DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

NOV 29 2005

TO: Dennis G. Smith
Director, Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services

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

SUBJECT: Medicaid Hospital Outlier Payments in Pennsylvania for State Fiscal Years 1998-1999 Through 2002-2003 (A-03-04-00211)

Attached is an advance copy of our final report on Pennsylvania's Medicaid hospital outlier payments for State fiscal years (SFYs) 1998-1999 through 2002-2003. We will issue this report to the Pennsylvania Medicaid agency within 5 business days. This audit is one of a series of audits of State Medicaid outlier payments.

Pennsylvania pays 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. Although a hospital's costs can vary significantly among patients within a specific DRG, the DRG base payment is fixed. Pennsylvania also makes outlier payments for situations in which the cost of treating a Medicaid patient is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. The outlier policy acts as a safeguard to avoid premature discharge of high-cost patients.

Our objective was to determine whether Pennsylvania's method of computing inpatient hospital day outlier and cost outlier Medicaid payments resulted in reasonable payments.

Pennsylvania's method resulted in reasonable day outlier payments. For the three hospitals reviewed, the State accurately calculated day outlier financial transactions. Only inpatient hospital stays that exceeded the established number of days for a DRG received a day outlier payment.

However, Pennsylvania's method did not result in reasonable cost outlier payments because the State used an outdated cost-to-charge ratio in its calculations. As a result, cost outlier payments increased significantly and at a faster rate than other types of Medicaid payments. On a per admission basis from SFYs 1998-1999 to 2002-2003, for claims that received a cost outlier payment, cost outlier payments increased by 75.3 percent, DRG base payments increased by 22.5 percent, and total Medicaid payments increased by 62.6 percent. If Pennsylvania had applied a more current cost-to-charge ratio to convert billed charges to costs, it could have saved approximately $11.42 million between SFYs 1998-1999 and 2002-2003 at the three hospitals reviewed. Additional potential savings may exist at other hospitals. If Pennsylvania does not address the outlier policy deficiencies, including the outdated cost-to-charge ratio, it is likely that cost outlier payments will continue to increase as hospitals increase charges faster than costs.

We recommend that Pennsylvania (1) develop a methodology to monitor the cost-to-charge ratio during the fiscal year and adjust the ratio as necessary and (2) revise the State Medicaid outlier policy to use the cost-to-charge ratio from the most recent cost reporting period and retroactively adjust provider payments for each year based on the actual cost-to-charge ratio calculated for that year.

In its comments on our draft report, Pennsylvania did not concur with the specific recommendations but stated that it would thoroughly evaluate its outlier payment policy to provide more precise provider payments for inpatient services. Pennsylvania stated that it (1) was converting its current DRG grouping system to a revised grouping system, (2) was developing updated cost-to-charge ratios to more closely reflect costs, and (3) would assess the feasibility of initiating retroactive payment adjustments. However, according to Pennsylvania, retroactive payment adjustments would require additional changes in the State's processes and revisions to hospital regulations affecting acute care payments.

The State has taken positive actions to update its cost-to-charge ratios and monitor its inpatient provider payment system in line with our recommendations.

If you have any questions or comments about this report, please call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4470. Please refer to report number A-03-04-00211.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services – Region III
Public Ledger Building, Room 316
150 South Independence Mall West
Philadelphia, PA 19106-3499

NOV 30 2005

Report Number: A-03-04-00211

Mr. Michael L. Stauffer
Deputy Secretary for Administration
Department of Public Welfare
Health & Welfare Building, Room 234
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

Dear Mr. Stauffer:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Medicaid Hospital Outlier Payments in Pennsylvania for State Fiscal Years 1998-1999 Through 2002-2003." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

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 reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent the information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (see 45 CFR part 45).

If you have any questions or comments about this report, please do not hesitate to contact me, or your staff may contact Bernard Siegel, audit manager, at (215) 861-4484, or through e-mail at bernard.siegel@oig.hhs.gov. Please refer to report number A-03-04-00211 in all correspondence.

Sincerely,

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosures – as stated

cc: Richard J Polek/Andrew J. Johnson
Audit Resolution Section

Direct Reply to HHS Action Official:

Nancy B. O'Connor
Regional Administrator
Public Ledger Building, Room 216
150 South Independence Mall West
Philadelphia, PA 19106-3499

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID HOSPITAL OUTLIER PAYMENTS IN PENNSYLVANIA FOR STATE FISCAL YEARS 1998-1999 THROUGH 2002-2003

Daniel R. Levinson
Inspector General

NOVEMBER 2005
A-03-04-00211

Office of Inspector General

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pennsylvania Medicaid Payments

Pennsylvania pays 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. Although DRG payments vary by category of inpatient Medicaid cases, the payments for each category are fixed. The DRG system gives hospitals a financial incentive to avoid extremely costly cases. To counter that incentive and promote access to hospital care for high-cost patients, Pennsylvania makes additional payments called day outlier and cost outlier payments. Outlier payments can be viewed as a form of insurance for hospitals against the large losses that could result from extremely expensive cases.

