DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

May 16, 2003

CIN: A-06-02-00001

Ms. Marti Mahaffey
Executive Vice President & COO
TrailBlazer Health Enterprises, LLC
8330 LBJ Freeway, Executive Center III
Dallas, Texas 75243

Dear Ms. Mahaffey:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services' report entitled "Review of Financial Systems and Internal Controls over Medicare Accounts Receivable – TrailBlazer Health Enterprises, LLC". This report centers on Medicare accounts receivable activity for the quarter ended December 31, 2000, but also includes Medicare cost report activity applicable to the period June 30, 1998 through July 31, 2001, as well as cost reports due in fiscal year (FY) 2001. A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

TrailBlazer officials agreed with most of the recommendations included in the draft audit report and provided specific responses to each of the recommendations. We have incorporated TrailBlazer's written comments in the body of the report following the Conclusions and Recommendations sections of each finding. We appreciate the cooperation given to us by TrailBlazer officials and staff throughout this audit.

Final determination as to actions taken on all matters reported will be 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 (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports issued to the Department's grantees and contractors are made available to members of the press and 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.) As such, within ten business days after the final report is issued, it will be posted on the world wide web at http://oig.hhs.gov.

To facilitate identification, please refer to CIN: A-06-02-00001 in all correspondence relating to this report.

Sincerely yours,

for Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

James R. Farris, MD
Regional Administrator
Centers for Medicare and Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF FINANCIAL SYSTEMS AND INTERNAL CONTROLS OVER MEDICARE ACCOUNTS RECEIVABLE – TRAILBLAZER HEALTH ENTERPRISES, LLC.

JANET REHNQUIST
Inspector General

MAY 2003
A-06-02-00001

EXECUTIVE SUMMARY

BACKGROUND

The Medicare accounts receivable information reported by Medicare contractors to the Centers for Medicare and Medicaid Services (CMS) represents one of the most significant assets on CMS' financial statements. In this regard, CMS is responsible for ensuring that the Medicare accounts receivable balance reported on its financial statements is fairly presented in all material respects. The CMS and its contractors have not provided adequate oversight or implemented compensating internal controls to ensure that receivables are properly accounted for and reflected in CMS' financial statements.

The CMS intends to address its fundamental weaknesses in reporting the Medicare accounts receivable balances by developing a system that will extend to Medicare contractors. However, because CMS does not expect to have this system fully in place until fiscal year (FY) 2007, the Secretary of Health and Human Services requested the Office of Inspector General (OIG) to identify a set of specific and cost-efficient controls that would: (1) substantially strengthen the Medicare contractors' control environment; and (2) considerably reduce errors in Medicare accounts receivable. This special review effort is referred to in our report as the Secretary's Initiative.

As part of the Secretary's Initiative, the OIG reviewed the internal control environment at three of the larger Medicare contractors to determine if these contractors had effective controls and procedures over their accounts receivable operations. TrailBlazer Health Enterprises, LLC, (TrailBlazer) was one of the three Medicare contractors included in this special review effort.

OBJECTIVES

The overall objective of our audit was to evaluate the adequacy of TrailBlazer's systems and internal controls over the recording, tracking, collecting and reporting of Medicare accounts receivable resulting from amounts owed to Medicare by various providers. These receivables result primarily from adjustments to provider claims submitted to Medicare by the providers or from amounts owed to Medicare by the providers in connection with the cost report settlement process. Specifically, our objectives were to determine whether TrailBlazer had adequate:

- Internal controls and procedures in place for tracking and reporting the various Part A non-MSP accounts receivable categories on the Status of Accounts Receivable (CMS 751) submitted to CMS for the quarter ended December 31, 2000;

- Internal controls and procedures in place for tracking and reporting the cash collections and offsets reported on the Monthly Contractor Financial Report (CMS 1522) submitted to CMS for the month ended December 31, 2000;

- Procedures in place to ensure that TrailBlazer had adequately completed and/or documented corrective actions reported in response to the Contractor Performance Evaluation (CPE) Reviews conducted at TrailBlazer by CMS; and

- Written policies and procedures covering its accounts receivable operations. If not, the Secretary's Initiative required us to provide written policies and procedures to TrailBlazer for implementation.

SUMMARY OF FINDINGS

At the outset of our fieldwork, TrailBlazer did not have adequate written policies and procedures in place or did not always follow existing policies and procedures related to (1) the Part A non-MSP accounts receivable reported on the CMS 751 and (2) the Part A cash balances reported on the Part A CMS 1522. This, along with the results of our judgmental sample reviews related to these two areas, raised concerns as to whether the amounts reported on the CMS 751 for the quarter ended December 31, 2000, and on the CMS 1522 for the month ended December 31, 2000, were (1) determined in accordance with CMS' or TrailBlazer's requirements, or (2) accurately reported in some instances. However, during and subsequent to the completion of our fieldwork, TrailBlazer provided us with both written policies and procedures and verbal explanations of the corrective actions taken to address the concerns identified during our fieldwork. Although the scope of our audit did not provide for us to perform detailed tests of TrailBlazer's corrective actions, we believe that many of our concerns have now been addressed by these corrective actions.

Part of our audit work under the Secretary's Initiative required us to review TrailBlazer's policies and procedures related to corrective actions planned or taken in relation to Part A Audit and Reimbursement deficiencies identified during CPE reviews performed by CMS. At the outset of our fieldwork, TrailBlazer did not have adequate procedures in place to fully document corrective actions planned and taken and to monitor the progress made in correcting the deficiencies. However, during and subsequent to our fieldwork and with input from the CMS representative on the OIG audit team, TrailBlazer developed and implemented a formal methodology to document and monitor corrective actions to address Part A Audit and Reimbursement deficiencies noted by CMS during CPE reviews.

The corrective actions taken by TrailBlazer reduced the number of recommendations included in our report. However, we are making some additional recommendations that we believe will provide further improvements or clarifications of TrailBlazer's policies and procedures related to the Part A non-MSP accounts receivable reported on the CMS 751 and the Part A cash balances reported on the Part A CMS 1522.

Controls Related to the CMS 751 for Part A Non-MSP Accounts Receivable

The CMS requires fiscal intermediaries (FIs) to report Part A non-MSP accounts receivable on the CMS 751 in four major categories. We identified problems in three of the four categories: (1) credit balances; (2) carryover adjustments; and (3) cost report settlement amounts.

Credit Balances

At the time of our fieldwork, TrailBlazer did not have adequate policies and procedures in place to provide us with the information needed to determine the credit balance amount reported on the CMS 751 for the quarter ended December 31, 2000. However, we were able to select and review a judgmental sample of credit balance amounts, applicable to this quarter, from TrailBlazer's credit balance database. The results of our judgmental sample disclosed that TrailBlazer was not properly reporting credit balances reported by providers that were accompanied by a check and one of the credit balance amounts in our judgmental sample was reported as a receivable in the wrong quarter. Although the net effect of these errors had little or no impact on the accounts receivable balance, they represented areas that TrailBlazer needed to correct. Subsequent to the completion of our fieldwork, TrailBlazer provided us with policies and procedures that explain how it tracks and reports credit balances. While these policies address most of the concerns disclosed in our judgmental sample, we are making a recommendation for TrailBlazer to reconcile the credit balance database to the accounts receivable reported on the CMS 751.

Carryover Adjustments

At the time of our fieldwork, TrailBlazer did not have adequate written policies and procedures in place to provide us with the information needed to determine how it reported carryover adjustment amounts on the CMS 751. However, we were able to select a judgmental sample of five carryover adjustments from the accounts receivable report (8044 report) for the quarter ended December 31, 2000. The required adjustments were properly established in the claims processing system for all five adjustments. However, one of the five adjustments involved a mass adjustment initiated by TrailBlazer that applied to several providers. The mass adjustment did not take effect in the claims processing system. The provider selected in our sample, who was a part of the mass adjustment, determined that the adjustment needed to be made and voluntarily initiated the adjustment electronically in the claims processing system. Subsequent to the completion of our fieldwork, TrailBlazer provided us with written policies and procedures addressing carryover adjustments. However, the new policies and procedures do not address mass adjustments. TrailBlazer needs to establish procedures to ensure that mass adjustments entered into the claims processing system actually take effect.

Cost Report Settlement Amounts

TrailBlazer reported Part A non-MSP cost report settlement amounts totaling over $177 million on the CMS 751 for the quarter ended December 31, 2000. This amount represents an account receivable to Medicare. TrailBlazer provided us with a schedule that showed that TrailBlazer understated its reported Medicare Part A non-MSP accounts receivable balance by about $13.3 million and its unapplied cash by about $3.1 million. These understatements occurred as a result of a change, with unintended consequences, in the policy for establishing accounts receivable whereby the initial cost report accepted date, rather than the cost report received date, became the determination date for the accounts receivable. However, although TrailBlazer understated its unapplied cash by about $3.1 million, it did report approximately $8.5 million of unapplied cash related to the $13.3 million unrecorded receivables as "Other Liabilities". The providers had not submitted payments for the approximately $1.7 million difference between the $11.6

million in unapplied cash and Other Liabilities, therefore TrailBlazer appropriately did not record that amount as Other Liabilities. If TrailBlazer had reconciled the cost report received report to other reports, it could have identified the $13.3 million accounts receivable and $3.1 million unapplied cash understatements and included the appropriate amounts on the CMS 750/751 for the quarter ended December 31, 2000.

After surveying the complexity of the cost report settlement process as part of the Secretary's Initiative, we determined that detailed testing and analysis of the cost report settlement process was needed. The problems we identified in this testing and analysis raised additional concerns about the accounts receivable amounts reported by TrailBlazer on the CMS 751s. The problems identified are summarized below:

- TrailBlazer did not enter reminder letter dates into the Cost Report Received System (CRRS) for five out of the seven reminder letters we reviewed. These letters are sent to providers when cost reports are due. The CRRS allows TrailBlazer to track providers who have not submitted cost reports.

- TrailBlazer did not consistently follow CMS' guidelines for the processing of demand letters related to providers who did not file required Medicare cost reports. In addition, TrailBlazer did not send certified demand letters to these providers as required by CMS guidelines.

- For overpayment demand letters, out of the nine providers reviewed, TrailBlazer did not submit three of the second demand letters or four of the third demand letters timely, as required by CMS guidelines.

- For 6 of the 10 providers reviewed, TrailBlazer did not code the status of interest associated with overpayments established in the Provider Overpayment Reporting (POR) System consistent with the status codes of the overpayment principal recorded in the system.

- TrailBlazer did not complete tentative and final settlements in lieu of tentative settlements timely for the initial cost reports with due dates in FY 2001 as required by its established goals or CMS guidelines. Out of 2,646 cost reports, we reviewed the timeliness for 1,972 cost reports that required either tentative or final settlements in lieu of tentative settlements to be performed. However, TrailBlazer did not complete 1,485 of these tentative or final settlements timely.

- TrailBlazer did not complete required interim rate reviews timely for 7 of the 15 providers we reviewed, as required by TrailBlazer's policies and procedures.

During and subsequent to our fieldwork, TrailBlazer provided us with both written policies and procedures and verbal explanations of the corrective actions taken to address our concerns related to the above issues.

Controls Related to Cash Collections Reported on the Part A CMS 1522

At the time of our fieldwork, TrailBlazer did not (1) provide us with adequate written policies and procedures applicable to its cash collection process involving Medicare Part A funds collected at its Dallas location; (2) have a centralized cash collection unit responsible for preparing deposit slips, reconciling deposits and tracking deposits through the system; or (3) have records available for us to select a sample of individual check receipts to verify and trace through TrailBlazer's financial records. TrailBlazer reported about $38 million in cash collections on the Part A CMS 1522 for the month of December 2000. The problems disclosed during our fieldwork raised concerns about TrailBlazer's ability to accurately process and report cash collections on the Part A CMS 1522. However, subsequent to completion of our fieldwork in this area, TrailBlazer implemented cash collection policies and procedures and created a centralized cash collection location. While TrailBlazer addressed many of our concerns, we are making some recommendations for TrailBlazer to clarify or amend its cash collection policies and procedures.

Part A Audit and Reimbursement Contractor Performance Evaluation Reviews

We also identified an additional concern related to TrailBlazer's properly accounting for and reporting Medicare accounts receivable. At the outset of our fieldwork, TrailBlazer did not have adequate procedures in place to fully document and monitor the progress made in correcting the Part A Audit and Reimbursement deficiencies in response to Contractor Performance Evaluation (CPE) reviews conducted at TrailBlazer by CMS. The lack of a formal tracking methodology and policies and procedures could result in TrailBlazer not taking corrective action on CPE deficiencies identified by CMS during reviews of TrailBlazer's Medicare operations, which could impact the accounts receivable balances reported on the CMS 750/751. However, during and subsequent to our fieldwork and with input from the CMS representative on the OIG audit team, TrailBlazer developed and implemented a formal methodology to document and monitor corrective actions to address Part A Audit and Reimbursement deficiencies noted by CMS during CPE reviews. Therefore, we are not making any further recommendations regarding this issue.

Written Policies and Procedures

At the time of our fieldwork, TrailBlazer did not provide us with adequate written policies and procedures applicable to cash collections, credit balances, and carryover adjustments. As part of the Secretary's Initiative, we prepared written policies and procedures for these areas and provided them to TrailBlazer officials for their use in making improvements to its accounts receivable operations. However, TrailBlazer had numerous written policies and procedures applicable to its cost report settlement process. Where appropriate, we provided proposed changes to those policies and procedures. We are addressing additional changes needed in these policies and procedures in the body of this report.

In addition, as part of the Secretary's Initiative, we prepared flow charts of TrailBlazer's cash collection procedures, credit balance procedures, claims adjustment procedures, and the cost report settlement process. We provided both the written policies and procedures and the flow charts to TrailBlazer officials under separate cover with recommendations that these documents

be used to make improvements in TrailBlazer's accounts receivable operations and in its reporting to CMS. Because these documents have already been provided to TrailBlazer, we are not including any additional information about this area in the body of the report. We do refer to these written policies and procedures as appropriate in our Conclusions and Recommendations sections of the report.

RECOMMENDATIONS

TrailBlazer has made substantial improvements in many of the areas that we are reporting on in this report, including providing us with written policies and procedures prepared by TrailBlazer during and subsequent to our fieldwork. In this regard, we are including information about these improvements, including the written policies and procedures provided to us, in the Conclusions and Recommendations section of each finding. Our report includes several recommendations that TrailBlazer needs to implement to further improve its accounts receivable operations. Because of the number of recommendations, we are not listing them separately in this summary section of the report. However, the Conclusions and Recommendations section of each finding contains the recommendations that apply to those findings.

