DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Washington, D.C. 20201

July 27, 2011

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Medicaid Hospital Outlier Payment Followup for Fiscal Years 2004 Through 2006 (A-07-10-04160)

The attached final report provides the results of our review of Medicaid hospital outlier payments for fiscal years 2004 through 2007.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (OIG) post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov. We look forward to receiving your final management decision within 6 months. Please refer to report number A-07-10-04160 in all correspondence.

Attachment

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID HOSPITAL OUTLIER PAYMENT FOLLOWUP FOR FISCAL YEARS 2004 THROUGH 2006

Daniel R. Levinson
Inspector General

July 2011
A-07-10-04160

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

BACKGROUND

Medicaid Program

The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Within broad Federal requirements, each State makes decisions as to eligibility, types and ranges of services, payment levels for services, and administrative and operating procedures.

Medicaid Inpatient Hospital Outlier Payments

State Medicaid agencies (State agency) may pay hospitals for Medicaid inpatient stays using a prospective payment system that includes a preestablished amount for each discharge based on a diagnosis-related group (DRG) code, which can vary by State. Although the base payment within each DRG is fixed, hospitals may sustain significantly varying costs among patients within a specific DRG. To protect hospitals against large financial losses from extraordinarily high-cost cases, State agencies may supplement base payments with an additional payment referred to as a Medicaid inpatient hospital cost outlier payment (Medicaid outlier payment). Medicaid outlier payments are calculated using formulas that vary by State. Because hospitals cannot identify actual costs for specific patients, the formulas apply cost-to-charge ratios to current charges to convert those charges to estimated costs. The formulas include State-determined threshold amounts used to evaluate each claim for outlier status. (The threshold amount is the dollar amount by which the hospital's estimated costs for an inpatient case must exceed its prospective payments for that hospital to qualify for a Medicaid outlier payment.)

Medicare Inpatient Hospital Outlier Payments

CMS also administers the Medicare program, which has its own method of calculating outlier payments. Pursuant to Federal statute, CMS sets the Medicare fixed-loss threshold at a level projected to make Medicare outlier payments 5.1 percent of the total DRG payments for inpatient care. (For this report, a "fixed-loss threshold" in the Medicare program serves the same function as the "threshold amount" in the Medicaid program.) In 2003, CMS modified relevant Medicare regulations after reporting that from Federal fiscal years (FY) 1998 to 2002, it paid approximately $9.0 billion more in outlier payments than intended because the outlier calculation overestimated costs for hospitals that increased their charges faster than actual costs. As a result of the modified regulations, Medicare outlier payments decreased from 9.1 percent of total DRG payments in December 2002 to 5.2 percent of total DRG payments in December 2003. More recent data also indicate that the modification to the Medicare outlier regulations has been effective in limiting outlier payments.

Prior Office of Inspector General Audits

Because the Medicaid programs could have been experiencing the same vulnerabilities that the Medicare program identified and addressed in the 2003 modifications, in FY 2004 we conducted

audits of Medicaid outlier payments in eight selected State agencies. We determined that all eight State agencies used cost reports that were at least 2 years old to calculate their cost-to-charge ratios.

We also determined that if the eight State agencies had used more up-to-date cost-to-charge ratios in a manner similar to Medicare's revised outlier payment methodology, the State agencies could have saved approximately $236.6 million from 1998 through 2003 in Medicaid outlier payments made to the hospitals reviewed.

OBJECTIVE

Our objective was to determine whether the eight State agencies calculated Medicaid inpatient hospital outlier payments to effectively limit the payments to extraordinarily high-cost cases.

SUMMARY OF FINDINGS

The eight State agencies did not calculate Medicaid outlier payments to effectively limit the payments to extraordinarily high-cost cases. For all hospitals in seven of the eight States, Medicaid outlier payments increased from approximately $913.0 million in FY 2004 to approximately $1.2 billion in FY 2006. During this period, Medicaid outlier payments increased substantially faster than Medicaid DRG base payments and Medicare outlier payments.

This occurred because the eight State agencies (1) used outdated cost-to-charge ratios to convert charges to estimated costs and (2) did not reconcile Medicaid outlier payments upon cost report settlement.

If the 8 State agencies had used the most recent cost reports to calculate the cost-to-charge ratios for the 27 hospitals we reviewed, those State agencies could have, between FYs 2004 and 2006, more effectively limited the payments to extraordinarily high-cost cases, thereby reducing those Medicaid outlier payments by $320.0 million. Those State agencies could have used the savings from lower Medicaid outlier payments to the 27 hospitals (and to other hospitals that aggressively increased their charges) to make higher Medicaid outlier payments to hospitals that did not increase charges faster than actual costs.