Medicare Outlier Payments

Pennsylvania's Medicaid outlier policy was designed to be similar to the Medicare outlier policy. Pennsylvania's program includes day outlier and cost outlier payments for extraordinarily high-cost claims. In 2003, the Medicare program adopted new regulations to prevent excessive payments to certain hospitals that were aggressively increasing charges. Because of these increases, the Centers for Medicare & Medicaid Services (CMS) outlier formula overestimated the hospitals' costs, and CMS paid approximately $9 billion in excessive Medicare outlier payments in Federal fiscal years 1998 to 2002.

OBJECTIVE

Our objective was to determine whether Pennsylvania's method of computing inpatient hospital day outlier and cost outlier Medicaid payments resulted in reasonable payments.

SUMMARY OF FINDINGS

Pennsylvania's method resulted in reasonable day outlier payments. For the three hospitals reviewed, the State accurately calculated day outlier financial transactions. Only inpatient hospital stays that exceeded the established number of days for a DRG received a day outlier payment.

However, Pennsylvania's method did not result in reasonable cost outlier payments because the State used an outdated cost-to-charge ratio in its calculations. As a result, cost outlier payments increased significantly and at a faster rate than other types of Medicaid payments. On a per admission basis from State fiscal years (SFYs) 1998-1999 to 2002-2003, for claims that received a cost outlier payment, cost outlier payments increased by 75.3 percent, DRG base payments increased by 22.5 percent, and total Medicaid payments increased by 62.6 percent. If Pennsylvania had applied a more current cost-to-charge ratio to convert billed charges to costs, it could have saved approximately $11.42 million between SFYs 1998-1999 and 2002-2003 at the three hospitals reviewed. Additional potential savings may exist at other hospitals. If

Pennsylvania does not address the outlier policy deficiencies, including the outdated cost-to-charge ratio, it is likely that cost outlier payments will continue to increase as hospitals increase charges faster than costs.

RECOMMENDATIONS

We recommend that Pennsylvania:

- develop a methodology to monitor the cost-to-charge ratio during the fiscal year and adjust the ratio as necessary and

- revise the State Medicaid outlier policy to use the cost-to-charge ratio from the most recent cost reporting period and retroactively adjust provider payments for each year based on the actual cost-to-charge ratio calculated for that year.

PENNSYLVANIA'S COMMENTS

In its comments on our draft report, Pennsylvania did not concur with the specific recommendations but stated that it would thoroughly evaluate its outlier payment policy to provide more precise provider payments for inpatient services. Pennsylvania stated that it (1) was converting its current DRG grouping system to a revised grouping system, (2) was developing updated cost-to-charge ratios to more closely reflect costs, and (3) would assess the feasibility of initiating retroactive payment adjustments. However, according to Pennsylvania, retroactive payment adjustments would require additional changes in the State's processes and revisions to hospital regulations affecting acute care payments.

Pennsylvania's comments are included as Appendix C.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

The State has taken positive actions to update its cost-to-charge ratios and monitor its inpatient provider payment system in line with our recommendations.

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INTRODUCTION

BACKGROUND

Medicaid Program

Medicaid was established in 1965 under Title XIX of the Social Security Act as a joint Federal and State program. Medicaid provides medical assistance to low-income persons who are age 65 or over, blind, disabled, members of families with dependent children, or qualified children and pregnant women. Each State administers its Medicaid program in accordance with a State plan that the Centers for Medicare & Medicaid Services (CMS) approves for compliance with Federal laws and regulations. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.

In Pennsylvania, the Department of Public Welfare (the State agency) administers the Medicaid program.

Outlier Payments and the Prospective Payment System

Pennsylvania pays 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. Although a hospital's costs can vary significantly among patients within a specific DRG, the DRG base payment is fixed. Congress established Medicare outlier payments for situations in which the cost of treating a Medicare patient is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. The outlier policy acts as a safeguard to avoid premature discharge of high-cost patients.