AUDITEE COMMENTS

On March 21, 2003, TrailBlazer officials provided written comments in response to the OIG draft audit report. TrailBlazer officials noted that although numerous weaknesses were identified at the outset of the OIG review, it believes the significant improvements reflected in the report, as well as TrailBlazer's efforts to continue strengthening its financial management controls demonstrate its commitment toward this essential responsibility. TrailBlazer officials further noted that while it has already corrected many of the weaknesses originally identified, it is taking further actions to ensure that the OIG's remaining recommendations are addressed.

TrailBlazer officials agreed with most of the recommendations included in the draft audit report and provided specific responses to each of the recommendations. We have incorporated TrailBlazer's written comments in the body of the report following the Conclusions and Recommendations section of each finding.

Finally, TrailBlazer officials noted their appreciation that the OIG recognized in the report the substantial improvements made by TrailBlazer during the course of the review. They also noted that they were encouraged that the OIG considered three processes implemented within their Part A Audit & Reimbursement Division to be "best practices" worthy of possible implementation at other contractors to improve accounts receivable processes.

The full text of TrailBlazer's written comments is included as APPENDIX B to this report.

OIG RESPONSE

We have explained in the Auditee Comments sections those instances where TrailBlazer officials did not fully agree with our recommended corrective actions. We also provided OIG responses, as appropriate, in the body of the report following the Auditee Comments sections.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicare accounts receivable are primarily composed of: (1) overpayments to Medicare providers and Medicare beneficiaries which are also referred to as non-Medicare Secondary Payer (non-MSP) receivables; and (2) Medicare Secondary Payer (MSP) overpayments which represents amounts due Medicare from other sources. The MSP receivables are comprised of paid claims in which Medicare should have been the secondary rather than the primary payer.

Medicare contractors have contracted with the Centers for Medicare and Medicaid Services (CMS) to administer the day-to-day operations of the Medicare program. The Medicare contractors pay Medicare claims, audit cost reports, and establish and collect overpayments. Since these contractors maintain most of the accounts receivable on CMS' behalf, it is important that the contractors provide CMS with accurate accounts receivable information for CMS to use in preparing its financial statements. In this regard, the contractors need to ensure that the accounts receivable balances reported to CMS actually exist, are adequately supported, are complete and are properly valued.

The Medicare accounts receivable information reported by Medicare contractors to CMS represents one of the most significant assets on CMS' financial statements. In this regard, CMS is responsible for ensuring that the Medicare accounts receivable balance reported on its financial statements is fairly presented in all material respects. On its FY 2000 financial statements, CMS reported a net Medicare accounts receivable balance of approximately $3.7 billion. The CMS and its contractors have not provided adequate oversight or implemented compensating internal controls to ensure that receivables are properly accounted for and reflected in CMS' financial statements.

The CMS intends to address its fundamental weaknesses in reporting the Medicare accounts receivable balances by developing the Healthcare Integrated General Ledger Accounting System (HIGLAS), which will extend to the Medicare contractors. However, CMS does not expect to have HIGLAS fully implemented until FY 2007. In the interim, the Secretary of Health and Human Services requested the Office of Inspector General (OIG) to identify a set of specific, cost-efficient controls that would: (1) substantially strengthen the Medicare contractors' control environment; and (2) considerably reduce errors in Medicare accounts receivable. This special review effort is referred to in our report as the Secretary's Initiative.

As part of the Secretary's Initiative, the OIG reviewed the internal control environment at three of the larger Medicare contractors. The purpose of our reviews at these three contractors was to determine if these contractors had existing controls and procedures that were effective for identifying and resolving weaknesses related to accounts receivable in a timely manner. TrailBlazer Health Enterprises, LLC, (TrailBlazer) was one of the three Medicare contractors included in this special review effort.

TrailBlazer, whose headquarters is located in Dallas, Texas, serves as the Medicare Part A FI for the states of Colorado, New Mexico and Texas, and the Medicare Part B carrier for the states of Delaware, Maryland, Texas, and Virginia, as well as the District of Columbia Metropolitan Area. One of TrailBlazer's responsibilities is to ensure that the Medicare accounts receivable balances reported to CMS actually exist, are properly supported, are complete and are properly valued. This responsibility includes having adequate policies and procedures in place to record, track, collect and report on the Medicare accounts receivable activity resulting from TrailBlazer's Medicare operations.

The Part A non-MSP receivables related to provider claims overpayments are handled by the Part A Claims department within TrailBlazer. This department is responsible for the determination, establishment and billing of Medicare accounts receivable. The Chief Financial Officer (CFO) report preparation for the Medicare accounts receivable is handled by the reimbursement reporting department within the Provider Audit and Reimbursement Division, which also handles the Part A non-MSP receivables related to provider cost report settlements. The MSP post-pay recoveries department handles all MSP receivables. The CMS has provided contractors with guidance as to how the receivables are to be recorded, tracked, collected and reported on to CMS. In some instances, TrailBlazer has established its own internal policies and procedures for handling the accounts receivable process. During our audit, we considered both the guidance provided by CMS and, when available, the policies and procedures established by TrailBlazer.

The CMS requires contractors to provide various reports related to its Medicare accounts receivable operations. The CMS developed a Quarterly CMS 750 "Statement of Financial Position" and a CMS 751 "Status of Accounts Receivable" report. The CMS requires contractors to report MSP and non-MSP accounts receivable activity on separate CMS 751 reports. The CMS 750/751s are cumulative reports for each quarter within the fiscal year. The CMS 750 captures both accounts receivable and accounts payable activity, while the CMS 751 reports only accounts receivable information. In addition, CMS also requires TrailBlazer to report all of its accounts receivable cash collections information on the CMS 1522. TrailBlazer is required to prepare and submit the CMS 1522 monthly.

An integral part of the CMS 751 includes the accounts receivable resulting from TrailBlazer's on-going cost report settlement process. Because we expanded the Secretary's Initiative review to include detailed testing and analysis of the cost report settlement process, we have included a brief summary of this process as Appendix A to this report.

OBJECTIVES

The overall objective of our review was to evaluate the adequacy of TrailBlazer's systems and internal controls over the recording, tracking, collecting and reporting of Medicare accounts receivable resulting from amounts owed to Medicare by various providers. These receivables

result primarily from adjustments to provider claims submitted to Medicare by the providers or from amounts owed to Medicare by the providers in connection with the cost report settlement process. Specifically, our objectives were to determine whether TrailBlazer had adequate:

- Internal controls and procedures in place for tracking and reporting the various accounts receivable categories on the Status of Accounts Receivable (CMS 751) submitted to CMS for the quarter ended December 31, 2000;

- Internal controls and procedures in place for tracking and reporting the cash collections and offsets reported on the Monthly Contractor Financial Report (CMS 1522) submitted to CMS for the month ended December 31, 2000;

- Procedures in place to ensure that TrailBlazer had adequately completed and documented corrective actions reported to CMS in response to Contractor Performance Evaluation (CPE) reviews conducted at TrailBlazer by CMS; and

- Written policies and procedures covering its accounts receivable operations. If not, the Secretary's Initiative required us to provide written policies and procedures to TrailBlazer for implementation.

SCOPE AND METHODOLOGY

Our audit was conducted in accordance with generally accepted government auditing standards. The audit work performed under the Secretary's Initiative represented a limited scope audit to gain an understanding of TrailBlazer's policies and procedures related to its accounts receivable operations and, where applicable, to provide TrailBlazer with written policies and procedures for its consideration in making changes and improvements to its accounts receivable operations. The focus of our audit work under the Secretary's Initiative centered on Medicare accounts receivable activity related to:

- The Medicare Part A non-MSP accounts receivable reported on the CMS 751 for the quarter ended December 31, 2000. This included the credit balance amount, the carryover adjustment amount, and the cost report settlement amount.

- The Medicare cash collections received at TrailBlazer's headquarters office in Dallas, Texas, as reported on Line 16b "Other Deposits" of the CMS Part A 1522 for the month ended December 31, 2000.

Our audit scope did not include a review of the MSP accounts receivable reported on the CMS 751. In addition, it was not within the scope of our audit work, under the Secretary's Initiative, to perform the audit steps necessary to verify the accuracy of the amounts reported on either of these documents. However, where possible, we used judgmental sampling of the amounts reported on these documents along with interviews of TrailBlazer's staff to serve as a basis to gain an understanding of TrailBlazer's controls and policies and procedures related to reporting

amounts on both the CMS 751 and the CMS 1522. We also reviewed any applicable written policies and procedures that TrailBlazer provided to us at the outset of our audit work under the Secretary's Initiative. In addition, we performed a walk-through of various portions of TrailBlazer's accounts receivable operations to help us better understand these processes and to document the processes.

As part of the Secretary's Initiative, we were requested not only to review TrailBlazer's written policies and procedures covering its Part A accounts receivable operations, but to also provide TrailBlazer with written policies and procedures in those areas where written policies and procedures did not exist or were inadequate. The written policies and procedures we provided were to be used by TrailBlazer, as appropriate, to improve its Part A accounts receivable operations. In connection with the audit work performed under the Secretary's Initiative, we provided TrailBlazer with the following:

- Written policies and procedures related to credit balances and carryover adjustments reported on the CMS 751 and cash collections reported on the CMS 1522;

- Proposed changes to the cost report settlement written policies and procedures made available to us by TrailBlazer; and

- Flow charts covering credit balances, carryover adjustments, cash collections and the cost report settlement process.

Most of the fieldwork under the Secretary's Initiative related to credit balances, carryover adjustments, cash collections, and part of the cost report settlement process was completed during the period April 2001 to October 2001. The limited testing, walk-throughs, and interviews conducted as part of the Secretary's Initiative for credit balances, carryover adjustments and cash collections were sufficient to provide us with an understanding of TrailBlazer's operations in these areas and to identify where improvements were needed. However, due to the complexity of the cost report settlement process, it was necessary for us to perform more detailed testing and analysis of this area in order to gain a better understanding of this process and to identify areas where improvements were needed.

Due to the reporting requirements applicable to various portions of the cost report settlement process, it was necessary for us to allow for a wide range of dates to ensure that we tested the critical aspects of the cost report settlement process. As a result, with the exception of the judgmental sample we reviewed for completion and timeliness of tentative and final settlements, our judgmental samples involved selecting provider cost reports with fiscal year ended dates ranging from June 30, 1998 through July 31, 2001. Regarding tentative and final settlements, we selected a judgmental sample of cost reports due in FY 2001. The judgmental samples selected in our review are explained in each of the cost report settlement findings included in our report. As a result of expanding our review of the cost report settlement area, our fieldwork related to this area was not completed until the end of March 2002.

As part of our analysis of the adequacy of TrailBlazer's Part A accounts receivable operations, we determined whether TrailBlazer had policies and procedures in place to ensure that TrailBlazer had adequately completed and documented corrective actions reported to CMS in response to Part A Audit and Reimbursement deficiencies identified during Contractor Performance Evaluation (CPE) reviews conducted at TrailBlazer by CMS. In accomplishing this, we reviewed the CPE reviews performed by CMS for the periods of July 17-21, September 11-15, and December 11-14 of 2000.

We provided the results of our audit work performed through October 2001 to our OIG Region I staff for inclusion in a document that identified a list of controls and corrective actions needed to achieve a more accurate, consistent and sound financial information system for Medicare accounts receivable. Our OIG headquarters provided this document to CMS' Central Office for its consideration in making appropriate changes to the Medicare FIs' accounts receivable operations.

Our fieldwork was performed at TrailBlazer's headquarters in Dallas, Texas. A member of the CMS Region VI office served as a team member with the OIG review team during the initial review of the cost report settlement process that was part of the Secretary's Initiative. The CMS team member provided the OIG with valuable assistance as we gained an understanding of TrailBlazer's cost report settlement process and CMS' requirements related to this process. The CMS team member was also instrumental in working with TrailBlazer's staff to develop policies and procedures for completing and documenting corrective actions related to CPE reviews conducted by CMS.

FINDINGS AND RECOMMENDATIONS

At the outset of our fieldwork, TrailBlazer did not have adequate written policies and procedures in place or did not always follow existing policies and procedures related to (1) the Part A non-MSP accounts receivable reported on the CMS 751 and (2) the Part A cash balances reported on the Part A CMS 1522. This, along with the results of our judgmental sample reviews related to these two areas, raised concerns as to whether the amounts reported on the CMS 751 for the quarter ended December 31, 2000, and on the CMS 1522 for the month ended December 31, 2000, were (1) determined in accordance with CMS' or TrailBlazer's requirements, or (2) accurately reported in some instances. However, during and subsequent to the completion of our fieldwork, TrailBlazer provided us with both written policies and procedures and verbal explanations of the corrective actions taken to address the concerns identified during our fieldwork. Although the scope of our audit did not provide for us to perform detailed tests of TrailBlazer's corrective actions, we believe that many of our concerns have now been addressed by these corrective actions.

Part of our audit work under the Secretary's Initiative required us to review TrailBlazer's policies and procedures related to corrective actions planned or taken in relation to Part A Audit and Reimbursement deficiencies identified during CPE reviews performed by CMS. At the outset of our fieldwork, TrailBlazer did not have adequate procedures in place to fully document

corrective actions planned and taken and to monitor the progress made in correcting the deficiencies. However, during and subsequent to our fieldwork and with input from the CMS representative on the OIG audit team, TrailBlazer developed and implemented a formal methodology to document and monitor corrective actions to address deficiencies noted by CMS during CPE reviews.

Our findings and recommendations are presented and discussed under the following major captions:

- Controls Related to the CMS 751 for Part A Non-MSP Accounts Receivable;
- Controls Related to Cash Collections Reported on the Part A CMS 1522; and
- Part A Audit and Reimbursement Contractor Performance Evaluation Reviews.

CONTROLS RELATED TO THE CMS 751 FOR PART A NON-MSP ACCOUNTS RECEIVABLE

The CMS requires fiscal intermediaries (FIs) to report Part A non-MSP accounts receivable on the CMS 751 in four major categories:

- Periodic interim payment amounts;
- Credit balances;
- Carryover adjustments; and
- Cost report settlement amounts.

Our audit did not include a review of periodic interim payments because there were only 24 providers being paid through periodic interim payments. Our audit did disclose problems in the controls and policies and procedures related to the remaining three categories. Our findings related to each of these three categories are discussed below.

Credit Balances

At the time of our fieldwork, TrailBlazer did not have adequate policies and procedures in place to provide us with the information needed to determine the credit balance amount reported on the CMS 751 for the quarter ended December 31, 2000. However, we were able to select and review a judgmental sample of credit balance amounts, applicable to this quarter, from TrailBlazer's credit balance database. The results of our judgmental sample disclosed that TrailBlazer was not properly reporting credit balances reported by providers that were accompanied by a check and one of the credit balance amounts in our judgmental sample was reported as a receivable in the wrong quarter. Although the net effect of these errors had little or no impact on the accounts receivable balance, they represented areas that TrailBlazer needed to correct. Subsequent to the completion of our fieldwork, TrailBlazer provided us with policies and procedures that explain how it tracks and reports credit balances. While these policies address most of the concerns

disclosed in our judgmental sample, we are making a recommendation for TrailBlazer to reconcile the credit balance database to the accounts receivable reported on the CMS 751.

