed that Rhode Island Hospital was inappropriately reimbursed $663,479 in cost outlier payments.

RECOMMENDATIONS

We recommend that the FI

- ensure that the provider specific files contain the appropriate RCC;
- make the necessary adjustments to the cost reports of Miriam Hospital and Rhode Island Hospital to recoup the overpayments;
- recoup overpayments, if cost effective, at the remaining Rhode Island hospitals;
- ensure the cost outlier payments associated with three claims are recouped (approximately $660,000); and
- consider implementing a system edit to identify unreasonable charges.

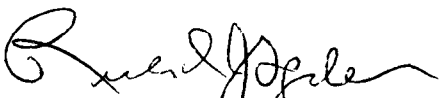
AUDITEE RESPONSE AND OIG COMMENTS

In response to the draft report, the FI concurred with the findings relative to the RCC. We have provided the FI with our calculations of the overpayments for the 301 outlier cases. The FI is in the process of reviewing our data for determining the exact amount of the overpayment for Miriam and Rhode Island Hospital. The FI has also indicated that it will review the cost effectiveness of recouping overpayments at the remaining Rhode Island hospitals. With respect to the incorrect billing problem, the FI indicates that this issue remains unresolved; however, in our meeting with the FI, there was agreement that the three outlier payments need to be recouped and corrective action would be taken.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General, Office of Audit Services' reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and the general public to the extent information contained therein is not subject to exemptions in the act which the Department chooses to exercise. (See 45 CFR Part 5).

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. Please refer to Common Identification Number A-01-94-00519 in all correspondence relating to this report.

Sincerely yours,



Richard J. Ogden
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Norma Burke, Associate Regional Administrator
Division of Medicare, HCFA

COMPARISON OF HCFA ESTABLISHED PARAMETERS TO HOSPITAL SPECIFIC RATIO OF COSTS-TO-CHARGES RHODE ISLAND HOSPITALS

HOSPITAL NAME	HOSPITAL SPECIFIC RCC	
	FY 1993	FY 1994
UPPER LIMIT	128.5%	128.8%
PAWTUCKET MEMORIAL HOSPITAL	70.6%	68.3%
COMMUNITY HOSPITAL OF RI	60.6%	56.1%
ROGER WILLIAMS MEDICAL CENTER	60.3%	53.6%
ST. JOSEPH HOSPITAL	67.6%	47.9%
NEWPORT HOSPITAL	76.4%	70.0%
RHODE ISLAND HOSPITAL	62.2%	55.9%
SOUTH COUNTY HOSPITAL	70.5%	68.6%
KENT COUNTY MEMORIAL HOSPITAL	65.7%	69.4%
WOMEN & INFANTS HOSPITAL	76.1%	74.4%
LANDMARK MEDICAL CENTER	54.6%	38.8%
MIRIAM HOSPITAL	51.5%	51.9%
WESTERLY HOSPITAL	64.9%	68.2%
LOWER LIMIT	31.1%	29.6%

The 42 CFR Section 412.84(h) requires the hospital specific RCC to fall outside the upper and lower reasonable RCC in order to use the statewide RCC. The RCCs for all Rhode Island hospitals fall within the upper and the lower limits; therefore, the hospital specific RCC should be used in the calculation of cost outlier payments.

Note: The hospital specific RCCs applicable to FY 1992 were not obtained.

COST REPORT SETTLEMENT DATES AND APPLICABLE OUTLIER PAYMENT PERIOD

FY OF SETTLED COST REPORT	COST REPORT SETTLEMENT DATE	FY OF OUTLIER PAYMENTS
MIRIAM HOSPITAL		
1990	09/30/91	1992
1990	09/30/91	1993 (10/1 - 6/30)
1991	07/30/93	1993 (7/1 - 9/30)
1991	07/30/93	1994 (10/1 - 7/29)
1992	07/29/94	1994 (7/30 - 9/30)
RHODE ISLAND HOSPITAL		
1990	09/30/91	1992
1991	09/30/92	1993
1992	09/10/93	1994

SUMMARY OF OVERPAYMENTS BY FISCAL YEAR

Fiscal Year	Number of Outlier Cases	Amount of Overpayment
Miriam Hospital		
1992	35	$ 407,887
1993	30	187,486
1994	38	224,070
Subtotal	103	819,443
Rhode Island Hospital		
1992	54	$ 357,502
1993	63	412,157
1994	81	384,286
Subtotal	198	1,153,945
Total	301	$1,973,388