Pennsylvania Medicaid Outlier Payments

To compensate hospitals when they incur unusually high costs for Medicaid patients, the State makes Medicaid outlier payments. For a few DRGs, primarily neonatal and burn cases, the State makes cost outlier payments that are based on the estimated cost of the claim; for all other DRGs, the State makes day outlier payments that are based on the length of stay.

Day Outlier Formula

For most DRGs, Pennsylvania makes day outlier payments for each day beyond the statewide average length of stay. The amount is calculated as 60 percent of the average daily DRG base payment (DRG base payment amount divided by the statewide average length of stay).

Cost Outlier Formula

Pennsylvania makes cost outlier payments for extraordinarily high-cost claims for neonatal and burn cases. The amount is calculated as the estimated cost (total charges multiplied by the hospital-specific cost-to-charge ratio) less a threshold amount (150 percent of the DRG base amount). Estimated costs above the threshold are reimbursed as cost outlier payments.

Because hospitals cannot calculate the exact cost for each admission, Pennsylvania must convert billed charges to estimated costs using a cost-to-charge ratio to determine whether a claim qualifies as an extraordinary high-cost case. The cost-to-charge ratio is calculated from financial data that providers submit annually. In Pennsylvania, the ratio used for the State fiscal year (SFY) generally comes from the Medicaid cost report from 3 years earlier.[1] When the cost-to-charge ratio is determined, Pennsylvania does not retroactively adjust payments for claims from the applicable cost report fiscal year. The higher the cost-to-charge ratio and inpatient hospital charges, the higher the cost outlier payment.

Potential Problems With the Cost-to-Charge Ratio

As long as hospital costs and charges change at roughly the same rate, estimating costs using the hospital-specific cost-to-charge ratio produces a reliable result. Over time, the cost-to-charge ratio will reflect the changes in the costs and charges. However, when a hospital dramatically increases its charges relative to costs and the State uses a cost-to-charge ratio that is not based on those increased charges, the estimated cost will not be reliable or representative of current conditions. Using an outdated cost-to-charge ratio can yield higher cost outlier payments than would be appropriate because the payment could be triggered by higher charges and not by higher costs. On a national basis, hospitals have steadily increased charges in relationship to costs since the mid-1980s.[2] In addition, CMS found that hospital charges have continued to increase faster than hospital costs.[3]

Excessive Medicare Outlier Payments

In 2003, CMS modified the Medicare inpatient prospective payment system policy to correct a problem that resulted in excessive outlier payments. From 1998 to 2002, CMS reported that it paid approximately $9 billion more in outlier payments than intended because its outlier computation overestimated costs for hospitals that raised charges faster than costs. As a result, hospitals that dramatically increased their charges received outlier payments for cases with high charges rather than high costs. Upon discovering the vulnerabilities of the Medicare outlier policy, CMS revised the formula to use the cost-to-charge ratio from the latest cost reporting period, i.e., the most recent settled or tentatively settled cost report. Using the cost-to-charge ratios from tentatively settled cost reports reduces the time lag for updating the cost-to-charge ratio by a year or more. In addition, outlier payments are now subject to adjustment when the hospital's cost report is settled and the actual cost-to-charge ratio is determined. That adjustment will ensure that the outlier payment appropriately reflects the hospital's costs of providing care.

[1]Pennsylvania's SFY begins on July 1 and is identified by the beginning and ending year (e.g., SFY 2000-2001). Pennsylvania may adjust the cost-to-charge ratio at its discretion based on other factors.

[2]MedPac analysis of data from the American Hospital Association annual survey of hospitals from 1985 to 2001.

[3]CMS determined that hospital charges increased 7.63 percent and 10 percent in 2000 and 2001, respectively, and that those rates were higher than rates of hospital cost increases (Federal Register, volume 67, No. 148, page 50124, dated August 1, 2002).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Pennsylvania's method of computing inpatient hospital day outlier and cost outlier Medicaid payments resulted in reasonable payments.

Scope

This audit is one of a series of audits of State Medicaid outlier payments.

Between SFY 1998-1999 and 2002-2003, Pennsylvania paid approximately $2.9 billion for inpatient hospital services under the DRG system: $2.7 billion for DRG base payments and $197 million for day outlier and cost outlier payments. (See Appendix A for details by type of payment for each fiscal year.)

To determine whether specific hospitals received disproportionately higher levels of day outlier and cost outlier payments, we reviewed claims paid to three hospitals during calendar years 1999 to 2003. We selected providers for onsite reviews based on high cost outlier payments. The three hospitals reviewed received $262.4 million for hospital services—$197.2 million for DRG base payments, $12.7 million for day outlier payments, and $52.5 million for cost outlier payments—for discharges occurring from 1993 through 2003.