A credit balance is an improper or excess payment made to a provider as a result of patient billing or claims processing errors. The amounts can consist of instances where a provider is:

- Paid twice for the same service either by Medicare or by Medicare and another insurer;
- Paid for services planned but not performed or for non-covered services;
- Overpaid/Underpaid because of errors made in calculating beneficiary deductible and/or coinsurance amounts; or
- Paid for outpatient services included in a beneficiary's inpatient claim.

The CMS policy requires that all accounts receivable activity should be shown on the CMS 751. Because credit balances represent amounts owed to the Medicare program, they should be shown as accounts receivable due Medicare. According to TrailBlazer officials, TrailBlazer reports a zero credit balance amount on the CMS 751 because CMS allows them to report fully processed credit balances as part of the amount reported on the CMS 751 for carryover adjustments.

Providers can submit the credit balance adjustments to TrailBlazer electronically in which case the claims processing system will track the credit balance and use it to offset the providers' future claims. The providers are also required to submit all credit balance adjustments to TrailBlazer on a quarterly report. TrailBlazer then records the credit balances on a credit balance database and verifies whether or not the credit balance has been set up in the claims processing system. For those credit balances that have not been set up in the system electronically by the provider, TrailBlazer manually sets them up in the system. In some cases, the providers submit checks with the quarterly reports to reimburse Medicare rather than setting up the credit balance amount electronically. In those cases, TrailBlazer is required to establish the receivable and show the receipt as a collection. If properly processed, all credit balance amounts are reported on the CMS 751 as a new carryover adjustment receivable and as a cash collection when claims are offset electronically or payment is received by check.

Although TrailBlazer was unable to provide us with the credit balance amount included with the carryover adjustment amount, we were able to select a judgmental sample of credit balance amounts, applicable to the quarter ended December 31, 2000, from TrailBlazer's credit balance database. We selected a judgmental sample of six credit balances, totaling $134,462 that applied to this quarter. We reviewed this sample to determine whether TrailBlazer was properly processing and reporting credit balance amounts on the CMS 751. Our review disclosed the following for four of the six credit balances reviewed:

- Four credit balance amounts, totaling $131,662 were not recorded as new accounts receivable and as collections on the applicable lines of the CMS 751. Because providers submitted checks covering all but $13 of these receivables, TrailBlazer did not consider the amounts to be accounts receivable to be reported on the CMS 751. Except for the $13, these reporting errors had no effect on the accounts receivable balance since the amounts were offsetting. However, the new accounts receivable line on the CMS 751 for

the quarter ended December 31, 2000, was understated by $131,662 and the collections line was understated by $131,649.

- One of the four credit balance amounts, totaling $130,481, was partially reimbursed to Medicare by a check submitted by the provider for $130,468, leaving an account receivable balance due Medicare of $13. The receivable should have been established and reported on the CMS 751 for the quarter ended December 31, 2000. However, TrailBlazer did not set up the $13 receivable until June 20, 2001. We recognize that this receivable amount is small. However, it is an indication of the need for TrailBlazer to establish procedures and controls to ensure that accounts receivable are established timely and reported in the proper quarter.

TrailBlazer did not have a procedure set up to reconcile the credit balance database to the credit balance amount reported on the CMS 751 that is included in the carryover adjustment amount. We believe that this reconciliation would help to ensure that all credit balance amounts are accounted for and reported in the proper quarter.

Conclusions and Recommendations

After the completion of our fieldwork, TrailBlazer provided us with written policies and procedures that address how it handles the tracking and reporting of credit balances. Further, a TrailBlazer official told us that they had implemented the written policies and procedures, as appropriate, that we provided to them as part of the Secretary's Initiative review. TrailBlazer's written policies and procedures provided to us state that credit balances are to be recorded as accounts receivable and as a cash collection on the appropriate lines of the CMS 751. The scope of our audit did not provide for us to test the new policies and procedures provided to us. However, we did review the policies and procedures to determine if they addressed the problems identified in our audit.

The new policies and procedures address several of our concerns. However, the policies and procedures do not contain a requirement to reconcile, on a quarterly basis, the credit balance database to the accounts receivable reported on the CMS 751 that result from credit balances. Therefore, we recommend that TrailBlazer:

- Reconcile, at least quarterly, the credit balance database to the accounts receivable reported on the CMS 751 that result from credit balances reported during the quarter by providers. This control would help to ensure that Trailblazer reports accounts receivable in the proper quarter.

Auditee Comments

In their written response addressing this finding, TrailBlazer officials stated that during the course of the OIG's review, they analyzed their credit balance database and how it is used to support the Credit Balance Summary Report submitted quarterly to CMS. As a result of that analysis, TrailBlazer changed the timing applicable to the submission of the Credit Balance

Summary Report to coincide with the quarter-end dates used for CFO reporting. TrailBlazer officials further explained that this now allows for a clearer audit trail for determining the amount of unprocessed credit balance reports because these unprocessed reports are reconciled to the amount of unprocessed reports shown on the credit balance database at the end of a quarter. The amount of these unprocessed credit balance reports represents the credit balance receivables amount reported on the CFO reports. TrailBlazer officials further stated that they obtained CMS Central Office concurrence with this credit balance reporting methodology in November 2002.

TrailBlazer officials expressed concern that our recommendation requires more reconciliation effort than that required in the methodology concurred in by CMS. These officials pointed out that our recommendation would require them to not only reconcile the unprocessed credit balance reports to the credit balance database but they would also have to reconcile the processed credit balance amounts to the credit balance database. In order to accomplish this, these officials stated that there would have to be significant shared system changes and additional manual analysis performed. TrailBlazer officials also stated that this increased level of analysis exceeds CMS' expectations and current contractor capabilities. For this reason, they stated that they have requested guidance on whether CMS believes it is required. They further stated that, since other fiscal intermediaries would likely be affected, they thought our recommendation should be directed to CMS to ensure appropriate evaluation, consideration, and consistency.

OIG Response

We recognize that TrailBlazer has made significant improvements in its methodology for reporting credit balance amounts on the CMS 751 which is one of the CFO reports referred to in TrailBlazer's written comments. For example, at the time of our audit, TrailBlazer consistently reported a zero dollar amount for credit balances on the CMS 751. They are now reconciling the unprocessed credit balance reports to the credit balance database and reporting the unprocessed credit balance amounts as a receivable quarterly. However, we are concerned that if the credit balance amounts that are processed and reported as claims accounts receivable are not also reconciled to the credit balance report there is no assurance that all of the processed credit balance amounts are reported on the CMS 751. As pointed out in our report, we identified four credit balance amounts that had been processed and were never established as a receivable. We recognize that there would be additional effort involved in making this reconciliation, but we believe that such a reconciliation would provide added assurance that the proper amount of Medicare accounts receivable are reported on the CMS 751. However, if CMS does not believe that our recommendation is warranted, we are confident that it will not require TrailBlazer or other fiscal intermediaries to perform the recommended reconciliation.

Carryover Adjustments

At the time of our fieldwork, TrailBlazer did not have adequate written policies and procedures in place to provide us with the information needed to determine how it reported carryover adjustment amounts on the CMS 751. However, we were able to select a judgmental sample of five carryover adjustments from the accounts receivable report (8044 report) for the quarter ended December 31, 2000. The required adjustments were properly established in the claims

processing system for all five adjustments. However, one of the five adjustments involved a mass adjustment initiated by TrailBlazer that applied to several providers. The mass adjustment did not take effect in the claims processing system. The provider selected in our sample, who was a part of the mass adjustment, determined that the adjustment needed to be made and voluntarily initiated the adjustment electronically in the claims processing system. Subsequent to the completion of our fieldwork, TrailBlazer provided us with written policies and procedures addressing carryover adjustments. However, the new policies and procedures do not address mass adjustments. TrailBlazer needs to establish procedures to ensure that mass adjustments entered into the claims processing system actually take effect.

Carryover adjustments are predominately the result of providers and contractors adjusting previously paid claims for such items as duplicate billings or overlapping of hospital outpatient and inpatient services. If the provider identifies the adjustment, the provider can make an adjustment electronically directly to the claims processing system or the provider can submit the adjustment to TrailBlazer to make the adjustment. If TrailBlazer identifies the need for an adjustment, TrailBlazer enters the adjustment directly into the claims processing system. In either case, these adjustments are referred to as adjustment claims and will generally be set up in the claims processing system as an offset to other current and future claims submitted by the provider. Until the adjustment claim is fully recouped by offset, any balance should be included on the CMS 751 as an account receivable. For the quarter ended December 31, 2000, TrailBlazer reported claims accounts receivable, which includes carryover adjustments and credit balances, totaling $5.9 million on the CMS 751. We could not determine how much of the $5.9 million represented carryover adjustments.

We selected a judgmental sample of five carryover adjustments totaling $10,662 reported by TrailBlazer on the accounts receivable report (8044 report) for the quarter ended December 31, 2000. Our review of these five adjustments, along with interviews of several TrailBlazer employees, disclosed the following concerns:

- One of the five adjustments in our sample represented part of an adjustment referred to by TrailBlazer as a mass adjustment. Mass adjustments consist of similar claims applicable to several providers that are adjusted at one time. Our sample adjustment was part of an end stage renal disease (ESRD) mass adjustment. According to a TrailBlazer official, the ESRD mass adjustments must be entered manually for the adjustment to take effect. However, in this case, the manual adjustment did not take effect and the provider determined that the adjustment was not made and voluntarily initiated the adjustment electronically. According to TrailBlazer officials, they test the mass adjustments prior to initiating them to ensure the correct providers and correct claims are selected for adjustment. In addition, TrailBlazer notifies the affected providers by posting the adjustment information on a website that a mass adjustment was initiated. However, TrailBlazer told us that they do not test the mass adjustments after they initiate them to ensure the mass adjustment actually took place.

- According to a TrailBlazer official, TrailBlazer did not have procedures in place to record collections on their records in those instances where another FI had collected payment on

a Part A claims account receivable. This generally occurs when a provider changes from TrailBlazer to another FI and submits payments to the new FI that are applicable to receivables maintained by TrailBlazer.

Conclusions and Recommendations

After the completion of our audit work, TrailBlazer provided us with policies and procedures that address the tracking and reporting of carryover adjustments. In addition, a TrailBlazer official told us that they had implemented the written policies and procedures, as appropriate, that we provided to them as part of the Secretary's Initiative review. The scope of our audit did not provide for us to select current carryover adjustments to test the new policies and procedures provided to us. However, we did review the policies and procedures to determine if they addressed the problems identified in our audit. Most of our concerns were addressed in the policies and procedures provided to us. However, we recommend that TrailBlazer amend its policies and procedures to address mass adjustments as follows:

- Establish procedures to ensure that mass adjustments actually take effect by being properly posted to the applicable provider claims and that the applicable providers are notified if the mass adjustment does not take effect.

Auditee Comments

In their written response to this finding, TrailBlazer officials stated that TrailBlazer had updated its policies and procedures, as applicable, based on the OIG recommendations related to mass adjustments. In addition, they stated that TrailBlazer had sampled five additional claims that were involved in the mass adjustment noted in the report and found that the mass adjustment processed these claims correctly. Further, TrailBlazer officials explained that other, unrelated system issues associated with the claim noted in the report caused the mass adjustment to process incorrectly.

TrailBlazer officials explained that the fiscal intermediary shared system (FISS) allows them to currently tests mass adjustments prior to putting them into production. These officials agree that testing claims involved in a mass adjustment subsequent to implementation validates whether the mass adjustment did, in fact, process correctly. However, they stated that manually testing each claim that should have been adjusted, would be inefficient and cost prohibitive. To validate the effectiveness of mass adjustments more efficiently, TrailBlazer, by May 1, 2003, plans to develop and implement procedures that mimic the testing performed prior to the mass adjustment being put into production. TrailBlazer also plans to work with its provider education staff to develop and implement a procedure, by May 1, 2003, to notify providers if TrailBlazer does find that a mass adjustment did not take effect as planned.

OIG Response

We believe that TrailBlazer's plans for testing mass adjustments prior to putting them into production will help to ensure that the intended results of the mass adjustments are properly established. We concur that manually testing each of the mass adjustment claims after the adjustment is implemented would not be practical. However, we believe that TrailBlazer should establish procedures to test a sample of the claims involved to help ensure that the intended results of the mass adjustment are accomplished.

Cost Report Settlement Amounts

TrailBlazer reported Part A non-MSP cost report settlement amounts totaling over $177 million on the CMS 751 for the quarter ended December 31, 2000. This amount represents an account receivable to Medicare. TrailBlazer provided us with a schedule that showed that TrailBlazer understated its reported Medicare Part A non-MSP accounts receivable balance by about $13.3 million and its unapplied cash by about $3.1 million. These understatements occurred as a result of a change, with unintended consequences, in the policy for establishing accounts receivable whereby the initial cost report accepted date, rather than the cost report received date, became the determination date for the accounts receivable. However, although TrailBlazer understated its unapplied cash by about $3.1 million, it did report approximately $8.5 million of unapplied cash related to the $13.3 million unrecorded receivables as "Other Liabilities". The providers had not submitted payments for the approximately $1.7 million difference between the $11.6 million in unapplied cash and Other Liabilities, therefore TrailBlazer appropriately did not record that amount as Other Liabilities. If TrailBlazer had reconciled the cost report received report to other reports, it could have identified the $13.3 million accounts receivable and $3.1 million unapplied cash understatements and included the appropriate amounts on the CMS 750/751 for the quarter ended December 31, 2000.

In November 2000, TrailBlazer changed its financial policies from recording accounts receivable related to initial cost reports into the Fiscal Intermediary Shared System (FISS) upon receipt to recording the accounts receivable upon acceptance of the cost reports. The FISS is predominately a CMS claims processing system with the capability to track, record, collect and report accounts receivable activity. According to a TrailBlazer official, the intent of the policy change was to enable TrailBlazer to enter the accounts receivable into the Provider Overpayment Reporting (POR) System within the 10-day period established by CMS. With this change in policy, the acceptability date, rather than the cost report receipt date, became the determination date for the accounts receivable.

TrailBlazer officials subsequently realized that the new policy would result in a significant understatement of the accounts receivable, and accordingly, returned to using their original policy in January 2001. In addition to TrailBlazer returning to its original policy, it subsequently included the appropriate amounts related to these understatements in the CMS 750/751 for the next quarter. Accordingly, we have no recommendations regarding that policy.