Blue Cross
Blue Shield
of Rhode Island

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CIN: A-01-94-00519
Appendix IV

January 17, 1995

Mr. Richard J. Ogden
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services - Region I
John F. Kennedy Federal Building
Boston, Massachusetts 02203

Dear Mr. Ogden:

This is in response to your letter (Common Identification Number A-01-94-00519) dated December 19, 1994, which contains the findings and recommendations resulting from the review of outlier hospital payments under the Medicare program made by Blue Cross & Blue Shield of Rhode Island in fiscal years 1992, 1993, and 1994.

We concur with the findings that the inappropriate RCCs were used. The federal register statewide average was used rather than the actual. The exact amount of overpayment cannot be determined until we reconcile the recent data received from your office.

In response to the other matter's section on page 7, which referred to a room and board billing problem at Rhode Island Hospital, a meeting was held with Ms. Martin of your staff, the Manager of our Part A Medicare Claims Department, and the Supervisor of our Cash Disbursement Department. There are still unresolved questions related to the four claims, and they will continue to work to try to resolve this issue.

The cost outlier payments made to the other ten PPS hospitals will also be reviewed, and depending on cost effectiveness, appropriate cost report reopening(s) may be performed.

If there are any further questions, please contact me at 401-459-1400.

Sincerely,

Richard J. Maiorisi
Vice President

RJM:ame

GLOSSARY

COST OUTLIER	The hospital's charges for covered services furnished to a beneficiary, adjusted to operating costs by applying RCCs (statewide or hospital specific), exceed the greater of (1) a fixed dollar amount, as specified by HCFA, or (2) a fixed multiple of the Federal operating rate.
DAY OUTLIER	The beneficiary's length-of-stay exceeds the mean length-of-stay for the applicable DRG by the lesser of (1) a fixed number of days, as specified by HCFA, or (2) a fixed number of standard deviations, as specified by HCFA.
DISPROPORTIONATE SHARE	The Act provides for additional Medicare payment for hospitals that serve a disproportionate share of low income patients.
DRG RELATIVE WEIGHTS	Represents the average resources required to care for cases in that particular DRG relative to the average resources used to treat cases in other DRGs
DRG	For purposes of payment under PPS, discharges are classified into diagnosis related groups based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient.
GROUPER PROGRAM	Claims processing program which classifies each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (sex, age, discharge status). It is used both to classify past cases in order to measure relative hospital resource consumption to establish the DRG relative weights and to classify current cases for purposes of determining payment.
HOSPITAL SPECIFIC RCC	RCC computed using the hospital's own cost and charge data.
INDIRECT MEDICAL EDUCATION (IME)	The Act provides that hospitals under PPS that have residents in an approved graduate medical education program receive an additional payment to reflect the higher indirect operating costs associated with graduate medical education.
RCC	Derived from the latest settled cost report and corresponding charge data. Computed by dividing the Medicare operating costs by the Medicare covered charges. Used to adjust charges to cost for determining cost outlier payments
OUTLIER THRESHOLD	A specified number of days or a specified cost of services at which a discharge becomes an outlier payment. Thresholds are calculated annually by HCFA.

PRICER PROGRAM	Claims processing program supplied by HCFA which determines the price upon which to base payment under PPS. PRICER requires data from the GROUPER, provider specific file, as well as other files that contain DRG weights, average lengths of stays, outlier thresholds, and wage indices.
PROVIDER SPECIFIC FILE	Data file containing information about the facts specific to the provider that affect computations in determining payment, i.e., effective dates of PPS, type of provider, census division, metropolitan statistical area, adjusted cost per discharge, disproportionate share adjustment percentage, and capital data.
PROVIDER STATISTICAL & REIMBURSEMENT (PS&R)	Provides statistical data about Medicare dollars remitted by an intermediary to hospitals and other providers. Year-end summary data is utilized in final settlement of cost reports.
STATEWIDE RCC	Average RCCs used to calculate cost outlier payments for those hospitals where the intermediaries compute a hospital specific RCC which falls outside reasonable parameters as specified by HCFA. Statewide RCCs are calculated annually by HCFA.