The State provided the Medicaid payment data used in this report. To validate the accuracy of those data, we calculated the DRG base amount and any applicable day and cost outliers for 41,275 payment transactions (including payment, reversal, and adjustment transactions) made to the 3 hospitals during calendar years 1999 to 2003. Of the 41,275 payment transactions, 481 included day outlier payments, 1,648 included cost outlier payments, and the remaining 39,146 were not eligible for either a day or a cost outlier payment. In addition, we reconciled 90 claims paid by the State to detailed claims documentation at the 3 hospitals. Because the hospital cost-to-charge ratio did not affect day outlier payments, we limited our review of day outlier claims to the appropriateness and accuracy of the DRG base and day outlier amounts paid.

We did not perform a detailed review of the State agency's internal controls. We limited our review of internal controls to obtaining an understanding of the State agency's policies and procedures used to approve and make payments for Medicaid day and cost outlier payments.

We performed the audit at the Pennsylvania Department of Public Welfare in Harrisburg, PA, and at three Pennsylvania inpatient hospitals.

Methodology

State Agency

We conducted interviews and reviewed documentation to determine how Pennsylvania calculated and monitored outlier payments. Pennsylvania provided a listing of hospitals

receiving DRG base and outlier (day and cost) payments. We used that listing to identify three providers that received a high percentage of cost outlier payments. We analyzed the day and cost outliers and the DRG base payments made to these hospitals during calendar years 1999 to 2003 to determine trends.

To quantify the impact of high charges on cost outlier payments at specific hospitals, we calculated each outlier payment for the three hospitals using the cost-to-charge ratio from the hospitals' cost reports. We replaced the cost-to-charge ratio that Pennsylvania used with the cost-to-charge ratio from the cost report pertaining to the discharge date for each claim. For example, we calculated the outlier payment for a claim with a discharge date of September 1, 2000, using the cost-to-charge ratio from the hospital's fiscal year 2000-2001 cost report instead of the ratio that Pennsylvania used from its 1997-1998 cost report.

Because we intentionally selected hospitals that received high levels of cost outlier payments, the potential cost savings we calculated for the 3 hospitals are not representative of the entire population of 210 hospitals. Therefore, we did not project or extrapolate those results to all Pennsylvania hospitals.

Inpatient Hospital Providers

We reviewed claims with high cost outlier payments at each of the three selected hospitals to determine why these hospitals received significantly higher cost outlier payments. We reviewed board of directors meeting minutes and interviewed department managers to determine how the hospitals set procedure charges. We determined the ratio of increase by comparing the charges for procedures that triggered the largest cost outlier payments with the hospital's historical charges for procedures.

We performed the audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Pennsylvania's method resulted in reasonable day outlier payments. For the three hospitals reviewed, the State accurately calculated day outlier financial transactions. Only inpatient hospital stays that exceeded the established number of days for a DRG received a day outlier payment.

However, Pennsylvania's method did not result in reasonable cost outlier payments because the State used an outdated cost-to-charge ratio in its calculations. As a result, cost outlier payments increased significantly and at a faster rate than other types of Medicaid payments. On a per admission basis from SFY 1998-1999 to 2002-2003, for claims that received a cost outlier payment, cost outlier payments increased by 75.3 percent, DRG base payments increased by 22.5 percent, and total Medicaid payments increased by 62.6 percent. If Pennsylvania had applied a more current cost-to-charge ratio to convert billed charges to costs, it could have saved approximately $11.42 million between SFY 1998-1999 and 2002-2003 at the three hospitals reviewed. Additional potential savings may exist at other hospitals. If Pennsylvania does not

address the outlier policy deficiencies, including the outdated cost-to-charge ratio, it is likely that cost outlier payments will continue to increase as hospitals increase charges faster than costs.

STATE OUTLIER PAYMENT REQUIREMENTS

Pennsylvania Code, 55 Pa. Code § 1163.56, "Outliers," identifies the specific criteria under which Pennsylvania makes day and cost outlier payments for Medicaid inpatient hospital claims. Subsections (a) through (e) define the requirements and payment methodology for day outlier payments.