Conclusions and Recommendations

Because TrailBlazer had already rescinded the new policy as of January 2001 and reverted to the original policy whereby the determination date was the date the cost report was received, rather than the accepted date, no further action is required to correct the policy issue itself. Subsequent to our fieldwork, TrailBlazer eliminated the use of the Cost Report Received System that produced the cost report received report. However, according to a TrailBlazer official, TrailBlazer initiated review procedures both during and subsequent to our fieldwork to ensure that unapplied cash is properly reported on the CMS 750. Although the scope of our audit did not provide for us to test these new procedures, if properly followed, we believe they should prevent any future unapplied cash problems similar to the one identified during our review.

In addition to initiating the review procedures, during the course of our fieldwork, TrailBlazer also established and filled the CFO position to provide CFO reporting oversight needed to ensure adherence to CMS reporting guidelines. We believe that significant policy changes like the one that resulted in the unapplied cash problem identified during our review, should be discussed with the CFO prior to implementation. According to a TrailBlazer official, staff involved in the CFO reporting process are aware of the CFO's role and understand the need to consult with the CFO on significant CFO reporting policy changes. However, in order to ensure all appropriate staff are aware of this need, we recommend that TrailBlazer officials issue a reminder to the appropriate staff to consult with the CFO on any significant changes planned that could impact CFO reporting.

Auditee Comments

In regard to the finding related to cost report settlement amounts, TrailBlazer officials noted that it believes that staff involved in the CFO reporting process have been aware of the need to consult with the CFO on significant CFO reporting policy changes since the establishment of the CFO position in April 2001. The officials further noted that for the mistake identified, this would not have been possible since it relates to an issue arising prior to the establishment of that position. However, TrailBlazer did recently issue a reminder to emphasize the importance of coordinating and communicating current and planned changes with the CFO.

Detailed Testing and Analysis of the Cost Report Settlement Process

Due to the complexity of the cost report settlement process as part of the Secretary's Initiative, we determined that detailed testing and analysis of the cost report settlement process was needed. The detailed testing and analysis of the cost report settlement process involved a review of various reports and documents used by TrailBlazer in the settlement of cost reports. Appendix A to our report contains a brief summary of various activities involved in TrailBlazer's cost report settlement process. We identified findings in the following areas related to this process:

- Initial Cost Report Reminder Letters
- Unfiled Cost Report Demand Letters
- Overpayment Demand Letters

- Coding of Overpayment Interest
- Tentative and Final Settlements
- Interim Rate Reviews

Our findings and recommendations related to each of these areas are discussed below.

Initial Cost Report Reminder Letters

TrailBlazer did not enter reminder letter dates into the CRRS for five out of the seven reminder letters we reviewed. These letters are sent to providers when cost reports are due. The CRRS allows TrailBlazer to track providers who have not submitted cost reports. TrailBlazer did not enter the reminder letter dates into the CRRS system for the five reminder letters we reviewed because the reimbursement supervisors did not verify whether these dates had been entered. If reminder letters are not sent timely, this could result in unnecessary delays for the collection of overpayments from providers or payment of underpayments to providers. In addition, these potential overpayments and underpayments could impact the amounts reported for accounts receivable and accounts payable on the CMS 750/751s. Subsequent to our fieldwork, TrailBlazer implemented a new letter writing process to ensure timely mailing of reminder letters. Although the scope of our audit did not provide for us to test the process, it appears that it should result in the timely mailing of these letters. However, we are also recommending that TrailBlazer officials formalize written procedures to monitor the new letter writing process to ensure that clerks mail reminder letters timely.

TrailBlazer's policies and procedures required mailing a reminder letter to the provider approximately, but not later than, 30 days prior to the cost report due date. The purpose of the reminder letter was to notify the provider of its obligation to file a cost report. In addition, these policies and procedures also required that after reimbursement clerks entered the reminder letter dates into the CRRS, reimbursement supervisors conduct weekly reviews of the CRRS management reports to determine providers due reminder letters.

The reimbursement supervisors did not conduct the required weekly reviews of the CRRS management reports to verify whether the reminder letter dates had been entered into the CRRS. Otherwise, they would have been able to identify the providers with cost reports due that did not have reminder letter dates in the CRRS, and required the clerks to take appropriate action to ensure that reminder letters were sent and dates were entered into the CRRS.

Although the applicable dates had not been entered into CRRS for five of the seven letters we reviewed, the clerks had mailed the five letters timely to the providers. However, if the dates were not appropriately entered into the CRRS, supervisors would not have the most current status concerning whether the clerks had mailed reminder letters to the providers. If reminder letters are not sent, it could result in unnecessary delays for the collection of overpayments from providers or payment of underpayments to providers. In addition, these potential overpayments and underpayments could impact the amounts reported for accounts receivable and accounts payable on the CMS 750/751s.

Conclusions and Recommendations

According to TrailBlazer officials, TrailBlazer is no longer using the CRRS to process reminder letters. Instead, on April 12, 2002, subsequent to our fieldwork, TrailBlazer began using a STAR Letter Writer and mass Provider Statistical and Reimbursement (PS&R) report ordering capability process. The PS&R reports provide a summary of paid claims made for the reporting period of the cost report submitted, and are used by providers in preparing the annual cost reports and by auditors for their review of the reports.

This new process encompasses the use of the STAR system to generate an extract that allows for the generation of an electronic listing for all providers requiring PS&R reports and reminder letters, based on the providers' fiscal year ending (FYE). The information included in the extract is subsequently merged into an Initial Reminder Letter template and printed out. The letter date is the date the PS&Rs are to be mailed out. Signed letters are placed in the mail by 8:30 AM on the mailing date to ensure the letters are postmarked on the due dates. Although the scope of our audit did not provide for us to test this new process, it appears that it should result in the timely mailing of the cost report reminder letters. However, we recommend that TrailBlazer officials formalize written procedures to monitor the new letter writing and PS&R ordering process to ensure that clerks mail reminder letters timely.

Auditee Comments

TrailBlazer officials concurred with the OIG's recommendation related to initial cost report reminder letters, and plans to formalize its written procedures related to the Initial Cost Report Reminder Letters and the PS&R ordering process by June 30, 2003.

Unfiled Cost Report Demand Letters

For the seven providers we reviewed, TrailBlazer did not mail unfiled cost report demand letters timely for at least 15 out of a total of the required 21 demand letters (3 letters per provider). In addition, TrailBlazer did not have evidence in the provider file or in the CRRS indicating whether or not TrailBlazer had mailed one out of seven second demand letters, and did not mail a third demand letter to one provider that had no Medicare utilization. Further, TrailBlazer's policy provided for sending the reminder letter for initial cost reports via certified mail to the provider, rather than sending the first demand letter via certified mail as required by CMS guidelines. However, during and subsequent to our fieldwork, TrailBlazer took corrective actions to address the problems we identified with regard to unfiled cost report demand letters. Although the scope of our audit did not provide for us to test these new policies and procedures, we believe that they should significantly improve the timely processing of provider amounts owed to Medicare as a result of unfiled cost reports, as well as meet CMS requirements for mailing of first demand letters via certified mail. However, we are making recommendations for additional improvements related to unfiled cost report demand letters.

The CMS guidelines for overpayment demand letters for unfiled cost reports required that, as a rule, FIs send three demand letters to providers using the following time frames: (1) for the first

demand letter, we concluded that CMS guidelines allows for a grace period of 7 days from the cost report due date before a first demand letter is required to be mailed; and (2) for the second and third demand letters, CMS requires the letters be mailed 30 days after the date of the most recent demand letter. We used these criteria in our analysis of the data presented in Table 1.

Table 1 below shows that TrailBlazer did not comply with CMS guidelines regarding the timely issuance of the first, second, and third demand letters. With regard to the first demand letter, none of the 7 were timely, ranging from 1 to 13 days late. For the second demand letter, provider numbers 3 and 4 were 4 days late, and provider number 7 was 24 days late. Finally, 5 of the 7 third demand letters were late, with provider numbers 1 through 4 ranging from 5 to 11 days late. The demand letter for provider number 7 was 172 days late because TrailBlazer did not think that a third demand letter needed to be sent to this low/no Medicare utilization provider until we brought it to TrailBlazer's attention.

Table 1 – Unfiled Cost Report Demand Letters

			1st Demand Letter		2nd Demand Letter		3rd Demand Letter	
Provider #	FYE	Cost Report Due	Date Mailed	# of Days Late	Date Mailed	# of Days Late	Date Mailed	# of Days Late
1	12/31/00	05/31/01	06/13/01	6	07/05/01	0	08/15/01	11
2	12/31/00	05/31/01	06/13/01	6	07/05/01	0	08/09/01	5
3	12/31/00	05/31/01	06/14/01	7	07/18/01	4	08/23/01	6
4	12/31/00	05/31/01	06/14/01	7	07/18/01	4	08/22/01	5
5	06/30/00	12/10/00	12/18/00	1	-	-	07/13/01	-
6	12/31/00	05/31/01	06/12/01	5	07/06/01	0	N/A	-
7	12/31/00	07/21/01	08/10/01	13	10/03/01	24	04/23/02	172

The CMS guidelines also require that FIs mail the first demand letters for unfiled cost reports via certified mail. Although not shown in Table 1, TrailBlazer did not comply with this requirement.

For provider number 5 in Table 1, we could not find any evidence that the second demand letter was sent. We did have evidence that the third demand letter was sent, but we could not determine whether it was timely because we had no evidence that the second demand letter was sent. With regard to provider number 6 in Table 1, TrailBlazer did send first and second demand letters; the first was untimely, and the second one was timely. However, the reimbursement supervisor incorrectly determined that a third letter was not necessary because this provider did not have any Medicare patient utilization for the cost reporting period. According to a TrailBlazer official, TrailBlazer's policies and procedures required that all three demand letters be sent to such providers.

The untimely mailing of the demand letters resulted because the reimbursement supervisors did not properly review the weekly status reports from the CRRS or the Billing Follow-up System (BFS). These reports show the providers who should have been sent demand letters and would have allowed the supervisors to ensure that the letters were sent timely. With regard to mailing first demand letters for unfiled cost reports via certified mail, TrailBlazer did not have policies and procedures in place to follow CMS' guidelines. TrailBlazer's policy provided for sending

the reminder letter for initial cost reports via certified mail to the provider, rather than sending the first demand letter via certified mail.

TrailBlazer officials told us that they did not send the first demand letter certified because they thought it was more important to send the initial cost report reminder letter certified. They explained that they had concerns about providers potentially falsely claiming that they had not received the initial cost report reminder letters, resulting in the providers not filing the requested reports timely. While it may have helped TrailBlazer to receive cost reports timely by sending the reminder letters certified, it does not relieve them of their responsibility to comply with CMS guidelines requiring that the first demand letters also be sent via certified mail.

The untimely mailing of the unfiled cost report demand letters resulted in (1) subsequent demand letters being mailed later than normal and (2) ultimately delaying the establishment of provider accounts receivable and accounts payable which could impact the amounts reported for such accounts receivable and accounts payable on the CMS 750/751s.

Conclusions and Recommendations

During and subsequent to our fieldwork, TrailBlazer took corrective actions to address the problems we identified with regard to unfiled cost report demand letters. TrailBlazer officials provided us with the following information regarding the corrective actions taken to correct the problems we identified with regard to unfiled cost report demand letters.

1) TrailBlazer instituted a STAR Letter Writer process for the issuance of first demand letters for unfiled cost reports, effective with the first round of first demand letters generated on June 3, 2002. Home office teams will continue to have responsibility for first demand letter functions related to unfiled cost report overpayments and other provider overpayments.

2) Effective February 2002, a newly created reimbursement reporting department had been assigned responsibility for second and third demand letter functions for overpayments related to unfiled cost reports and other provider overpayments. Although according to a TrailBlazer official, the written policies and procedures related to this department have not been completed, the department instituted the above letter writing process, effective June 3, 2002, for second and third demand letters for unfiled cost reports.

3) Effective March 21, 2002, TrailBlazer initiated procedures to mail the unfiled cost report demand letters, as well as overpayment first demand letters, via certified mail. However, TrailBlazer needs to formalize written monitoring procedures to verify that such letters are mailed via certified mail.

Although the scope of our audit did not provide for us to test these new policies and procedures, we believe that they should significantly improve the timely processing of provider amounts owed to Medicare as a result of unfiled cost reports, as well as meet CMS requirements for mailing of first demand letters via certified mail. However, we believe that TrailBlazer needs to

make additional improvements related to unfiled cost report demand letters. Therefore, we recommend that TrailBlazer:

- Formalize written monitoring procedures to ensure that the Home office teams verify that initial cost report reminder and first demand letters are sent via certified mail; and

- Complete the development of its written policies and procedures within the new reimbursement reporting department to ensure TrailBlazer mails second and third unfiled cost report demand letters to providers in a timely manner.

Auditee Comments

TrailBlazer officials concurred with the OIG's recommendations related to unfiled cost report demand letters. Regarding the first recommendation, TrailBlazer officials noted that it plans to formalize written procedures related to both the Initial Cost Report Reminder Letters and First Demand Letters by June 30, 2003. According to TrailBlazer officials, these policies will include the requirement to send all First Demand Letters via certified mail. Regarding the second recommendation, TrailBlazer officials stated that it is currently revising its Unfiled Cost Report Reminder and Demand Letter Policy to address the Reimbursement Reporting Department's procedures related to the timely issuance of second and third unfiled cost report demand letters. The revised policy will be formally issued by June 30, 2003, and will include the use of STAR extracts and a Letter Checklist, which will identify the proper POR status code to be entered to the POR System.

Overpayment Demand Letters

We selected nine providers to review for timeliness of overpayment demand letters. Out of the nine providers reviewed, TrailBlazer did not submit three of the second demand letters or four of the third demand letters timely, as required by CMS guidelines. The untimely mailing of the demand letters resulted because the reimbursement supervisor responsible for these particular providers did not properly review the weekly status reports from the BFS. These reports would have shown which providers were due demand letters, and would have allowed the reimbursement supervisor to ensure the letters were sent timely. The untimely mailing of the second demand letters resulted in the third demand letters being mailed later than normal. In addition, the untimely mailing of the second and third demand letters resulted in a delay in reporting by TrailBlazer to CMS for referral of two overpayments to the Debt Collection Center (DCC) for collection. The remaining two overpayments are no longer eligible for referral. During and subsequent to our fieldwork, TrailBlazer took corrective actions to address the problems we identified with regard to overpayment demand letters. However, in addition to these actions, we are recommending that TrailBlazer complete the development of its written policies and procedures for its new reimbursement reporting department to ensure TrailBlazer mails overpayment demand letters to providers in a timely manner.