RECOMMENDATIONS

We recommend that CMS encourage all State agencies that make Medicaid outlier payments to (1) use the most recent cost-to-charge ratios to calculate Medicaid outlier payments, (2) reconcile Medicaid outlier payments upon cost report settlement or use an alternative method to ensure that outlier payments are more closely aligned with actual costs, and (3) amend their State plans accordingly.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS agreed with our first and third recommendations. CMS partially agreed with the second recommendation as it was phrased in our draft report.

Regarding that second recommendation, CMS agreed that reconciliation would better align outlier payments to the costs incurred by hospitals but added that "… it is more appropriate to defer to States and let them determine what changes, if any, are appropriate."

CMS's comments are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing CMS's comments, we revised our second recommendation to include a provision for an alternative method to align outlier payments with actual costs.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although each State has considerable flexibility in designing and operating its Medicaid program, the State must comply with applicable Federal requirements.

Within broad Federal requirements and guidelines for the administration of the Medicaid program, each State makes decisions as to eligibility, types and ranges of services, payment levels for services, and administrative and operating procedures.

Medicaid Inpatient Hospital Outlier Payments

We reviewed eight State Medicaid agencies (State agency) that we had previously audited. Seven of these eight State agencies paid hospitals for Medicaid inpatient stays using a prospective payment system that included a preestablished amount for each discharge based on a diagnosis-related group (DRG) code, which can vary by State. The eighth State agency, in Georgia, used both a DRG code and, in some cases, a hospital-specific cost-to-charge system.

Although the base payment within each DRG is fixed, hospitals may sustain significantly varying costs among patients within a specific DRG. To protect hospitals against large financial losses from extraordinarily high-cost cases, State agencies may supplement base payments with an additional payment referred to as a Medicaid inpatient hospital cost outlier payment (Medicaid outlier payment).[1]

Medicaid outlier payments are calculated using formulas that vary by State.[2] The eight State agencies calculated a hospital-specific cost-to-charge ratio based on actual costs and charges reported on each hospital's Medicaid cost report. Because hospitals cannot identify actual costs for specific patients, the formulas apply cost-to-charge ratios to current charges to convert charges to estimated costs.[3] The formulas include threshold amounts used to evaluate each claim

[1] Some State agencies make both day outlier payments and cost outlier payments for cases that have either a high number of days or high costs compared with days and costs in similar cases.

[2] Because Title XIX of the Act specifies that each State will administer its Medicaid program in accordance with a CMS-approved State plan, the State agencies' formulas to calculate the Medicaid outlier payments do not have to be the same from one State to the next.

[3] Criteria cited in this report use both "billed charges" and "charges." The meanings of the terms are identical; we will use the term "charges."

to determine whether it is an extraordinarily high-cost claim and thus qualifies for outlier status. (The threshold amount, determined by each State, is the specified dollar amount by which the hospital's estimated costs for a particular inpatient case must exceed its prospective payments for that hospital to qualify for a Medicaid outlier payment.)

Medicare Inpatient Hospital Outlier Payments

CMS also administers the Medicare program. The Medicare program, like these Medicaid programs, recognizes that some beneficiary cases are more complicated and expensive than others and therefore require an additional amount—an outlier—to be paid to hospitals. Federal regulations (42 CFR § 412.80(a) and (c)) specify that a hospital is to receive a Medicare outlier payment when the estimated cost of a Medicare inpatient stay exceeds a fixed-loss threshold. (A "fixed-loss threshold" in the Medicare program serves the same function as the "threshold amount" in the Medicaid program.)

For several years and pursuant to Federal statute,[4] CMS set the fixed-loss threshold at a level projected to make Medicare outlier payments 5.1 percent of the total DRG payments for inpatient care. In 2003, CMS modified relevant Medicare regulations after reporting (in its 2003 Medicare Final Rule[5]) that from Federal fiscal years (FY) 1998 to 2002, it paid approximately $9.0 billion more in Medicare outlier payments than intended because the outlier calculation overestimated costs for hospitals that increased charges faster than actual costs. CMS determined that its pre-2003 outlier formula did not effectively maintain outlier payments at the projected 5.1 percent of total Medicare payments for inpatient care.

In the Preamble to its 2003 Medicare Final Rule, CMS acknowledged that:

> … some hospitals have exploited [the current outlier payment methodology] to dramatically increase their outlier payments over a brief period of time by raising their charges in excess of increases in their costs. As these increases in outlier payments to those hospitals are reflected in the data used to calculate the outlier thresholds, they force the outlier threshold to rise…. The result is that hospitals that do not aggressively increase their charges do not receive outlier payments or receive reduced outlier payments for truly costly cases.

CMS determined that, as a result of the lengthy timelag between (1) the finalization date of the latest settled cost report (which was used as the basis to calculate cost-to-charge ratios and outlier payments) and (2) the timeframe of current charges, the charges generally continued to increase faster than costs. Cost-to-charge ratios were consequently too high, which in turn resulted in an overestimation of hospitals' current costs per case.