Subsections (f) through (j) define the requirements and payment methodology for cost outlier payments:

> (f) The Department will pay an amount in addition to the DRG payment for the hospital stay under subsection (i) if:
>
> (1) The hospital stay qualifies as a cost outlier under subsection (g).
>
> (2) The payment conditions in subsection (h) are met.
>
> (3) The hospital stay groups into DRG 385-390, 456-460 or 472, or is a major burn claim or abnormal newborn claim which would have grouped into one of those DRGs under grouper version 7.
>
> (g) A DRG specified under subsection (f) qualifies as a cost outlier if the cost of the case exceeds 150% of the hospital's DRG base payment. The Department will calculate the cost of the case by multiplying the charges indicated on the invoice by the hospital's cost-to-charge ratio.
>
> (h) To receive payment for a case identified as a cost outlier, the following conditions shall be met:
>
> (1) The hospital shall submit a copy of the patient's medical record with the invoice submitted for payment.
>
> (2) The Department will certify the medical necessity of the days of care and the services provided.
>
> (3) The hospital stay shall qualify as a cost outlier under subsection (g) based on the medically necessary days and services certified by the Department.
>
> (i) The outlier payment amount for a cost outlier is 100% of the cost of the case as certified under subsection (h) that exceeds 150% of the hospital's base payment amount for the DRG.

(j) If a hospital is requesting a cost outlier payment, the Department will approve or disapprove the inpatient services based on the medical necessity of the services. Only the cost of approved services is used in determining the cost outlier status of the inpatient case.

As noted, Pennsylvania makes cost outlier payments only when:

- the provider submits high-cost claims in selected DRGs for cost outlier payment,
- the State reviews medical records and certifies that medical necessity supports the billed charges, and
- the charges exceed a threshold amount based on billed charges and the DRG base payment amount.

The Pennsylvania State plan submitted to CMS under Title XIX of the Social Security Act generally echoes the criteria established in the Pennsylvania Code. Specifically, attachment 4.19-A of the Pennsylvania State plan specifies, "For DRGs that are designated as being eligible for cost outlier payments, the Department pays an additional amount for the inpatient hospital stay if the stay is found to be extremely costly in accordance with the outlier criteria outlined under the heading of Cost Outliers."

INFLUENCE OF INCREASED CHARGES ON COST OUTLIER PAYMENTS

Pennsylvania's use of outdated cost-to-charge ratios for calculating inpatient hospital cost outlier payments did not result in reasonable payments. By increasing charges faster than costs, some hospitals were able to increase cost outlier payments based on increased charges rather than higher costs. Hospitals that did not increase charges as fast as costs received smaller cost outlier payments.

Specifically, an analysis of the three hospitals demonstrated that:

- Two hospitals reviewed increased charges dramatically without a demonstrated increase in costs. Those increased charges resulted in higher than reasonable Medicaid cost outlier payments.
- One hospital reviewed increased charges less dramatically (only 6 percent per year), resulting in charges that increased at a rate less than costs. As a result, the hospital received lower than reasonable Medicaid cost outlier payments.

Hospitals can increase cost outlier payments simply by raising charges. By applying an outdated cost-to-charge ratio to those billed charges, the cost outlier formula creates inflated estimated costs.

Two of the hospitals reviewed received higher Medicaid cost outlier payments by increasing charges. When a claim exceeded the outlier dollar threshold, any increase in charges resulted in

increased cost outlier payments. Generally, the hospitals increased charges uniformly for all billed items. As shown in Table 1, Hospital A significantly increased charges for 2 of 3 years, including an increase of 130 percent during SFY 2002-2003. Hospital B had moderate increases, and Hospital C had nominal increases. Higher outliers reflect higher charges, not necessarily higher costs.

Table 1: Annual Percent Increases in Billing Charges[4] for Hospitals Reviewed

Year	Hospital A	Hospital B	Hospital C
2000-2001	50%	14%	6%
2001-2002	5%	15%	6%
2002-2003	130%	10%	6%

Examples of specific charge increases at the hospitals reviewed include:

- Hospital A increased charges for the neonate intensive care room by 130 percent, from $3,128 to $7,194.

- Hospital B increased charges for a neonatal monitoring kit by 20 percent, from $105.75 to $127.00.

- Hospital C increased charges for a double lumen catheter by 6 percent, from $200 to $212.

These increases were not always driven by commensurate cost increases.

REASONS FOR INCREASED COST OUTLIER PAYMENTS

Use of Outdated Information

Generally, Pennsylvania calculates the hospital-specific cost-to-charge ratios each year using 3-year old cost data. Hospitals that increase charges during the 3-year period may take advantage of the disproportionate cost-to-charge ratio to claim higher cost outlier payments. For two of the hospitals reviewed, the actual cost-to-charge ratio for the years that we reviewed was lower than the outdated ratio that Pennsylvania used to calculate outlier payments.