According to CMS guidelines, the purpose of an overpayment demand letter is to notify the provider of the existence and amount of an overpayment and to request repayment. These guidelines require FIs to send, as a rule, three demand letters to providers. The following time frames apply: (1) first demand letter – mailed immediately after discovery or determination of the overpayment; and (2) second and third demand letters – mailed 30 days after the most recent demand letter. According to a CMS official, CMS does not require FIs to send second and third demand letters to bankrupt providers. Finally, CMS guidelines require that if there was no response by the provider to the third demand letter after 60 days, these FIs should report this delinquent debt through the Debt Collection System to CMS for referral to the DCC for collection.

Table 2 below contains a schedule of the nine providers we reviewed to determine whether TrailBlazer was complying with CMS guidelines. As noted in the table, TrailBlazer mailed the first demand letters timely, including provider numbers 5 through 9 who were bankrupt. The four providers who were not bankrupt were required to be sent second and third demand letters. However, three out of the four second demand letters were untimely, with delays ranging from approximately 5 to 53 days. In addition, all four of the third demand letters were untimely with delays ranging from approximately 2 to 85 days.

Table 2 – Overpayment Demand Letters

Provider #	Bankrupt	FYE	Overpayment Determination Date	1st Demand Letter		2nd Demand Letter		3rd Demand Letter	
				Date Mailed	# of Days Late	Date Mailed	# of Days Late	Date Mailed	# of Days Late
1	No	12/31/98	08/28/01	08/28/01	0	11/02/01	36	02/25/02	85
2	No	03/31/99	08/14/01	08/14/01	0	11/05/01	53	12/07/01	2
3	No	12/31/98	09/28/01	09/28/01	0	11/02/01	5	12/07/01	5
4	No	06/30/99	08/20/01	08/20/01	0	09/06/01	0	11/09/01	34
5	Yes	12/31/98	09/28/01	09/28/01	0	-	-	-	-
6	Yes	12/31/98	09/28/01	09/28/01	0	-	-	-	-
7	Yes	12/31/98	09/28/01	09/28/01	0	-	-	-	-
8	Yes	11/16/98	09/28/01	09/28/01	0	-	-	-	-
9	Yes	12/31/98	08/31/01	08/31/01	0	-	-	-	-

TrailBlazer's policies and procedures required reimbursement supervisors to run weekly BFS status reports to monitor the weekly debt collection activity to ensure that appropriate and timely action is taken by their staff. The untimely mailing of the demand letters resulted because the reimbursement supervisor responsible for these particular providers did not properly review the weekly status reports from the BFS. These reports would have shown which providers were due demand letters, and would have allowed the reimbursement supervisor to ensure that the letters were sent timely.

The untimely mailing of the second overpayment demand letters resulted in the third demand letters being mailed later than normal. In addition, the untimely mailing of the second and third demand letters resulted in a delay in reporting by TrailBlazer to CMS for referral of two

overpayments to the DCC for collection. The two remaining overpayments are no longer eligible for referral.

Conclusions and Recommendations

During and subsequent to our fieldwork, TrailBlazer took corrective actions to address the problems we identified with regard to overpayment demand letters. According to a TrailBlazer official, although TrailBlazer has initiated the development of written policies and procedures for this newly created department, the written policies and procedures have not been finalized.

A TrailBlazer official told us that the reimbursement reporting department created a debt collection system database during our fieldwork that it now uses to manage the second and third demand letters, and that they also initiated during this timeframe the use of BFS reports as another check to ensure that all overpayments are included in the database. In addition, beginning in August 2002, subsequent to our fieldwork, the reimbursement reporting department initiated other reconciliation policies and procedures between the POR and the debt collection database. TrailBlazer developed this process to ensure the overpayments have been entered into the database for continuation of the debt collection process, including mailing of second and third demand letters. Further, each week, the reimbursement reporting department runs a database query based on first or second demand letter dates, as appropriate, to identify providers which are due the next demand letter for overpayments.

Although the scope of our audit did not provide for us to test these new policies and procedures, we believe that TrailBlazer is taking appropriate actions to correct the problem concerning the untimely mailing of overpayment demand letters. However, in addition to these actions, we recommend that TrailBlazer finalize the completion of its written policies and procedures for its new reimbursement reporting department to ensure TrailBlazer mails overpayment demand letters to providers in a timely manner.

Auditee Comments

TrailBlazer officials stated that they are currently revising their Debt Collection Policy and plan to issue this revised policy by June 30, 2003. This revised policy will incorporate the changes in the debt collection process and address the debt collection functions performed by the Home Office Teams, as well as the debt collection functions performed by the Reimbursement Reporting Department. The policy will include procedures for determining the demand letters to be issued and for monitoring the debt collection process. In addition, the policy will also include a letter checklist to ensure the POR Clerks are notified of the proper POR status codes to be entered.

Coding of Overpayment Interest

TrailBlazer did not have an adequate system in place to ensure that the interest associated with overpayments was assigned codes that were consistent with overpayment principal codes. As a result, TrailBlazer provided CMS with incorrect information through the POR System that

impacts the accuracy of management information compiled by CMS. During and subsequent to our fieldwork, TrailBlazer took corrective actions to address the problems we identified regarding the assignment of incorrect interest status codes in the POR system. However, we are recommending that TrailBlazer establish monitoring procedures to ensure that the new procedures result in status codes being correctly entered into the POR System.

The CMS guidelines require FIs to report any outstanding provider overpayments to CMS through the use of the electronic on-line POR System. The POR System serves as a uniform method for all FIs to report both the principal and interest associated with provider overpayments, including the length of time an overpayment is outstanding, and provides a base for CMS to use in compiling management information on overpayments.

We selected and reviewed 10 providers to determine if TrailBlazer coded the status of interest associated with overpayments consistent with the codes assigned to the overpayment principal amounts. Our review of these 10 providers disclosed the following:

- Four of the 10 providers did not have coding issues related to interest codes being inconsistent with overpayment principal codes. The interest code was consistent with the overpayment principal code for one of the four providers. For two of the providers, TrailBlazer correctly had not yet assessed interest, since interest was not yet due based on overpayment cut-off dates we established for this portion of our fieldwork. In addition, for the fourth provider, TrailBlazer, consistent with its own policy, did not assess interest because the overpayment principal did not require interest since the overpayment was for an unfiled cost report.

- For the remaining six providers, TrailBlazer did not assign codes to the interest that was consistent with the overpayment principal codes.

TrailBlazer's policies and procedures implemented in late July 2001 required that POR entry clerks code interest associated with established overpayments consistently with the codes assigned to the related overpayment principal. The policies and procedures called for the clerks to enter various two-digit status codes into the POR System to indicate the latest status of the overpayment. For example, if a provider had filed for bankruptcy, the two-digit status code for bankruptcy should have been input into the POR System for both the overpayment principal and for the interest associated with that overpayment principal amount.

For six providers that had incorrect interest status codes assigned, TrailBlazer did not follow its established procedures that required coding the status of interest associated with overpayments consistent with the status codes of the overpayment principal. According to TrailBlazer personnel, the incorrect coding resulted from the following:

- Interest associated with overpayments does not go into effect until 31 days after the determination that an overpayment exists. Codes are assigned to the overpayment principal at the time the overpayment is entered into the POR System. However, the

codes assigned to the interest are not entered for at least 31 days later. As a result of this timing difference, the entry clerks did not always use the same code.

- TrailBlazer's procedures for making corrections to the POR System status codes were complex and, as a result, the procedures were either not followed or the procedures were not consistently followed by the various teams assigned to ensure correct coding into the POR System.

- Due to the competing workload priorities by the teams responsible for coding interest into the POR System, errors were made in assigning the interest codes.

Because CMS uses the POR System information in compiling management information on overpayments, TrailBlazer should ensure that the codes entered into the POR System are accurate.

Conclusions and Recommendations

During and subsequent to our fieldwork, TrailBlazer took corrective actions to address the problems we identified regarding the assignment of incorrect interest status codes in the POR system, as follows:

- Effective February 1, 2002, during our fieldwork, TrailBlazer's management reassigned the staff and the function for entering codes into the POR System to its reimbursement reporting department. This department has modified TrailBlazer's POR System entry policies and procedures including the implementation of the use of a POR System Status Code Checklist. This checklist includes a place for the reimbursement staff to select the overpayment type, including both the overpayment principal and if applicable, interest associated with the overpayment principal. A TrailBlazer official stated that these changes should help to ensure that both principal and interest are consistently coded into the POR System.

- Further, the official noted that beginning in April 2002, subsequent to our fieldwork, TrailBlazer initiated a quarterly reconciliation between overpayments with outstanding balances in the CFO database to compare the principal POR status codes with the related POR interest status codes. Where discrepancies in the POR System status codes exists, corrections are entered into the POR System.

- Finally, subsequent to our review of this area, TrailBlazer corrected the POR System for each of the incorrect interest status codes for the six providers who had incorrect codes. Accordingly, we have no further recommendations regarding these six providers.

Although the scope of our audit did not provide for us to test the new procedures recently implemented by TrailBlazer to address the POR interest status code problem, we believe that TrailBlazer is taking appropriate actions to correct the problem. However, we recommend that

TrailBlazer formalize written monitoring procedures to ensure that the new procedures result in status codes being correctly entered into the POR System.

Auditee Comments

TrailBlazer officials stated in their response related to coding of overpayment interest that they are currently revising their Debt Collection Policy to incorporate the changes in the debt collection process, and that they plan to formally issue the revised policy by June 30, 2003. The revised policy will require a Debt Collection Checklist be completed as part of the development of the second and third demand letters. The revised policy will also require Reimbursement Reporting Analysts to complete a POR Status Code Checklist, which is completed and submitted to the POR Clerks for proper coding of the principal and related interest in the POR System.

Tentative and Final Settlements

TrailBlazer did not complete tentative and final settlements in lieu of tentative settlements timely for initial cost reports with due dates in FY 2001 as required by its established goals or CMS' guidelines. Out of 2,646 cost reports with due dates in FY 2001, there were at least 1,972 cost reports that required either tentative or final settlements in lieu of tentative settlements to be performed. Of the 1,972 cost reports, 487 were settled timely. However, TrailBlazer officials stated that it did not complete 26 tentative settlements timely due to a variety of reasons. More importantly, according to TrailBlazer, the untimely completion of the 1,459 final settlements completed or planned in lieu of tentative settlements resulted primarily because (1) CMS did not provide TrailBlazer with adequate funding over a five-year period needed to handle the large volume of tentative and final settlements that were required to be completed and (2) because of a workload peaking problem. These untimely settlements resulted in or will result in the following:

- Payments due Medicare from the providers or due the providers from Medicare were delayed;

- TrailBlazer's CMS 750/751s for FY 2001 not reflecting the Medicare accounts receivable and accounts payable amounts which would have been reported had the settlements been completed timely; and

- TrailBlazer's 750/751s' accounts receivable and accounts payable amounts will be affected for subsequent years until the settlements are completed.

However, TrailBlazer submitted documentation to CMS, dated September 10, 2002, to propose workload changes to achieve workload currency by September 30, 2005. With regard to the need for additional funding, based on the documentation submitted to CMS by TrailBlazer, the CMS Region VI Regional Office proposed to provide an additional $1 million in special funding for FY 2003 to assist TrailBlazer in addressing its cost report backlog. Accordingly, we are making recommendations related to TrailBlazer's efforts to resolve these issues with CMS.

The CMS guidelines set forth the following with regard to tentative and final settlements:

- Tentative settlements are required by CMS guidelines to bring interim payments made to providers during the cost reporting period into agreement with the reimbursable amount payable to the provider for the services provided to program beneficiaries during that period. According to TrailBlazer's policies and procedures, TrailBlazer's goal was to complete all tentative settlements within 60 days of receipt of an acceptable initial cost report from the provider in accordance with CMS guidelines. These guidelines were clarified by CMS in instructions issued July 3, 2001, which stated that FIs were required to complete tentative settlements within 60 days of the receipt of an acceptable cost report.

- Final settlements of provider cost reports come after tentative settlements and are completed either as problem resolutions, field audits or focused reviews. The CMS guidelines, issued July 2001, state that CMS expects all cost reports settled via problem resolution to be completed within 12 months of acceptance of a cost report. The FY 2002 Budget Performance Requirements (BPRs) issued to the FIs by CMS required all FIs to achieve currency in settlement of all provider cost reports within 24-30 months from the beginning of FY 2002. According to the BPRs, this means that by mid-FY 2004, all FIs should be current in settlements. In the FY 2003 BPRs, CMS further extended the time period for FIs to attain settlement currency to September 2005.

Around June of 2001, TrailBlazer requested that CMS allow TrailBlazer to omit performing tentative settlements and go straight to final settlement for certain provider types. According to a TrailBlazer official, TrailBlazer made this request in an effort to reduce the large backlog of tentative settlements. The request applied to most non-hospital and non-Community Mental Health Center (non-CMHC) providers, such as end stage renal disease (ESRD) facilities, rural health clinics and skilled nursing facilities. The CMS officials informed us that they concurred with this proposal. However, they noted that their expectations were that (1) TrailBlazer would complete the final settlements within the same general timeframes of the required 60 days for tentative settlements, and at the most, up to 90 days after receipt of an acceptable cost report, and (2) the cost reports settled in this manner would be relatively problem-free. In assessing timeliness for final settlements, we used the more conservative 90-day threshold.

As noted in the SCHEDULE attached to our report, TrailBlazer did not complete tentative and final settlements timely in lieu of tentative settlements for initial cost reports with due dates in FY 2001 as required by its established goals or CMS' guidelines. The attached SCHEDULE reflects the following:

- Out of 2,646 cost reports, we reviewed the timeliness for 1,972 cost reports that required either tentative or final settlements be performed. However, TrailBlazer did not complete 1,485 of these tentative (26) or final settlements (1,459) timely.

- Of the 421 tentative settlements TrailBlazer completed or was in the process of completing, 26 were untimely.

- Of the 520 final settlements it completed in lieu of tentative settlements, it completed 428 untimely.

- Of the additional 1,031 final settlements planned in lieu of tentative settlement, TrailBlazer had not completed any of the 1,031 final settlements as of our review and therefore these final settlements were also untimely.

TrailBlazer officials stated that it did not complete these 26 tentative settlements timely for a variety of reasons, including overlooking the cost reports or because of a special directive from CMS that prohibited TrailBlazer from performing settlements for all providers affiliated with a specific hospital chain. More importantly, according to TrailBlazer, the untimely completion of the 1,459 final settlements completed or planned in lieu of tentative settlements resulted primarily because (1) CMS did not provide adequate funding over a five-year period (FY 1996-FY 2000) needed to obtain staff to handle the large backlog of unsettled cost reports and (2) of a workload peaking problem, where TrailBlazer receives over 75 percent of its cost reports on or about June 1st of each year.