The 2003 modifications changed the outlier payment calculation in several ways:

[4] Section 1886(d)(5)(A)(iv) of the Act. See also CMS's explanation at 68 Fed. Reg. 34494, 34496 (Jun. 9, 2003).

[5] 68 Fed. Reg. 34494, 34497 (Jun. 9, 2003).

- Federal regulations at 42 CFR § 412.84(i)(2) provide for Medicare outlier payments to be calculated with the cost-to-charge ratios from the most recent ("settled cost report or the most recent tentative settled") cost report. This change was intended to reduce the timelag for updating the cost-to-charge ratio by a year or more.

- Federal regulations at 42 CFR § 412.84(i)(4) provide for a reconciliation to retroactively revise Medicare outlier payments during cost report settlement based on an updated hospital cost-to-charge ratio for the year that coincides with the case for which the outlier was calculated. This change was intended to account for hospitals that were rapidly increasing their charges faster than their costs.[6]

In 2004, we audited the effectiveness of the modified Medicare outlier payment regulations.[7] We determined that as a result of the modified regulations, Medicare outlier payments decreased from 9.1 percent of total DRG payments in December 2002 to 5.2 percent of total DRG payments in December 2003.

More recent data also indicate that the modification to the Medicare outlier regulations has been effective in limiting outlier payments. Each year CMS publishes, in the *Federal Register*, the percentage of actual Medicare outlier payments related to the actual Medicare total DRG payments. CMS publishes this information to establish whether or not it has met the projected 5.1-percent target. For FYs 2003 through 2006, the percentages were 5.7 percent, 3.5 percent, 4.0 percent, and 4.7 percent, respectively.

Potential Problems With the Use of the Cost-to-Charge Ratio in Medicaid

As long as a hospital's actual costs and its charges change at roughly the same rate, the estimate of costs, using the hospital-specific cost-to-charge ratio from a hospital's most recent cost report, will produce a reliable and reasonable result. However, when a hospital dramatically increases its charges relative to costs and the State agency does not update the cost-to-charge ratio accordingly or in a sufficiently timely manner, the estimated cost will no longer be reliable or reflective of current conditions. Using an outdated cost-to-charge ratio may result in a higher estimate of costs and may cause a State agency to make higher Medicaid outlier payments than would be appropriate.

Prior Office of Inspector General Audits

The Medicaid programs could have been experiencing the same vulnerabilities that the Medicare program identified and addressed in its 2003 regulation modifications. Consequently, in FY 2004 we conducted audits of Medicaid outlier payments in eight selected State agencies. Our

[6] CMS's Manual System Publication 100-04, *Medicare Claims Processing*, elaborates on 42 CFR § 412.84(i)(4) and states that a fiscal intermediary or Medicare contractor is to reconcile outlier payments at the time of cost report final settlement if: (1) the actual cost-to-charge ratio is found to be plus or minus 10 percentage points from the cost-to-charge ratio used during that time period to make outlier payments and (2) total outlier payments in that cost reporting period exceed $500,000.

[7] *Audit of the Effectiveness of the Revised Medicare Outlier Payment Regulations for Inpatient Acute Care Hospitals* (A-07-04-04032), issued September 9, 2005.

objectives were to determine whether the eight State agencies' methods of calculating Medicaid outlier payments were reasonable. We determined that all eight State agencies made Medicaid outlier payments using outdated cost-to-charge ratios to convert charges to estimated costs. The eight State agencies used cost reports that were at least 2 years old to calculate their cost-to-charge ratios.

We also determined that if the eight State agencies had used more up-to-date cost-to-charge ratios in a manner similar to Medicare's revised outlier payment methodology, they could have saved approximately $236.6 million from 1998 through 2003 in Medicaid outlier payments made to the hospitals reviewed.[8] The following table summarizes the scopes of, and potential savings identified in, our prior audit reports.

State (Audit Report No.)	Audit Period	Basis of Results	Potential Savings (in millions)
Georgia (A-04-04-00009)	July 1998–December 2002	3 hospitals	$22.7
Illinois (A-07-04-04031)	State FYs 1998–2002	3 hospitals	56.5
North Carolina (A-07-04-04038)	State FYs 1998–2003	Statewide	89.4
Ohio (A-05-04-00064)	State FYs 2000–2003	Statewide	24.7
New York (A-02-04-01022)	State FYs 1998–2002	3 hospitals	21.5
Pennsylvania (A-03-04-00211)	State FYs 1998–99 and 2002–03	3 hospitals	11.4
Virginia (A-03-04-00212)	State FYs 2001–2003	3 hospitals	5.8
Texas (A-06-04-00051)	State FYs 2000, 2002, 2003	4 hospitals	4.6
TOTAL			**$236.6**

At the time they were conducted, our eight prior audits were not part of a unified nationwide review; consequently, their audit scopes varied, as did, to a lesser extent, their objectives and recommendations. These prior audits, though, identified very similar vulnerabilities in the methodologies used by the eight State agencies to calculate Medicaid outlier payments. That fact, combined with the potential cost savings identified in those prior reports, led us to review the same State agencies during a more recent audit period. This audit thus focused on Medicaid outlier payment methodologies, which included the identification and review of any corrective action the eight State agencies may have undertaken since the conclusion of the fieldwork in our prior audits.