Pennsylvania's cost-to-charge ratios resulted in significantly higher cost outlier payments than would have occurred had Pennsylvania used more current cost-to-charge ratios. As shown in Table 2, the cost-to-charge ratio that Pennsylvania used for Hospital A was almost three times the actual cost-to-charge ratio for SFY 2001-2002, resulting in significantly higher outlier payments for Hospital A. Conversely, the cost-to-charge ratio that Pennsylvania used for Hospital C was only about 90 percent of the actual cost-to-charge ratio, resulting in lower outlier payments.

[4]Based on our review of hospital pricing records, the percentages in Table 1 represent general increases in billing charges. Some charges could have increased at lower or higher rates.

Table 2: Comparison of Cost-to-Charge Ratios That Pennsylvania Used and the Final Cost-to-Charge Ratio on Current Year's Cost Report

SFY	Hospital A			Hospital B			Hospital C		
	Used[5]	Final	Ratio[6]	Used	Final	Ratio	Used	Final	Ratio
1995-1996	0.2844	0.2861	0.99	0.5116	0.4856	1.05	0.4915	0.4012	1.23
1996-1997	0.2939	0.2278	1.29	0.4865	0.4442	1.10	0.4555	0.4016	1.13
1997-1998	0.2861	0.2974	0.96	0.4894	0.4418	1.11	0.4495	0.3793	1.19
1998-1999	0.2861	0.2625	1.09	0.4865	0.4102	1.18	0.4012	0.3730	1.08
1999-2000	0.2278	0.2006	1.14	0.4442	0.4043	1.10	0.4016	0.4220	0.95
2000-2001	0.2974	0.1419	2.10	0.4418	0.3892	1.14	0.3793	0.4409	0.86
2001-2002	0.2757	0.0921	2.99	0.4102	0.3376	1.22	0.3730	0.4065	0.92
2002-2003	0.2757	0.1005	2.74	0.4102	0.2541	1.61	0.3730	0.4527	0.82

Ineffective Monitoring of Cost Outlier Payments

Although Pennsylvania recognized that overall cost outlier payments were increasing, the State did not monitor specific hospital outlier activity to ensure that cost outlier payments were paid only for extraordinarily high-cost cases. Pennsylvania did not review current cost reports in a timely manner to identify hospitals for which the actual cost-to-charge ratio had decreased significantly in relation to the State's cost-to-charge ratio. In addition, the State did not review each hospital's charge structure to identify why particular hospitals were able to achieve higher levels of outlier payments. A hospital intent on increasing or maximizing its cost outlier payments could simply increase its charges to exceed the higher threshold criterion. A hospital that was not aggressively increasing charges would be forced to absorb its higher costs, while a relatively small number of hospitals that aggressively increased charges could receive a disproportionate share of cost outlier payments.[7]

EFFECT OF NOT LIMITING COST OUTLIER PAYMENTS

Because Pennsylvania's payment methodology did not limit cost outlier payments to extraordinarily high-cost cases, cost outlier payments increased significantly. If the State does not address the outlier policy deficiencies, cost outlier payments may continue to increase at a much faster rate than DRG base payments as hospitals continue to increase charges. The State could have saved approximately $11.42 million between SFY 1998-1999 and 2002-2003 at the hospitals reviewed if it had applied a more current factor to convert billed charges to costs. Additional savings may exist at other hospitals.

[5]The "Used" ratio is the cost-to-charge ratio generally used during the year. Changes may be made quarterly.

[6]The "Ratio" represents the "Used" cost-to-charge ratio divided by the "Final" cost-to-charge ratio.

[7]To address disparate and excessive payments of Medicare outlier payments, the CMS Administrator testified before the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education on March 11, 2003. The Administrator testified that as a direct result of the increased Medicare outlier thresholds, more hospitals were forced to absorb the cost of complex cases, while a relatively small number of hospitals that had aggressively gamed the system benefited by getting a hugely disproportionate share of Medicare outlier payments.

Significant Increases in Cost Outlier Payments

On a per admission basis from SFY 1998-1999 to 2002-2003, for claims that received a cost outlier payment, cost outlier payments increased by 75.3 percent, DRG base payments increased by 22.5 percent, and total Medicaid payments increased by 62.6 percent.

During the same period, for claims that received a cost outlier payment, total cost outlier payments increased by 122.4 percent, total DRG payments increased by 55.4 percent, and total Medicaid payments increased by 106.3 percent. If additional hospitals dramatically increase charges without the State correcting the outlier policy, cost outlier payments will increase further. Pennsylvania cost outlier payments for inpatient hospital cases may continue to grow rapidly unless the State alters its payment policy.