TrailBlazer submitted documentation to CMS, dated September 10, 2002, to propose workload changes to achieve workload currency by September 30, 2005. According to this documentation, TrailBlazer's cost report settlement workload increased from approximately 1,700 to 2,700 after it acquired, in December 1995, a significant portion of providers from a contractor that transitioned out of the Medicare program and when a large SNF chain transitioned to TrailBlazer. However, the funding provided to TrailBlazer to perform settlements of these cost reports was not adequately adjusted to reflect the tremendous increase in cost report workload. Further, according to an analysis by TrailBlazer included as part of the documentation, as a result of underfunding by CMS of TrailBlazer's cost report settlement process during the FY 1996-FY 2000 period, TrailBlazer's settlement workload quickly lost pace with the cost reports received subsequent to transitioning of the new providers. This underfunding significantly contributed to the creation of a tremendous backlog of unsettled cost reports, including those untimely final settlements completed or planned in lieu of tentative settlements that we identified. With regard to the need for additional funding, based on the documentation provided to CMS by TrailBlazer, the CMS Region VI Regional Office proposed to provide an additional $1 million in special funding for FY 2003 to assist TrailBlazer in addressing its cost report backlog.

According to the documentation noted above, a workload peaking problem, where TrailBlazer receives over 75 percent of its cost reports on or about June 1st of each year, also contributed to the untimely completion of final settlements completed or planned in lieu of tentative settlements. The documentation showed that of the approximately 2,400 cost reports received by TrailBlazer, over 75 percent relate to providers with a FYE of December 31. Therefore, it receives approximately 1,800 cost reports on or about June 1st of each year. The document further explained that the normal acceptability (30 days) and tentative settlement (60 days) timeliness requirements are based on the expectation that FIs receive their cost reports on an equal basis throughout the year. TrailBlazer acknowledged its commitment to maintaining the cost report acceptability and tentative settlement timeliness standards for the projected 400

hospital cost reports filed throughout the year. In its CPE review for the FY 2002 scored units for acceptability and tentative settlement timeliness, CMS reported that TrailBlazer exceeded CMS' timeliness goals in both areas. However, TrailBlazer stated that it believes that it will continue to be impossible for TrailBlazer to fully meet the acceptability and tentative settlement timeliness requirements on non-hospital cost reports received every year as part of the June 1st workload peak.

TrailBlazer further noted in the documentation it provided to CMS that it expects to continue to take most non-hospital/non-CMHC cost reports straight to final settlement, bypassing the tentative settlement process. Most of these provider types are reimbursed on a prospective basis, and as a result, there is little cost report settlement impact. For those unusual providers where a large settlement amount is claimed on their filed cost report (e.g., for bad debts), it expects to perform tentative settlements. TrailBlazer further stated that it believes it is necessary to continue this process in FY 2003 through FY 2005 and beyond in order to work through the backlog of unsettled cost reports and to help address its workload peaking problem. Therefore, TrailBlazer requested that CMS allow for an extended acceptability and tentative settlement timeframe during this annual peak period, and requested that appropriate consideration be given to its plans to continue to take most non-hospital/non-CMHC cost reports straight to final settlement.

The untimely settlements identified in our audit resulted in (1) payments due Medicare or the providers being delayed and (2) TrailBlazer's CMS 750/751s for FY 2001 not reflecting the Medicare accounts receivable and accounts payable amounts which would have been reported had the settlements been completed timely. These untimely settlements will also affect TrailBlazer's 750/751s' accounts receivable and accounts payable amounts for subsequent years until the settlements are completed.

Conclusions and Recommendations

We believe that TrailBlazer's efforts to address these issues with the ongoing efforts directed to CMS by TrailBlazer will help to (1) eliminate TrailBlazer's backlog of tentative and final settlements and (2) maintain timeliness of tentative and final settlements in the future. Therefore, we recommend that TrailBlazer continue to work with CMS to:

- Resolve the backlog and maintain timeliness of completion of tentative settlements, and of final settlements used in lieu of tentative settlements;

- Obtain approval to continue to take most non-hospital/non-CMHC cost reports straight to final settlement, bypassing the tentative settlement process; and

- Obtain a timely decision concerning timeliness requirements for completion of tentative and final settlements during the peak workloads.

Auditee Comments

Our first recommendation contained three areas that needed to be addressed by TrailBlazer officials. With regard to the first area that addressed resolution of the backlog, TrailBlazer officials stated that they will continue to work with CMS officials to find long-term solutions to completion of the backlog due to past under-funding issues. With regard to the second area related to maintaining timeliness of completion of tentative settlements, TrailBlazer will continue to focus on performing timely tentative settlements on those provider cost reports that have the most Medicare dollars at risk (primarily Hospital and CMHC providers). Finally, for the third area related to maintaining timeliness of completion of final settlements used in lieu of tentative settlements, TrailBlazer officials stated that TrailBlazer will continue to focus on finalizing lower risk provider cost reports (SNFs, RHCs, ESRDs, CORFs, OPTs, Home Offices) without routinely performing a tentative settlement. These cost reports will generally be prioritized on a first-in, first-out basis in order to adequately address the backlog.

Regarding our second recommendation, TrailBlazer officials stated that they currently have CMS' approval to take most non-hospital/non-CMHC cost reports straight to final settlement. The officials further explained that while TrailBlazer currently has this approval, CMS still requires that TrailBlazer perform these final settlements within the tentative settlement timeliness guidelines. The officials stated, however, that TrailBlazer has not been able to meet the timeliness requirements on these finals due to the backlog and workload peaking problems noted in the OIG's report.

Finally, regarding our third recommendation, TrailBlazer officials stated that they would continue to work with CMS officials to find long-term solutions to the workload peaking problem.

In addition to addressing our recommendations, TrailBlazer further stated that CMS representatives from both the CMS Central Office and the CMS Dallas Regional Office visited TrailBlazer on March 11, 12, and 13, 2003 to discuss these issues. During the exit conference, CMS suggested that all parties continue to brainstorm for solutions on how TrailBlazer can achieve CMS expectations in these areas. TrailBlazer officials noted that their plan was to continue to work with CMS to identify solutions that will enable them to meet all CMS expectations. Finally, TrailBlazer officials stated that until solutions can be agreed upon, current CMS requirements would not be met due to TrailBlazer's significant backlog and workload peaking problems.

Interim Rate Reviews

We selected 15 providers for review to determine whether TrailBlazer had completed the required interim rate reviews timely. Of the 15 reviewed, TrailBlazer did not complete interim rate reviews timely for 7 providers, as required by its policies and procedures. TrailBlazer's policies and procedures required that interim rate reviews be completed immediately after completion of tentative settlement reviews. However, TrailBlazer did not have adequate procedures in place to meet this requirement. Further, because of this problem, TrailBlazer made

or could have made unnecessary overpayments or underpayments to the providers for the periods the reviews were late. In addition, TrailBlazer's CMS 750/751s for the quarters ended September 30, 2001 and December 31, 2001, did not reflect the accounts receivable and accounts payable amounts which would have been reported had the interim rate reviews been completed timely. However, during and subsequent to our fieldwork, TrailBlazer resolved, where necessary, over and underpayments related to the seven providers in our sample which had untimely interim rate reviews. In addition, according to TrailBlazer officials, subsequent to our fieldwork, TrailBlazer instituted revised interim rate review policies and procedures. Accordingly, we have no further recommendations concerning interim rate reviews.

According to CMS guidelines, certain Medicare providers are to be paid on the basis of the reasonable cost of the services that they furnished to beneficiaries. Because the actual costs of services cannot be determined until the end of an accounting period, the providers must be reimbursed during the year using an interim payment amount that is based on estimated costs. The interim payment rate is estimated based on each provider's prior year cost report. TrailBlazer's policies and procedures, in effect at the time of our review, required interim rate reviews to be performed to determine the interim payment rates immediately after tentative settlement reviews were completed for the latest filed cost reports. After we initiated our audit, TrailBlazer changed its policy to state that interim rate reviews should be completed within two weeks after completion of the tentative settlement. For the purposes of our audit, we considered interim rate reviews completed within the 2-week time frame to be timely, and therefore allowed 14 days after the tentative settlement date in calculating the number of days late for delayed rate reviews.

As noted in Table 4 below, TrailBlazer was not required to complete interim rate reviews for 4 of the 15 providers in our sample. For the remaining 11 providers, TrailBlazer did not complete interim rate reviews timely for 7 providers. For these 7 interim rate reviews, the delays ranged from approximately 7 days to 197 days after the tentative settlement date (allowing for the 14 days noted above).

Table 4 – Interim Rate Reviews							
Prov#	Provider Type	Rate Applied to FYE	Tentative Settlement Date	Date Interim Rate Review Required	Interim Rate Review Date	# of Days Untimely	Effective Date of Change in Interim Rate
1	Rural Health Clinic	06/30/01	03/23/01	Not required	Not required	NA	NA
2	Rural Health Clinic	06/30/01	03/23/01	Not required	Not required	NA	NA
3	Rural Health Clinic	06/30/01	03/23/01	Not required	Not required	NA	NA
4	Rural Health Clinic	06/30/01	03/23/01	Not required	Not required	NA	NA
5	Psychiatric Hosp	12/31/01	07/24/01	08/07/01	02/20/02	197	02/22/02
6	Hospital (PPS)	06/30/01	05/25/01	06/08/01	06/21/01	13	06/25/01
7	Swing-Bed SNF	06/30/01	05/25/01	06/08/01	06/15/01	7	07/01/01
8	Hospital (PPS)	06/30/01	03/21/01	04/04/01	05/02/01	28	05/03/01
9	Hospital (PPS)	06/30/01	05/01/01	05/15/01	06/18/01	34	06/15/01
10	Critical Access Hosp	09/30/01	06/29/01	07/13/01	09/06/01	55	10/01/01
11	Swing-Bed SNF	09/30/01	06/29/01	07/13/01	09/06/01	55	09/01/01
12	Critical Access Hosp	09/30/01	06/11/01	06/25/01	06/22/01	Timely	07/01/01
13	Swing-Bed SNF	09/30/01	06/11/01	06/25/01	06/22/01	Timely	07/01/01
14	Rural Health Clinic	09/30/01	06/11/01	06/25/01	06/22/01	Timely	07/01/01
15	Hospital (PPS)	12/31/01	07/27/01	08/10/01	08/03/01	Timely	08/01/01

TrailBlazer's policies and procedures required that interim rate reviews be completed within two weeks of completion of tentative settlement reviews. However, TrailBlazer did not have adequate procedures in place to meet this requirement. As a result of the interim rate reviews not being completed timely, TrailBlazer made or could have made unnecessary overpayments or underpayments to the providers noted above for the periods for which the reviews were not completed or during which they were delayed. In addition, as a result of such reviews being completed untimely, TrailBlazer's 750/751s for the quarters ended September 30, 2001 and December 31, 2001 did not reflect the accounts receivable and accounts payable amounts which would have been reported had the interim rate reviews been completed timely. In order to preclude unnecessary over and underpayments, TrailBlazer should complete interim rate reviews timely.

Conclusions and Recommendations

During and subsequent to our fieldwork, TrailBlazer resolved, where necessary, over and underpayments related to the seven providers in our sample having untimely interim rate reviews. In addition, according to TrailBlazer officials, subsequent to our fieldwork, TrailBlazer instituted revised interim rate review policies and procedures. These policies and procedures require TrailBlazer staff to perform interim rate reviews concurrently with the submission of tentative settlements or final settlements in lieu of tentative settlements in order to finalize the interim rate reviews within two weeks following the approval and issuance (based on the STAR date) of the settlements. Although the scope of our audit did not provide for us to test these revised policies and procedures, we believe that TrailBlazer is taking appropriate actions to correct the problem. Accordingly, we have no further recommendations concerning interim rate reviews.

CONTROLS RELATED TO CASH COLLECTIONS REPORTED ON THE PART A CMS 1522

At the time of our fieldwork, TrailBlazer did not (1) provide us with adequate written policies and procedures applicable to its cash collection process involving Medicare Part A funds collected at its Dallas location; (2) have a centralized cash collection unit responsible for preparing deposit slips, reconciling deposits and tracking deposits through the system; or (3) have records available for us to select a sample of individual check receipts to verify and trace through TrailBlazer's financial records. TrailBlazer reported about $38 million in cash collections on the Part A CMS 1522 for the month of December 2000. The problems disclosed during our fieldwork raised concerns about TrailBlazer's ability to accurately process and report cash collections on the Part A CMS 1522. However, subsequent to completion of our fieldwork in this area, TrailBlazer implemented cash collection policies and procedures and created a centralized cash collection location. While TrailBlazer addressed many of our concerns, we are making some recommendations for TrailBlazer to clarify its cash collection policies and procedures.

Cash collections represent Medicare funds that are collected from a number of different sources. Primarily, the amounts come from collections of accounts receivable due Medicare from providers. The CMS requires TrailBlazer to report these collections monthly on the Part A CMS 1522. Our review focused on Line 16b "Other Deposits" of the Part A CMS 1522 that for the month of December 2000 totaled about $38 million.

Because, at the time of our review, TrailBlazer did not provide us with adequate written policies and procedures applicable to the Part A cash collections area, we interviewed a number of TrailBlazer employees and performed a walk through of several of TrailBlazer's cash collections processes. These review efforts disclosed the following internal control and procedural problems:

- Provider checks were not opened in one central location, and in some cases, the checks were addressed to a particular employee. Mail containing checks addressed to a specific employee was delivered to that employee and opened by that employee.

- The check receipt log did not include all checks received by TrailBlazer, and in many cases, checks were logged in batch totals rather than by individual check. In addition, this log included both checks that needed to be deposited and returned checks.

- The original documentation stayed with a check as it was processed through the system instead of being separated and sent to the appropriate department for processing.

- There was a lack of separation of duties because the same employee recorded checks, posted checks, voided and reissued checks and prepared the deposit slips. This would potentially allow an employee to control all aspects of the cash collection process.

- There was no supervisory review of the cash collection process.

- Because the check receipt log did not list checks individually, we were not able to select a sample to determine if the cash collections were: (1) authorized before posting to the financial records and restricted to authorized users; (2) complete and reconciled to data; or (3) posted accurately to the financial records.