[8] In each of our eight prior audits, we gave our findings and recommendations to the State agency at the conclusion of our fieldwork (in 2004). Thus, although some of these prior audits were issued within the audit scope of this review, all the State agencies were aware of our findings and recommendations.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the eight State agencies calculated Medicaid inpatient hospital outlier payments to effectively limit the payments to extraordinarily high-cost cases.

Scope

We reviewed the same 8 State agencies that we reviewed in the prior audits, and we reviewed 27 sample hospitals, most but not all of which were reviewed in the prior audits. The 8 State agencies paid the 27 sampled hospitals approximately $516.3 million in Medicaid DRG base payments and $918.5 million in Medicaid outlier payments between FYs 2004 and 2006.

We did not perform a detailed review of the eight State agencies' internal controls. We limited our review of internal controls to obtaining an understanding of the eight State agencies' policies and procedures used to calculate and approve Medicaid outlier payments.

We analyzed the Medicaid outlier payments in our field offices.

Methodology

To accomplish our objective, we:

- reviewed the State Medicaid plans and policies associated with the Medicaid outlier payments for the 8 State agencies for FYs 2004 through 2006;

- reviewed our prior audits of the 8 State agencies and in particular reviewed those State agencies' comments on our findings and recommendations;

- analyzed the 8 State agencies' Medicaid outlier payment data by:

    - identifying Medicaid outlier payments for all hospitals in the 8 States, based on medical claims data provided to us by the relevant State agencies,[9]

    - recalculating for each of the 27 sampled hospitals and for each FY what the Medicaid outlier payment would have been using the hospital's cost-to-charge ratio from its most recent final or submitted cost report and so quantifying the impact of the State agencies' use of outdated cost-to-charge ratios on their calculations of Medicaid outlier payments, and

    - calculating the percentage increase of total Medicaid DRG base payments and outlier payments on a per-admission basis using the medical claims data;

[9] The Pennsylvania State agency's data were not included in this portion of our review because the Pennsylvania State agency converted to a new claims system in March 2004 and did not distinguish between different types of Medicaid outlier payments.

- compared Medicaid outlier payments to Medicare outlier payments for hospitals in the 8 State agencies to evaluate the impact of using outdated cost-to-charge ratios on the Medicaid program relative to the impact of using the most recent cost-to-charge ratios on the Medicare program; and

- discussed more current Medicaid outlier payment methodologies and, where applicable, corrective action based on our prior audits with officials of the 8 State agencies.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The eight State agencies did not calculate Medicaid outlier payments to effectively limit the payments to extraordinarily high-cost cases. For all hospitals in seven of the eight States, Medicaid outlier payments increased from approximately $913.0 million in FY 2004 to approximately $1.2 billion in FY 2006. During this period, Medicaid outlier payments increased substantially faster than Medicaid DRG base payments and Medicare outlier payments.

This occurred because the eight State agencies (1) used outdated cost-to-charge ratios to convert charges to estimated costs and (2) did not reconcile Medicaid outlier payments upon cost report settlement.

If the 8 State agencies had used the most recent cost reports to calculate the cost-to-charge ratios for the 27 hospitals we reviewed, those State agencies could have, between FYs 2004 and 2006, more effectively limited the payments to extraordinarily high-cost cases, thereby reducing those Medicaid outlier payments by $320.0 million. Those State agencies could have used the savings from lower Medicaid outlier payments to the 27 hospitals (and to other hospitals that aggressively increased their charges) to make higher Medicaid outlier payments to hospitals that did not increase charges faster than actual costs.

STATE MEDICAID PLAN REQUIREMENTS

The eight State Medicaid plans provide for the use of Medicaid outlier payments to hospitals for extraordinarily high-cost cases. For example, the Illinois Medicaid State plan, Attachment 4.19-A, chapter V, section C, "Payments for Extraordinarily High Cost Cases," states that the Illinois State agency will make an additional payment to hospitals to cover costs in cases when the applicable threshold is exceeded. Although the State Medicaid plans for the other seven State agencies do not always use the term "extraordinarily high-cost," they provide criteria for Medicaid outlier payments that are similar to the language in the Illinois Medicaid State plan.