EXAMPLE 1
OUTLIER CASE PAID AT A LOWER COST OUTLIER AMOUNT

COST OUTLIER PAYMENT CALCULATION		
AMOUNT PAID PER PS&R		$33,535
COST OUTLIER THRESHOLD		$35,500
BILLED CHARGES		$137,105
FEDERAL AMOUNT FOR DRG		$17,314
DRG RELATIVE WEIGHT		4.2348
WAGE INDEX		1.1561
LABOR PERCENTAGE		0.714
NON-LABOR PERCENTAGE		0.286
MARGINAL COST FACTOR		0.75
IME PERCENTAGE		0.2289
DISPROPORTIONATE SHARE		0.0483
	STATEWIDE	HOSPITAL SPECIFIC
RATIO OF COSTS-TO-CHARGES		
OPERATING	0.765	0.622
CAPITAL	0.042	0.029
OPERATING PORTION OF COST THRESHOLD	0.948	0.9555
WAGE INDEX ADJUSTED COST THRESHOLD	$37,405	$37,701
STANDARDIZED OPERATING COST	$82,121	$66,770
OPERATING OUTLIER COST	$44,716	$29,069
OPERATING PORTION OF OUTLIER PAYMENT	$33,535	$21,802
OVERPAYMENT AMOUNT		$11,733

In this example, the case still qualified for an outlier payment. Using the hospital specific RCC, the cost outlier amount decrease from $33,535 to $21,802 resulting in an overpayment of $11,733

EXAMPLE 2
CASE WHICH NO LONGER QUALIFIES FOR AN OUTLIER PAYMENT

COST OUTLIER PAYMENT CALCULATION		
AMOUNT PAID PER PS&R		$5,722
COST OUTLIER THRESHOLD		$36,000
BILLED CHARGES		$79,465
FEDERAL AMOUNT FOR DRG		$3,012
DRG RELATIVE WEIGHT		0.7617
WAGE INDEX		1.0717
LABOR PERCENTAGE		0.714
NON-LABOR PERCENTAGE		0.286
MARGINAL COST FACTOR		0.75
IME PERCENTAGE		0.1520
	STATEWIDE	HOSPITAL SPECIFIC
RATIO OF COSTS-TO-CHARGES		
OPERATING	0.632	0.515
CAPITAL	0.033	0.019
OPERATING PORTION OF COST THRESHOLD	0.9504	0.9644
WAGE INDEX ADJUSTED COST THRESHOLD	$35,966	$36,496
STANDARDIZED OPERATING COST	$43,595	$35,525
OPERATING OUTLIER COST	$7,629	$0
OPERATING PORTION OF OUTLIER PAYMENT	$5,722	$0
OVERPAYMENT AMOUNT		$5,722

In this example, the case no longer qualifies for an outlier payment. Using the hospital specific RCC, the cost outlier amount decrease from $5,722 to $0 resulting in an overpayment of $5,722

EXAMPLE 3
OUTLIER CASE PAID UNDER DAY OUTLIER METHODOLOGY

COST OUTLIER PAYMENT CALCULATION		
AMOUNT PAID PER PS&R		$17,646
COST OUTLIER THRESHOLD		$35,500
BILLED CHARGES		$101,733
FEDERAL AMOUNT FOR DRG		$5,559
DRG RELATIVE WEIGHT		1.3597
WAGE INDEX		1.1561
LABOR PERCENTAGE		0.714
NON-LABOR PERCENTAGE		0.286
MARGINAL COST FACTOR		0.75
IME PERCENTAGE		0.2289
DISPROPORTIONATE SHARE		0.0483
	STATEWIDE	HOSPITAL SPECIFIC
RATIO OF COSTS-TO-CHARGES		
OPERATING	0.765	0.622
CAPITAL	0.042	0.029
OPERATING PORTION OF COST THRESHOLD	0.948	0.9555
WAGE INDEX ADJUSTED COST THRESHOLD	$37,405	$37,701
STANDARDIZED OPERATING COST	$60,935	$49,544
OPERATING OUTLIER COST	$23,530	$11,843
OPERATING PORTION OF OUTLIER PAYMENT	$17,646	$8,883
DAY OUTLIER PAYMENT		$9,554
OVERPAYMENT AMOUNT		$8,092

In this example, the case still qualified for an outlier payment. Using the hospital specific RCC, the day outlier methodology yielded a high payment. An overpayment of $8,092 occurred ($17,646 - $9,554).