Conclusions and Recommendations

The lack of adequate written cash collection policies and procedures, internal controls, and the lack of adequate records to be able to trace cash collections through the financial records, raised concerns about TrailBlazer's ability to accurately report Part A cash collections on the CMS 1522. After the completion of our fieldwork in the cash collection area, TrailBlazer prepared and implemented cash collection policies and procedures in the mailroom and finance departments. Although the scope of our audit did not provide for us to select current transactions to test the policies and procedures that were implemented, we did review the policies and procedures to determine whether they addressed the concerns disclosed during our fieldwork. We believe that many of our concerns have now been addressed by TrailBlazer. However, in reviewing the policies and procedures for the mailroom check procedures and the job procedures for the Deposit Clerk I and II and the CFO/Cash Supervisor, we identified the following areas that need clarification:

- The mailroom check procedures did not address the policies and procedures to be followed if cash was received from a provider/beneficiary. Additionally, the policies and procedures were vague. For example, the policy stated: "Obtain appropriate management signatures". The policies do not contain information as to who the appropriate management personnel are or the purpose of obtaining their signatures. In addition, the policy provided did not address what to do if the management personnel were not available. In another example, the policy stated: "All checks received after the 1:00 delivery to the CFO unit will be locked in a metal safe in the supervisor's office...". The policy does not address logging each check onto the log sheet in order to properly account for each check and to verify that checks are properly deposited. We could not determine from the policy whether the checks were to be logged when received or placed in the safe and not logged until the next day when the safe was opened.

- The job procedures for the Deposit Clerks and the CFO/Cash Supervisor reference some documents but do not explain the purpose of these documents. For example, the job procedure for the Deposit Clerk II states "Review Daily Check Receipt Log and Mailroom Cash Receipt Log to ensure that cash receipts received are included in deposit". The job procedure for the CFO/Cash Supervisor states "Perform a review on: the Daily Cash Receipts Recap versus Mailroom Cash Receipt Log to ensure that all cash receipts received are properly deposited and accounted for." Without an explanation of the Daily Check Receipt Log or the Daily Cash Receipts Recap, we could not determine the purpose of these logs or who prepares the logs.

We believe that TrailBlazer needs to continue to make improvements in its cash collection area in order to ensure that Medicare Part A cash collections are properly accounted for and accurately reported. Therefore, we recommend that TrailBlazer clarify its new policies to address:

- The mailroom procedures when cash is received from a provider or beneficiary;
- Obtaining appropriate management signatures related to the receipt of cash from providers/beneficiaries;
- Timely logging checks onto log sheets; and
- Explanations of various forms listed in the procedures.

Auditee Comments

TrailBlazer concurred with the recommendation regarding controls related to cash collections reported on the Part A CMS 1522, and has clarified mailroom and cash policies accordingly.

PART A AUDIT AND REIMBURSEMENT CONTRACTOR PERFORMANCE EVALUATION REVIEWS

Our review of the Part A Audit and Reimbursement CPE reviews performed by CMS of TrailBlazer in July and September 2000 disclosed that, at the outset of our audit, TrailBlazer did not have adequate procedures in place to fully document corrective actions planned and taken and to monitor the progress made in correcting the Part A Audit and Reimbursement deficiencies. The lack of a formal tracking methodology and policies and procedures could have resulted in TrailBlazer not taking corrective action on CPE deficiencies identified by CMS during reviews of TrailBlazer's Medicare operations, which could have impacted the accounts receivable balances reported on the CMS 750/751. However, during and subsequent to our fieldwork and with input from the CMS representative on the OIG audit team, TrailBlazer developed and implemented a formal methodology to document and monitor corrective actions to address Part A Audit and Reimbursement deficiencies noted by CMS during CPE reviews. Therefore, we are not making any further recommendations regarding this issue.

Through its CPE review system, CMS measures and evaluates contractor compliance with program requirements and acknowledges contractor improvements in how they administer the Medicare program. The CMS internal policies state that contractors must develop and submit a performance improvement plan (PIP) to CMS to correct deficiencies identified during a CPE review. A PIP should address specific items, including (1) the actions that the contractor plans to implement to correct the deficiencies, including implementation of internal controls necessary to provide reasonable assurance that the objectives of the PIP will be met and that performance will continue to meet CMS requirements and (2) proposed dates for completing the actions that will correct each deficiency.

The lack of a formal tracking methodology and policies and procedures could have resulted in TrailBlazer not taking corrective action on Part A Audit and Reimbursement CPE deficiencies identified by CMS during reviews of TrailBlazer's Medicare operations. However, according to a TrailBlazer official, CMS reported that TrailBlazer had taken certain corrective actions to address specific deficiencies noted by CMS during its CPE reviews in July and September 2000. Although TrailBlazer had taken actions to address specific deficiencies, we determined that at the onset of our fieldwork, TrailBlazer had not developed a process to fully document corrective actions planned and taken and to monitor the progress made in correcting the deficiencies. However, during and subsequent to our fieldwork and with input from the CMS representative on the OIG audit team, TrailBlazer developed and implemented a formal methodology to document and monitor corrective actions to address Part A Audit and Reimbursement deficiencies noted by CMS during CPE reviews.

According to documentation provided by TrailBlazer, TrailBlazer developed and implemented this formal methodology during and subsequent to our fieldwork. This included (1) the development of tracking templates and policies and procedures to document corrective actions planned and taken, (2) maintaining a tracking file which will be available for future review that includes appropriate documentation of actions being taken on each PIP, and (3) monitoring the progress made in correcting the deficiencies.

Conclusions and Recommendations

Although TrailBlazer provided us with the formal methodology, including tracking templates and policies and procedures to document and monitor the corrective actions taken in response to Part A Audit and Reimbursement CPE review deficiencies, the scope of our audit did not provide for us to test the formal methodology. However, we believe that the formal methodology developed and implemented by TrailBlazer should help to ensure that TrailBlazer properly (1) documents corrective actions planned and taken to address the deficiencies noted in the CPE reviews and (2) monitors the progress in correcting the deficiencies. Therefore, we are not making any further recommendations regarding this issue.

OTHER MATTERS

As part of the Secretary's Initiative, we were asked to identify best practices at TrailBlazer that may be useful for implementation at other contractors to improve other contractors' accounts receivable processes. Accordingly, these best practices included three processes implemented by TrailBlazer, specifically its Provider Audit and Reimbursement function, that we believe would be useful to other contractors. The scope of our audit did not provide for us to perform a detailed review of these best practices.

The three processes implemented by TrailBlazer that we reported for best practices were:

- The Bankruptcy/Restricted Providers Tracking System is a database system designed to serve as a tool for tracking bankrupt or restricted providers, such as those terminated

from the Medicare program or those that required CMS' approval prior to payment. TrailBlazer developed this system in response to a finding by CMS, during CPEs conducted in July and September 2000, that identified a program deficiency in the Provider Audit and Reimbursement Department that had resulted in seven bankrupt providers being erroneously paid $4 million. The review noted a lack of managerial and supervisory review as being responsible for these erroneous payments. Subsequently, in June 2001, Trailblazer implemented its Bankruptcy/Restricted Providers Tracking System to prevent erroneous payments in the future.

- The Benefits Integrity Database System (BIDS) is a database system that allowed TrailBlazer's auditors to query the database and obtain instantaneous status as to whether a provider is under investigation for fraud or abuse by the contractor's Benefits Integrity (BI) department. TrailBlazer policies and procedures required that, prior to release of funds related to cost report settlements, that professional audit staff contact TrailBlazer's BI department to determine whether a provider was under investigation for fraud and abuse by the BI department. Prior to TrailBlazer initiating BIDS in June 2001, the auditors conducting a review of the cost settlement had to submit an email or call the BI department to make such an inquiry. According to TrailBlazer officials, it generally took longer than 8 hours to receive a response from the BI department concerning such status. With the implementation of the BIDS, auditors could query the database and receive instantaneous status of whether or not the provider is under investigation.

  However, effective October 1, 2002, TrailBlazer's BI department transitioned to a separate entity, TriCenturion. The data contained in TrailBlazer's current BIDS database was maintained and updated through September 23, 2002 (one week prior to the transition). When drafting the Joint Operating Agreement between TriCenturion and TrailBlazer, TrailBlazer requested and worked with TriCenturion to obtain the same type of access for TrailBlazer's audit and reimbursement staff. All TrailBlazer Audit and Reimbursement staff received access to the new TriCenturion database referred to as the Fraud Abuse Tracking System (FACTS) on December 31, 2002.

- The Provider Statistical and Reimbursement (PS&R) Ordering System is a database system designed by TrailBlazer in June 2001 that allows for user-friendly ordering and timely receipt of PS&R reports. The PS&R reports provide a summary of paid claims made for the reporting period of the cost report being settled, and are used by providers in preparing the annual cost reports and by auditors for their review of the reports. Prior to implementation of its PS&R database system, staff submitted requests for PS&R reports to a mainframe computer at TrailBlazer. This process often took up to two weeks for providers or auditors to receive the requested reports. Consequently, TrailBlazer implemented its PS&R database system. The new system provides a user-friendly PS&R ordering capability using TrailBlazer's intranet. After users identify and order the required reports on-line, the reports are automatically sent to the mainframe to be processed, and processed the next business day. The users can then review and print the reports in a personal computer environment.

SCHEDULE

Status of Completion of Tentative and Final Settlements in Lieu of Tentative Settlements With Due Dates in FY 2001										
Provider Description	**Tentative Settlements**			**Final Settlement Completed in Lieu of Tentative Settlement**			**Final Settlement Planned in Lieu of Tentative Settlement**			**Totals**
		Completed/In-process total 421								
	Total Req	**Timely**	**Untimely**	**Total**	**Timely**	**Untimely**	**Total**	**Timely**	**Untimely**	
Hospital	161	119	6	30	1	29	6	0	6	
SNFs	272	29	4	26	1	25	213	0	213	
Home Health Agency (HHA)	74	70	4	0	0	0	0	0	0	
RHCs	381	79	7	32	2	30	263	0	263	
Subprovider: Psychiatric	18	17	1	0	0	0	0	0	0	
Subprovider: Rehabilitation	17	16	1	0	0	0	0	0	0	
CORF*	36	1	0	3	3	0	32	0	32	
Hospice	10	8	1	0	0	0	1	0	1	
Swing-Bed SNF	50	46	1	1	0	1	2	0	2	
ESRDs	773	10	1	349	67	282	413	0	413	
Physical/Speech Therapy Facility	158	0	0	72	16	56	86	0	86	
Community Mental Health Centers	22	0	0	7	2	5	15	0	15	
Totals – Settlements Timely		395			92			0		487
Totals – Settlements Untimely			26			428			1,031	1,485
Totals	1,972	395	26	520	92	428[1]	1,031[1]	0	1,031	1,972

- CORF (Comprehensive Outpatient Rehabilitation Facility)

[1] The 1,459 final settlements completed untimely as referred to in the body of this report consisted of the total of 428 final settlements completed untimely and the 1,031 planned for completion.

TRAILBLAZER STANDARD COST REPORT SETTLEMENT PROCESS SUMMARY

Determinations of overpayments (accounts receivable) are made by TrailBlazer professional staff (auditors) during the cost report settlement process, and subsequently are included as part of the accounts receivable activity reported by TrailBlazer to CMS on the CMS 750/751 quarterly reports. Therefore, the cost report settlement process is an integral part of the reporting of accounts receivable by TrailBlazer. The following provides a brief summary of TrailBlazer's standard cost report settlement process.

- **Payment Method** – Medicare Part A providers receive estimated payments from Medicare via the FIs throughout their cost reporting period based on estimated costs. At the end of their cost reporting period, the providers are required to submit a cost report of their actual costs, as noted below.

- **Cost Report Filing Requirement** – The CMS requires each Medicare provider to submit an annual cost report within five months following the end of its cost reporting period to the FI for the purpose of final settlement after the provider receives claim payments throughout its cost reporting period.

- **Reminder Letter** – A reimbursement clerk from the appropriate Home Office Team mails a reminder letter to the provider approximately, but not later than, 30 days prior to the cost report due date. The purpose of the reminder letter is to notify the provider of its obligation to file a cost report.

- **Unfiled Cost Reports** –

    - **Demand Letters** – For providers not filing cost reports timely, the CMS guidelines for overpayment demand letters for unfiled cost reports requires that, as a rule, FIs send three demand letters to providers for unfiled cost reports using the following timeframes: (1) for the first demand letter, we concluded that the CMS guidelines allows for a grace period of 7 days from the cost report due date before the first letters were required to be mailed; and (2) for the second, and third demand letters, CMS requires the letters be mailed 30 days after the most recent demand letter. The CMS guidelines also require that FIs mail the first demand letters for unfiled cost reports via certified mail.

    - **Penalty Withholding** – The CMS guidelines also call for the FIs to initiate penalty withholding effective the first day after the cost report due date to reduce or suspend interim payments where a cost report has not been filed timely by the provider.

- **Certification of Debt for Referral** – If there is no response to the third demand letter ("intent to refer" letter for overpayments eligible for referral) after 60 days, the CMS guidelines required the FI to input the debt information into the Debt Collection System (DCS) database. This input certifies the debt as valid, legally enforceable, and ready for referral (by CMS). The DCS system is used to transmit and track debts to a Treasury designated DCC.
- **Interest Assessed for Late-Filed Cost Reports** – If the provider files an untimely cost report and the report indicates an amount is due Medicare, or it is subsequently determined that an additional overpayment exists later in the cost report process, interest is assessed on the overpayment from the due date of the cost report until the date the cost report is filed. In instances where providers cannot pay the full amount due Medicare, providers must submit a request for an extended repayment plan accompanied by a partial payment.

- **Interest Assessed on Timely Cost Report with Overpayment** – For a cost report filed timely but which indicates an amount is due Medicare (overpayment), interest will accrue on the overpayment from the date the cost report is due, unless appropriate arrangements are made with the contractor.

- **Overpayment Demand Letters** – According to CMS guidelines, the purpose of an overpayment demand letter is to notify the provider of the existence and amount of an overpayment and to request repayment. These guidelines require that, as a rule, FIs send three demand letters to providers for overpayments. The following time frames apply: (1) first demand letter – mailed immediately after discovery or determination of the overpayment; and (2) second and third demand letters – mailed 30 days after the most recent demand letter.

- **Cost Report Acceptability Process** – Following receipt of an initial cost report, TrailBlazer subjects each cost report to an acceptability process including the use of a series of edits to ensure that the provider properly submitted its cost report. In addition, upon receipt of the initial cost report, TrailBlazer's policies and procedures call for entering the settlement amounts into the Fiscal Intermediary Shared System (FISS). Subsequent overpayments are also entered into FISS. The FISS is predominately a CMS claims processing system with the capability to track, record, collect and report accounts receivable activity. If acceptable, the cost report is processed and entered into the System for Tracking Audit and Reimbursement (STAR).

- **Tentative Settlement Process** – Tentative settlements are required by CMS guidelines to bring interim payments made to providers during the cost reporting

period into agreement with the reimbursable amount payable to the provider for the services provided to program beneficiaries during that period. The tentative settlement is currently achieved through the TrailBlazer auditors' use of computer templates applicable to specific types of facilities.