MEDICAID OUTLIER PAYMENTS NOT LIMITED

The eight State agencies did not calculate Medicaid outlier payments to limit the payments to extraordinarily high-cost cases. For all hospitals in seven of the eight States, Medicaid outlier payments increased from approximately $913.0 million in FY 2004 to approximately $1.2 billion in FY 2006. For this time period, the average Medicaid outlier payment per admission for all hospitals in these seven States increased by 25.2 percent. Medicaid outlier payments also increased substantially faster than Medicare outlier payments and Medicaid DRG base payments.

The substantially higher rate of increase in Medicaid outlier payments relative to both Medicare outlier payments and Medicaid DRG base payments becomes even more pronounced when we use data from FY 2003—the FY before the first full year that CMS's modified Medicare regulations were effective—as the baseline for these comparisons.

- From FY 2003 to FY 2006, the average Medicare DRG base payment per admission for all hospitals in seven of the eight States increased by 21.0 percent, and the average Medicare outlier payment per admission for the same hospitals increased by 28.2 percent. In other words, Medicare outlier payments were increasing at roughly similar rates as the rates of increase in Medicare DRG base payments.

- During the same period, the average Medicaid DRG base payment per admission for all hospitals in these seven States increased by 2.6 percent. However, the average Medicaid outlier payment per admission for the same hospitals increased by 56.7 percent, a significantly higher rate of increase than was the case for the average Medicaid DRG base payment per admission.

For the hospitals we reviewed, the Medicaid percentage of outlier payments in relation to total DRG base payments was generally higher than the Medicare percentage of outlier payments in relation to total DRG base payments (Appendix A). In Illinois, Hospital C received Medicaid outlier payments that were 136.6 percent of total DRG base payments, compared with Medicare outlier payments that were 4.0 percent of total DRG base payments. In Georgia, Hospital D received Medicaid outlier payments that were 518.2 percent of total DRG base payments, compared with Medicare outlier payments that were 5.8 percent of total DRG base payments.

STATES DID NOT USE MOST RECENT COST-TO-CHARGE RATIOS

The eight State agencies did not limit Medicaid outlier payments because (1) they did not use the most recent cost report as the basis for the calculation of cost-to-charge ratios and (2) they did not reconcile Medicaid outlier payments upon cost report settlement. CMS employs these measures to limit Medicare outlier payments.

Moreover, using the cost-to-charge ratios from the most recent cost report reduces the timelag for updating the cost-to-charge ratio by a year or more, which helps prevent inpatient hospitals from receiving Medicaid outlier payments on the basis of high charges rather than high costs. CMS uses the reconciliation to account for differences between (1) the cost-to-charge ratio used to pay a particular claim at the time of its original submission by the inpatient hospital and

(2) the cost-to-charge ratio determined at the final settlement of the cost reporting period during which the patient's discharge occurred.

Appendix B shows each State agency's cost-to-charge ratios used and the cost-to-charge ratios we recalculated based on the latest cost reports for FYs 2004 and 2006.

EFFECT OF NOT USING MOST RECENT COST-TO-CHARGE RATIOS AND NOT RECONCILING MEDICAID OUTLIER PAYMENTS

Because the eight State agencies did not use the most recent cost-to-charge ratios to calculate Medicaid outlier payments and did not reconcile Medicaid outlier payments upon cost report settlement, these payments increased substantially during our audit period. If the eight State agencies (and by extension, all State agencies that make Medicaid outlier payments) do not amend their policies and procedures to discontinue use of outdated cost-to-charge ratios, Medicaid outlier payments may continue to increase disproportionately as certain hospitals increase charges faster than costs. At the same time, hospitals that do not increase charges as aggressively could continue to be adversely affected, particularly if State agencies make outlier formula changes (e.g., increasing outlier thresholds) in an attempt to restrain Medicaid outlier payment growth.[10]

For example, the Illinois State agency used a hospital-specific cost-to-charge ratio that was frozen by Illinois statute in 1995 and used a calculation to convert charges to costs based on 1989 cost report data. If the most recent cost-to-charge ratio had been used to calculate the Medicaid outlier payments, one hospital (Hospital C) would have received approximately $30.3 million less in Medicaid outlier payments for FYs 2004 through 2006.[11]

If the 8 State agencies had used the most recent cost reports to calculate the cost-to-charge ratios that convert charges to estimated costs for the 27 hospitals we reviewed, those State agencies could have, between FYs 2004 and 2006, more effectively limited the payments to extraordinarily high-cost cases, thereby reducing those Medicaid outlier payments by $320.0 million.

If the 8 State agencies had made changes to their Medicaid outlier payment formulas similar to the changes CMS made to the Medicare outlier payment formula, those State agencies could have used the savings from lower Medicaid outlier payments to these 27 hospitals (and to other hospitals that aggressively increased their charges) to make higher Medicaid outlier payments to hospitals that did not increase charges faster than costs. Using the most recent cost reports would have enabled State agencies to calculate and make Medicaid outlier payments in the same manner as Medicare outlier payments, thus putting those Medicaid funds to better use.