Potential Savings

In 2003, CMS changed its outlier policy to allow for a retroactive recalculation of Medicare outlier payments, applying the current cost-to-charge ratio for hospitals with significant changes in their cost-to-charge ratios. Table 3 reflects the potential cost savings for the three hospitals if the State had adopted a similar adjustment. For the three hospitals reviewed, cost outlier payments during SFY 1998-1999 to 2002-2003 would have been $11.42 million lower if Pennsylvania had applied current cost-to-charge ratios in its cost outlier formula instead of using cost-to-charge ratios derived from 3-year-old financial data.[8] We believe that additional potential savings exist at other hospitals.

Table 3: Potential Savings Using More Current Cost-to-Charge Ratios ($ Millions)

SFY	Hospital A			Hospital B			Hospital C		
	State	Audited	Difference	State	Audited	Difference	State	Audited	Difference
1998-1999	$0.91	$0.87	$0.04	$1.63	$1.54	$0.09	$1.29	$1.20	$0.09
1999-2000	1.70	1.62	0.08	2.92	2.32	0.60	2.79	2.58	0.21
2000-2001	2.69	2.10	0.59	3.49	2.86	0.63	3.84	4.06	(0.22)
2001-2000	4.78	2.12	2.66	2.78	2.28	0.50	2.23	2.58	(0.35)
2002-2003	8.23	2.28	5.95	3.68	2.83	0.85	3.06	3.36	(0.30)
Total	**$18.31**	**$8.99**	**$9.32**	**$14.50**	**$11.83**	**$2.67**	**$13.21**	**$13.78**	**($0.57)**

Total Cost Savings for the Three Hospitals Reviewed	**$11.42**

RECOMMENDATIONS

We recommend that Pennsylvania:

- develop a methodology to monitor the cost-to-charge ratio during the fiscal year and adjust the ratio as necessary and

[8]We obtained cost and charge information used to calculate the current cost-to-charge ratio from hospital cost reports.

- revise the State Medicaid outlier policy to use the cost-to-charge ratio from the most recent cost reporting period and retroactively adjust provider payments for each year based on the actual cost-to-charge ratio calculated for that year.

CENTERS FOR MEDICARE & MEDICAID SERVICES'S AND PENNSYLVANIA'S COMMENTS

In its response to our draft report, CMS did not comment on the findings or recommendations.

In its comments, Pennsylvania did not concur with the specific recommendations but stated that it intended to thoroughly evaluate its outlier payment policy to provide more precise provider payments for inpatient services.

Pennsylvania stated that it:

- was converting its current DRG grouping system to a revised grouping system,

- was developing updated cost-to-charge ratios to more closely reflect hospital costs and would evaluate methods for more timely updates, and

- would assess the feasibility of initiating retroactive payment adjustments based on updated cost-to-charge ratios.

However, Pennsylvania stated that it would be difficult to monitor and adjust the cost-to-charge ratio during the fiscal year because providers do not submit cost reports until after the fiscal year. In addition, according to Pennsylvania, initiating retroactive payment adjustments would require a revision to the hospital regulations affecting acute care payments.

CMS's and Pennsylvania's comments are included as Appendixes B and C, respectively.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

Although Pennsylvania's actions differ from the audit recommendations, the State has taken positive actions to update its cost-to-charge ratios and monitor its inpatient provider payment system in line with our recommendations. We continue to recommend that Pennsylvania implement a retroactive payment adjustment system that parallels the Medicare system.

APPENDIXES

APPENDIX A

PENNSYLVANIA MEDICAID INPATIENT CLAIM PAYMENTS TO ALL HOSPITALS

Claims With Cost Outlier Payments

SFY*	Number of Claims	Charges	Payment		
			Total	DRG Base*	Outlier
1998-1999	1,213	$80,480,446	$28,070,856	$6,749,311	$21,321,545
1999-2000	1,511	107,186,735	37,975,276	8,009,633	29,965,643
2000-2001	1,692	138,265,600	48,534,149	9,807,991	38,726,158
2001-2002	1,603	165,320,470	52,528,050	10,718,774	41,809,276
2002-2003	1,539	203,541,061	57,904,857	10,491,166	47,413,691
Total	**7,558**	**$694,794,312**	**$225,013,188**	**$45,776,875**	**$179,236,313**

Claims With Day Outlier Payments

SFY	Number of Claims	Charges	Payment		
			Total	DRG Base	Outlier
1998-1999	325	$57,230,434	$7,569,840	$4,146,680	$3,423,160
1999-2000	323	50,191,464	6,900,748	3,586,232	3,314,516
2000-2001	371	82,686,799	8,990,832	4,973,078	4,017,754
2001-2002	335	81,332,936	8,025,688	4,302,886	3,722,802
2002-2003	298	103,274,468	7,679,760	4,425,167	3,254,593
Total	**1,652**	**$374,716,101**	**$39,166,868**	**$21,434,043**	**$17,732,825**