- **Provider Overpayment Reporting (POR) System Status Codes** – The CMS guidelines require FIs to report any outstanding provider overpayments to CMS through the use of the electronic on-line POR System. The POR System serves as a uniform method for reporting both the principal and interest associated with provider overpayments including the length of time an overpayment is outstanding, and serves as a base for CMS to use in compiling management information on overpayments. The CMS guidelines require that accounts receivable and data pertaining to them be entered into the POR by the FIs no later than 10 calendar days after the date of an overpayment determination or information affecting it was received.

- **Interim Payment Rate/Interim Rate Reviews** – According to CMS guidelines, certain Medicare providers are paid on the basis of the reasonable cost of the services that they furnished to beneficiaries. Since the actual costs of services cannot be determined until the end of an accounting period, the providers must be reimbursed during the year using an interim payment amount that is based on estimated costs. The CMS guidelines call for the interim payment rate to be established based on each provider's prior year cost report. According to TrailBlazer's updated policies and procedures, an initial cost report interim rate review establishing such a rate should be completed within two weeks after the tentative settlement review is completed.

- **Final Settlement** –

    - **Method** – If the reimbursement amount for a cost report is under the pertinent CMS threshold, then the cost report is settled as a problem resolution. If the reimbursement amount is over the pertinent CMS threshold, the cost report is settled either through problem resolution, field audit or focused review.

    - **Adjustments/Submission of Cost Report to CMS and NPR to Provider and Transmission of Electronic Cost Report Data to CMS** – After the appropriate review is completed and adjustments have been formulated, TrailBlazer applies its adjustments to the providers' cost reports on an automated system used by TrailBlazer. The revised cost report is reviewed to ensure that the adjustments have been properly incorporated for final settlement of the cost report. TrailBlazer subsequently sends the finalized cost report and a Notice of Program Reimbursement (NPR) to the provider, and transmits electronic cost report data to CMS.

- **Balance Due Medicare** – If the final cost report settlement shows a balance is due Medicare (after inclusion of any tentative settlement adjustments), TrailBlazer sends a demand letter to the provider requiring a response within 15 days. The provider has three options: (1) send a check for the complete settlement amount; (2) set up a payment schedule; or (3) have the settlement withheld from future remittances. If the provider does not respond within 15 days, the provider is placed on withholding and TrailBlazer sends a second demand letter. If no response is received within 15 days of the second demand letter, a third demand letter is sent, and interest starts to accrue on the 31st day (effective as of the overpayment determination date). If an amount is due the provider, payment is made through the FISS.

- **Appeal/Reopening of Settled Provider Cost Report** – The provider is entitled to appeal any adjustment on the final cost report settlement by filing notice with the CMS Provider Reimbursement Review Board within 180 days following the date of the NPR. Further, under certain conditions, the settled cost report can be reopened within 3 years following the date of the NPR at the request of either the provider or the FI.

- **Special Safeguards** – TrailBlazer has implemented special safeguards to minimize the possibility of making inappropriate overpayments or underpayments to providers, or to ensure that Medicare monies are protected in the event of a provider declaring bankruptcy. These safeguards include, respectively:
  - **Policy – Review and Approval for Release and Collection of Medicare Funds**
    - TrailBlazer auditors complete various cost report settlement processes, including field audits, focused reviews, problem resolutions, tentative settlements and rate reviews, resulting in a determination in the amount of the overpayment or underpayment. In performing these reviews, the auditors must consider any activity that may have an impact on the release of monies or affect collection activities that may follow.
    - Accordingly, this policy requires TrailBlazer auditors to initiate a Professional Analysis and Release/Collection of Funds Approval Sheet for all cost report processes except for initial cost reports. For initial cost reports, the policy requires reimbursement clerks to initiate the sheet.
    - For the cost report processes excluding initial cost reports, the auditors must document on the sheet they initiated the determination of the overpayment or underpayment, the analysis of

the various activities that may have an impact on the release of monies or affect collection activities that may follow, and must obtain and document required approvals as noted below. These activities include reviewing: the Bankruptcy/Restricted Providers Tracking System to track bankrupt or restricted providers, such as those terminated from the Medicare program or those that CMS required CMS approval prior to payment; the BIDS, to determine whether a provider is under review for program integrity issues; and reviewing STAR to determine whether a provider terminated from the Medicare program.

- Before subsequent action is taken, a review and approval of the auditor's determination, as reported on the Approval Sheet, must be made and documented on the sheet by the appropriate approving authorities. Following this approval, and upon assignment by the reimbursement supervisor, the clerical staff will perform required activities including reviews of the Bankruptcy/Restricted Providers Tracking System and STAR, and posting the final amount of the overpayment or underpayment onto the Approval Sheet.

- Before the final release/collection of funds occur, the reimbursement supervisor will review the clerical activities performed. Following this review, management officials will review the related entire cost report activities packet and Approval Sheet, and approve/disapprove the final release or collection of funds. The levels of approval are dictated by the amount of the overpayments or underpayments.

- The policy also requires reimbursement clerks to perform and document clerical processing steps, including the reviews of the Bankruptcy/Restricted Providers Tracking System and reviewing STAR as noted above, for initial cost reports as well as for all other cost report processes.

- **Bankruptcy Policy** – TrailBlazer's bankruptcy policy includes the entering of bankrupt providers into the Bankruptcy/Restricted Providers Tracking System, and for TrailBlazer to contact the CMS Regional Office to notify them of the receipt of the bankruptcy documentation, and to request/discuss special instructions, if any, regarding the treatment of the bankruptcy.

TrailBlazer HEALTH ENTERPRISES, LLC℠

8330 LBJ Freeway
Executive Center III
Dallas, Texas 75243-1213

James A. Kernen, CPA
Chief Financial Officer

Phone: (469) 372-2600
E-mail: jim.kernen@trailblazerhealth.com
Fax: (469) 372-4701

March 21, 2003

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

Subject: Response to February 21, 2003 Draft Report "Review of Financial Systems and Internal Controls Over Medicare Accounts Receivable – TrailBlazer Health Enterprises, LLC" (CIN# A-06-02-00001)

Dear Mr. Sato:

Thank you for the recommendations resulting from your review of TrailBlazer Health Enterprises, LLC (TrailBlazer) financial systems and internal controls for processing and reporting Medicare Part A non-MSP accounts receivable activity and the opportunity to provide comments. TrailBlazer places a high priority on financial management and is committed to ensuring that appropriate controls are in place to protect against significant risks.

We are encouraged that through your review you consider three processes implemented within our Part A Audit & Reimbursement Division to be "best practices" worthy of possible implementation at other contractors to improve accounts receivable processes. We also appreciate recognition of the substantial improvements made during the course of the review in your report. Although numerous weaknesses were identified at the outset of your review, we believe the significant improvements reflected in your report as well as our efforts to continue strengthening our financial management controls demonstrate our commitment toward this essential responsibility. While our efforts have already corrected many of the weaknesses originally identified, we are taking further actions to ensure that the OIG's remaining recommendations are addressed.

We agree with most of the recommendations that remain and specific responses to each of them are attached and described, by report section, to facilitate your evaluation. In addition, we separately provided certain other technical clarifications that we understand will be incorporated into the report. Again, we appreciate the opportunity to comment on this draft report. If you have any questions regarding our comments or need additional information, please let us know.

Sincerely,

James A. Kernen, CPA
Chief Financial Officer

cc: Marti Mahaffey

ATTACHMENT- TrailBlazer Comments on OIG Draft Report (CIN# A-06-02-00001)

EXECUTIVE SUMMARY

1. Rather than repeating our comments on each of the findings and recommendations in this "Summary of Findings" section, please see our comments below that are directed to the specific section of the report where the findings and recommendations are discussed in detail.

CONTROLS RELATED TO THE CMS 751 FOR PART A NON-MSP ACCOUNTS RECEIVABLE

Credit Balances – Conclusions and Recommendations

2. During the course of your review, we analyzed our credit balance database and how it is used to support the Credit Balance Summary Report submitted quarterly to the CMS Dallas Regional Office. In addition to the changes made in how we process and report credit balance activity noted in your report, we changed the timing of our submission of this report (with CMS Dallas Regional Office approval) to coincide with the quarter-end dates used for CFO reporting. By doing so, we now have a clearer audit trail for determining the amount of unprocessed credit balance reports as of each quarter-end date to report as credit balance receivables on our CFO reports. In conjunction with this change, we reported credit balance receivables of $37,638.20 as of December 31, 2002. This amount was reconciled to the amount of unprocessed credit balance reports according to our credit balance database. In November 2002, we obtained CMS Central Office concurrence with this methodology for reporting credit balance receivables.

   Although we believe these changes result in an overall process that meets CMS requirements, we have concerns about your recommendation to reconcile (i.e., track and identify) amounts originally characterized as credit balances that, after subsequent processing, are classified and reported as claims accounts receivable. The ending claims accounts receivable balance for a particular provider is the product of numerous adjustments made over a period of time for which only a portion relate to credit balances. As a result, we believe this recommendation would require significant shared system changes and additional manual analysis and review to implement. In addition, this increased level of reconciliation is not included in any CMS CFO reporting guidance nor was it included in a methodology for credit balance receivable processing and reporting presented at CMS' 2002 CFO conference. We are concerned that this increased level of analysis exceeds CMS' expectations and current contractor capabilities and have requested their guidance on whether they believe it is required. Also, since this recommendation would likely affect most, if not all, other Medicare fiscal intermediaries, we believe it should be more appropriately directed to CMS to ensure appropriate evaluation, consideration, and consistency.

Carryover Adjustments – Conclusions and Recommendations

3. In addition to updating policies and procedures as applicable based on the OIG recommendations, we sampled five additional claims that were involved in the mass adjustment noted in the report and found that the mass adjustment processed these claims

correctly. Other, unrelated system issues associated with the claim noted in the report caused the mass adjustment to process incorrectly.

We currently test mass adjustments in the test region of the fiscal intermediary shared system (FISS) prior to putting them into production. We agree that testing claims involved in a mass adjustment subsequent to implementation validates whether the mass adjustment did, in fact, process correctly. Manually testing each claim that should have been adjusted, however, would be inefficient and cost prohibitive. To validate the effectiveness of mass adjustments more efficiently, we plan to develop and implement procedures that mimic the testing performed prior to the mass adjustment being put into production by May 1, 2003. We also plan to work with our provider education staff to develop and implement a procedure to notify providers if we do find that a mass adjustment did not take effect as planned by May 1, 2003.

Cost Report Settlement Amounts – Conclusions and Recommendations

4. As indicated in the draft report, we believe that staff involved in the CFO reporting process have been aware of the need to consult with the CFO on significant CFO reporting policy changes since the establishment of the CFO position in April 2001. For the mistake identified, this would not have been possible since it relates to an issue arising prior to the establishment of that position. However, a reminder was recently issued to emphasize the importance of coordinating and communicating current and planned changes with the CFO.

Initial Cost Report Reminder Letters – Conclusions and Recommendations

5. We concur with the OIG's recommendation and plan to formalize written procedures related to the Initial Cost Report Reminder Letters and the PS&R ordering process by June 30, 2003.

Unfiled Cost Report Demand Letters – Conclusions and Recommendations

6. We concur with the OIG's recommendation and plan to formalize written procedures related to both the Initial Cost Report Reminder Letters and First Demand Letters by June 30, 2003. These policies will include the requirement to send all First Demand Letters via certified mail.

7. We concur with the OIG's recommendation. We are currently revising our Unfiled Cost Report Reminder and Demand Letter Policy, to address the Reimbursement Reporting Department's procedures related to the timely issuance of second and third unfiled cost report demand letters. The revised policy will be formally issued by June 30, 2003 and will include the use of STAR extracts and a Letter Checklist, which will identify the proper POR status code to be entered to the POR System.

Overpayment Demand Letters – Conclusions and Recommendations

8. We are currently revising our Debt Collection Policy and plan to issue this revised policy by June 30, 2003. This revised policy will incorporate the changes in the debt collection process

and address the debt collection functions performed by the Home Office Teams, as well as the debt collection functions performed by the Reimbursement Reporting Department. The policy will include procedures for determining the demand letters to be issued and for monitoring the debt collection process. The policy will also include a Letter Checklist to ensure the POR Clerks are notified of the proper POR status codes to be entered.

Coding of Overpayment Interest – Conclusions and Recommendations

9. We are currently revising our Debt Collection Policy to incorporate the changes in the debt collection process, and plan to formally issue the revised policy by June 30, 2003. The revised policy will require a Debt Collection Checklist be completed as part of the development of the second and third demand letters. The revised policy will also require Reimbursement Reporting Analysts to complete a POR Status Code Checklist, which is completed and submitted to the POR Clerks for proper coding of the principal and related interest in the POR System.

Tentative and Final Settlements – Conclusions and Recommendations

10. We continue to work with both CMS Central Office and the CMS Dallas Regional Office for solutions to the three issues outlined in the OIG's recommendation. While we currently have CMS approval to continue to take most non-hospital/non-CMHC cost reports straight to final settlement, CMS still requires that we perform these final settlements within the tentative settlement timeliness guidelines. TrailBlazer has not been able to meet the timeliness requirements on these finals due to the backlog and workload peaking problems noted in the OIG's report.

    CMS representatives from both the CMS Central Office and the CMS Dallas Regional Office visited TrailBlazer on March 11, 12, and 13, 2003 to discuss these issues. During our exit conference CMS suggested that all parties continue to brainstorm for solutions on how we can achieve CMS expectations in these areas. Our plan is to continue to work with CMS to identify solutions that will enable us to meet all CMS expectations. Until solutions can be agreed upon, current CMS requirements will not be met due to our significant backlog and workload peaking problems.

    TrailBlazer continues to focus its efforts on the following:

    - TrailBlazer will continue to work with CMS officials to find long-term solutions to both the workload peaking problem and completion of the backlog due to past underfunding issues.

    - TrailBlazer will continue to focus on performing timely tentative settlements on those provider cost reports that have the most Medicare dollars at risk (primarily Hospital and CMHC providers).

    - TrailBlazer will continue to focus on finalizing lower risk provider cost reports (SNFs, RHCs, ESRDs, CORFs, OPTs, Home Offices) without routinely performing a tentative settlement. These cost reports will generally be prioritized on a first-in first-out basis in order to adequately address the backlog.

- Hospital cost reports will continue to be finalized and prioritized based on a first-in first-out basis where feasible.

CONTROLS RELATED TO CASH COLLECTIONS REPORTED ON THE PART A CMS 1522 – Conclusions and Recommendations

11. We concur with the OIG's recommendation and have clarified mailroom and cash policies accordingly.