[10] The CMS Administrator testified on Medicare outlier payments before the Senate Appropriations Subcommittee on Labor, Health and Human Services and Education on March 11, 2003. He said that as a direct result of the increased Medicare outlier thresholds, "… more hospitals have been forced to absorb the cost of the complex cases they treat, while a relatively small number of hospitals that have been aggressively gaming the current rules benefit by getting a hugely disproportionate share of Medicare outlier payments."

[11] We based the OIG-recalculated cost-to-charge ratios on the latest cost reports.

Appendix C displays a comparison for the eight States and hospitals reviewed of the total amounts of actual Medicaid outlier payments made; the total amounts of Medicaid outlier payments we recalculated using the most recent cost-to-charge ratios; and the differences between these two amounts for each hospital, or Medicaid funds that could have been put to better use.

RECOMMENDATIONS

We recommend that CMS encourage all State agencies that make Medicaid outlier payments to (1) use the most recent cost-to-charge ratios to calculate Medicaid outlier payments, (2) reconcile Medicaid outlier payments upon cost report settlement or use an alternative method to ensure that outlier payments are more closely aligned with actual costs, and (3) amend their State plans accordingly.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS agreed with our first and third recommendations. CMS partially agreed with the second recommendation as it was phrased in our draft report. Regarding that second recommendation, CMS agreed that reconciliation would better align outlier payments to the costs incurred by hospitals but added that "… it is more appropriate to defer to States and let them determine what changes, if any, are appropriate."

CMS's comments are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing CMS's comments, we revised our second recommendation to include a provision for an alternative method to align outlier payments with actual costs.

OTHER MATTERS

After our previous audits, some of the eight State agencies implemented corrective action to limit Medicaid outlier payments to extraordinarily high-cost cases. The implementation dates of the revised procedures were after our most recent audit period.

The New York State agency implemented procedures similar to those in Medicare that have proved effective in limiting outlier payments. This suggests that the revised procedures will limit outlier payments to extraordinarily high-cost cases. In contrast, the Illinois State agency increased the outlier threshold in State FYs 2006 and 2007, but the Medicaid outlier payments for the three hospitals we reviewed only slightly decreased. Increasing the outlier threshold did not address the outdated cost-to-charge ratio. Thus, the change was not effective in ensuring that outlier payments were limited to extraordinarily high-cost cases.

APPENDIXES

APPENDIX A: MEDICARE AND MEDICAID INPATIENT HOSPITAL OUTLIER PAYMENTS IN RELATION TO DIAGNOSIS-RELATED GROUP BASE PAYMENTS FOR FISCAL YEARS 2003 THROUGH 2006[1]

	MEDICARE			MEDICAID		
	DRG[2] Base Payment per Admission	Outlier Payment per Admission	Outlier Payment as a Percentage of DRG Base Payments	DRG Base Payment per Admission	Outlier Payment per Admission	Outlier Payment as a Percentage of DRG Base Payment
Georgia						
Hospital D	$18,187	$1,052	5.79%	$451	$2,339	518.21%
Hospital E	n/a[3]	n/a		978	6.222	636.33%
Hospital F	11,624	1,064	9.15%	133	797	599.72%
Illinois						
Hospital A	18,858	229	1.21%	567	144	25.40%
Hospital B	20,934	1,359	6.49%	1,015	540	53.20%
Hospital C	13,572	539	3.97%	514	702	136.58%
North Carolina						
Hospital G	17,811	740	4.15%	11,222	2,461	21.93%
Hospital H	23,634	1,488	6.30%	18,633	4,705	25.25%
Hospital I	12,038	391	3.25%	7,665	1,184	15.45%
Hospital J	11,906	242	2.03%	7,153	294	4.11%
Ohio						
Hospital U	19,741	539	2.73%	6,989	3,273	46.84%
Hospital V	12,817	148	1.15%	3,602	786	21.83%
Hospital W	n/a	n/a		4,570	11,073	242.29%
Hospital X	n/a	n/a		5,992	9,932	165.75%
New York						
Hospital K	28,162	1,360	4.83%	5,916	252	4.26%
Hospital L	27,136	1,061	3.91%	6,737	345	5.12%
Hospital M	24,703	394	1.60%	6,134	217	3.54%
Virginia						
Hospital Y	23,096	946	4.10%	8,948	1,436	16.05%
Hospital Z	21,841	1,106	5.06%	6,684	1,084	16.21%
Hospital AA	n/a	n/a		7,671	1,467	19.13%
Texas						
Hospital N	17,802	1,971	11.07%	11,377	1,897	16.67%
Hospital O	20,671	664	3.21%	3,890	332	8.54%
Hospital P	19,972	532	2.66%	2,644	194	7.32%
Hospital Q	15,767	467	2.96%	3,389	318	9.38%

[1] The Pennsylvania State agency's data were not included in this portion of our review because the Pennsylvania State agency converted to a new claims system in March 2004 and did not distinguish between different types of Medicaid outlier payments.

[2] Diagnosis-related group.

[3] Not applicable. This provider is not a Medicare inpatient prospective payment system hospital.

APPENDIX B: SUMMARY OF COST-TO-CHARGE RATIOS[1]

	2004 Cost-to-Charge Ratio Used	OIG[2]-Recalculated 2004 Cost-to-Charge Ratio	2006 Cost-to-Charge Ratio Used	OIG-Recalculated 2006 Cost-to-Charge Ratio	Status of Cost Reports Used for OIG-Recalculated Cost-to-Charge Ratios (2004/2006)[3]
Georgia					
Hospital D	0.4850	0.2580	0.4850	0.1980	As Submitted
Hospital E	0.5670	0.3720	0.5670	0.3450	Final/Amended
Hospital F	0.4490	0.3540	0.4490	0.3960	Final/Settled
Illinois					
Hospital A	0.5072	0.3407	0.5072	0.2914	Final/As Submitted
Hospital B	0.5896	0.4505	0.5896	0.4126	Final/As Submitted
Hospital C	0.7059	0.3758	0.7059	0.4099	Final/Preliminary
North Carolina					
Hospital G	0.5392	0.4623	0.5007 or 0.5056 or 0.5240	0.4763	As Submitted
Hospital H	0.6630 or 0.6697	0.4703	0.6907 or 0.7413	0.5113	As Submitted
Hospital I	0.4175	0.4835	0.4939 or 0.5039 or 0.5162	0.4803	As Submitted
Hospital J	0.6608	0.5765	0.6308 or 0.6315 or 0.6803	0.6308	As Submitted
Ohio					
Hospital U	0.6000 or 0.8000	0.3200	0.3600	0.3100	Final/Preliminary
Hospital V	0.6000 or 0.8000	0.3900	0.3900 or 0.6000 or 0.8000	0.3300	Final/As Submitted
Hospital W	0.7300 or 0.7500	0.5800	0.5800 or 0.6800	0.6000	Final
Hospital X	0.5900	0.6500	0.6500	0.5700	Interim
New York					
Hospital K	0.4478	0.4320	0.4285	0.4099	As Submitted
Hospital L	0.5161	0.4495	0.4584	0.3964	As Submitted
Hospital M	0.3535	0.2981	0.2981	0.2562	As Submitted

[1] Entries with more than one figure show when the State agency used more than one cost-to-charge ratio.

[2] Office of Inspector General.

[3] We based the OIG-recalculated cost-to-charge ratios on the latest cost reports. This column shows the status of the cost reports that we used to recalculate the 2004 and 2006 cost-to-charge ratios, separated by a slash.

	2004 Cost-to-Charge Ratio Used	OIG-Recalculated 2004 Cost-to-Charge Ratio	2006 Cost-to-Charge Ratio Used	OIG-Recalculated 2006 Cost-to-Charge Ratio	Status of Cost Reports Used for OIG-Recalculated Cost-to-Charge Ratios (2004/2006)
Pennsylvania					
Hospital R	0.2757	0.1005	0.2757	0.1082	Final
Hospital S	0.4102	0.2541	0.3376 or 0.4102	0.2412	Final
Hospital T	0.3730	0.4257	0.3730 or 0.3884 or 0.4065	0.3884	Final
Virginia					
Hospital Y	0.6724	0.4653	0.5656	0.3703	Cost Settlement
Hospital Z	0.4653	0.3480	0.4588	0.3839	Cost Settlement
Hospital AA	0.5018	0.4115	0.4693	0.3891	Cost Settlement
Texas					
Hospital N	0.2400 or 0.2600 or 0.2900	0.2300	0.2000 or 0.2300	0.2400	Final
Hospital O	0.4600 or 0.5300	0.4500	0.4500 or 0.5400	0.5100	Tentative/Final
Hospital P	0.4700 or 0.5200	0.4100	0.4200 or 0.4500	0.4300	Final/Tentative
Hospital Q	0.5600 or 0.5900	0.5600	0.5500 or 0.5900	0.5400	Final

APPENDIX C: CALCULATION OF FUNDS THAT COULD HAVE BEEN PUT TO BETTER USE

	Total Original Medicaid Outlier Payments	Total Medicaid Outlier Payments Using OIG-Recalculated Cost-to-Charge Ratios	Funds That Could Have Been Put to Better Use[1]
Georgia			
Hospital D	$ 58,935,240	$11,421,416	$47,513,824
Hospital E	116,273,928	59,265,204	57,008,724
Hospital F	18,573,717	12,274,519	6,299,198
			$110,821,746
Illinois			
Hospital A	15,493,572	5,101,777	10,276,265
Hospital B	33,909,965	16,334,958	15,577,428
Hospital C	49,400,188	18,839,937	30,254,967
			$56,108,660
North Carolina			
Hospital G	11,938,368	9,575,652	2,326,392
Hospital H	77,179,018	39,804,296	35,750,833
Hospital I	53,971,186	41,168,841	12,449,239
Hospital J	1,730,076	1,582,040	148,036
			$50,674,500
Ohio			
Hospital U	32,433,851	18,566,028	13,867,823
Hospital V	10,087,339	6,139,941	3,947,398
Hospital W	128,450,010	114,592,428	13,857,582
Hospital X	117,673,334	109,890,961	7,782,373
			$39,455,176
New York			
Hospital K	21,407,874	17,931,248	3,476,626
Hospital L	26,511,580	12,316,391	14,195,189
Hospital M	19,610,654	11,872,289	7,738,365
			$25,410,180

[1] Totals in this column do not always equal the difference between the original and recalculated amounts. This is because some State agencies make both day outlier payments and cost outlier payments for cases that have either a high number of days or high costs compared with days and costs in similar cases. Because this issue affected only two out of the eight State agencies we reviewed, we did not include day outlier payments in this table.

	Total Original Medicaid Outlier Payments	Total Medicaid Outlier Payments Using OIG-Recalculated Cost-to-Charge Ratios	Funds That Could Have Been Put to Better Use
Pennsylvania			
Hospital R	$17,949,640	$5,385,329	$12,564,311
Hospital S	17,387,692	9,385,444	8,002,248
Hospital T	11,024,131	12,100,644	(1,076,513)
			$19,490,046
Virginia			
Hospital Y	14,200,923	5,412,536	8,788,387
Hospital Z	8,369,108	4,365,727	4,003,381
Hospital AA	3,875,517	2,272,747	1,602,770
			$14,394,538
Texas			
Hospital N	6,355,816	5,415,215	845,227
Hospital O	11,370,273	12,969,879	(1,628,907)
Hospital P	14,147,065	11,678,510	1,933,746
Hospital Q	20,192,526	17,348,669	2,507,212
			$3,657,278
	Total Funds That Could Have Been Put to Better Use		**$320,012,124**

APPENDIX D: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAY 0 4 2011

TO: Daniel R. Levinson
Inspector General

FROM: Donald M. Berwick, M.D.
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicaid Hospital Outlier Payment Follow-up for Fiscal years 2004 Through 2006" (A-07-10-04160)

Thank you for the opportunity to review and comment on the above-referenced report. The Centers for Medicare & Medicaid Services (CMS) appreciates the contributions and valuable input from the OIG on the subject of this study. This report examined inpatient hospital outlier payment policies in eight State Medicaid programs. It is a follow-up to audits conducted in 2004 by the OIG for the years 1998 through 2003. In this report, the OIG found that these States were not effective in limiting outlier payments for extraordinary high-cost cases because they used outdated cost-to-charge ratios and did not reconcile Medicaid outlier payments to costs upon cost report settlements. The OIG estimated if these States had adopted procedures recommended in the 2004 report, Medicaid payments could have been reduced by $320 million for the 27 hospitals included in the review between fiscal years 2004–2006.

OIG Recommendation

CMS encourage all State agencies that make Medicaid outlier payments to use the most recent cost-to-charge ratios to calculate Medicaid outlier payments.

CMS Response

We agree with this recommendation. This report is very timely as States across the country are looking for ways to appropriately contain Medicaid costs. We plan to incorporate this recommendation into our guidance to States on identifying efficiencies in their payment programs.

OIG Recommendation

CMS encourage all State agencies that make Medicaid outlier payments to reconcile Medicaid outlier payments upon cost report settlement.

CMS Response

We partially agree with this recommendation. Under the Medicaid program, States are responsible for establishing payment rates for inpatient hospital services, including outlier policies. While we agree cost reconciliation would better align State outlier payments to the costs incurred by hospitals for qualifying cases, we believe other alternatives may be available should States wish to revise their payment methodologies. For example, rather than adopting a cost reconciliation process, States might wish to maintain a prospective approach such as applying a factor to the earlier period cost to charge ratios to better align them with current period costs. Because outlier payments fit within an overall reimbursement scheme, States may wish to examine their payment policies more broadly before altering any specific elements to avoid unintended consequences. Rather than encouraging States to make a specific change in methodology, given their primary role in rate setting, we believe it is more appropriate to defer to States and let them determine what changes, if any, are appropriate.

OIG Recommendation

CMS encourage all State agencies that make Medicaid outlier payments to amend their State plans accordingly.

CMS Response

We agree with this recommendation. We will provide States with this report and will encourage them to examine their outlier payment policies and make amendments to their State plan as they determine appropriate.

We appreciate the efforts that went into this report and look forward to working with the OIG on this and other issues.