Claims With No Outlier Payments

SFY	Number of Claims	Charges	Payment		
			Total	DRG Base	Outlier
1998-1999	101,584	$1,183,663,453	$461,486,190	$461,486,190	$0
1999-2000	114,036	1,418,757,778	506,928,919	506,928,919	0
2000-2001	120,595	1,659,319,873	544,328,663	544,328,663	0
2001-2002	118,710	1,990,125,113	566,303,450	566,303,450	0
2002-2003	108,750	2,408,662,273	561,681,085	561,681,085	0
Total	**563,675**	**$8,660,528,490**	**$2,640,728,307**	**$2,640,728,307**	**$0**

Total Claims

SFY	Number of Claims	Charges	Payment		
			Total	DRG Base	Outlier
1998-1999	103,122	$1,321,374,333	$497,126,886	$472,382,181	$24,744,705
1999-2000	115,870	1,576,135,977	551,804,943	518,524,784	33,280,159
2000-2001	122,658	1,880,272,272	601,853,644	559,109,732	42,743,912
2001-2002	120,648	2,236,778,519	626,857,188	581,325,110	45,532,078
2002-2003	110,587	2,715,477,802	627,265,702	576,597,418	50,668,284
Total	**572,885**	**$9,730,038,903**	**$2,904,908,363**	**$2,707,939,225**	**$196,969,138**

*SFY is State fiscal year; DRG is diagnosis-related group.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Memorandum

Centers for Medicare & Medicaid Services
Region III
Suite 216, The Public Ledger Bldg
150 S. Independence Mall West
Philadelphia, PA 19106-3499

Date: AUG 3 1 2005

To: Regional Inspector General for Audit Services

From: Manager, Financial Review Branch
Division of Medicaid and Children's Health

Subject: Draft Audit Report – PA #A-03-04-00211

We have reviewed the subject draft audit report and the recommendations contained therein and we have no comments. However, we would like the opportunity to review the State's responses to the recommendations prior to their submittal in the final audit report. If you should have any questions regarding this matter, please contact Regina McIntyre of my staff at (215) 861-4469.

Ted Gallagher

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
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OCT 0 4 2005

Mr. Stephen Virbitsky, Regional Inspector
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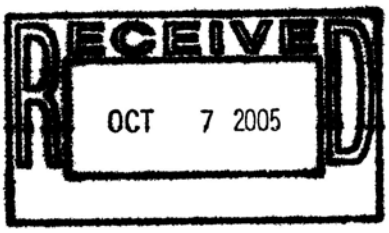

Dear Mr. Virbitsky:

This is in response to the August 15, 2005, letter which transmitted the draft report entitled "Medicaid Hospital Outlier Payments in Pennsylvania for State Fiscal Years 1998-1999 Through 2002-2003" (Report No. A-03-04-00211). The Department of Public Welfare (DPW) appreciates the opportunity to review the draft report concerning the current method of calculating outlier payments.

The DPW's Office of Medical Assistance Programs (OMAP) is currently in the process of developing updated cost-to-charge ratios that will more closely reflect hospitals costs of providing services in cost outlier cases. It will be very difficult to implement the recommendation to monitor and adjust the cost-to-charge ratio during the fiscal year. The OMAP's primary data source for computing a cost-to-charge ratio is the Medical Assistance Hospital Cost Report, which is submitted after the fiscal year; however, OMAP will evaluate methods that will result in more timely updates of the cost-to-charge ratios.

The OMAP will also assess the feasibility of initiating retroactive payment adjustments to providers for each fiscal year based on the amended cost-to-charge ratios calculated for each appropriate fiscal year. This would require a revision of the hospital regulations, given that they currently require prospective payments for the affected acute care payment system.

The OMAP is currently in the process of converting from the Medicare Diagnostic Related Groups (DRG) grouping system, to the All Patient Revised DRG grouping system, which will ultimately affect the cost outlier payments. It is the OMAP's intention to thoroughly evaluate its outlier payment policy in order to provide more precise provider payments for inpatient services.

Mr. Stephen Virbitsky – 2 –

Thank you for the opportunity to respond to this audit report. Please contact Andrew Johnson, Bureau of Financial Operations, Audit Resolution Section, at (717)783-6329 if you need further assistance.

Sincerely,

Michael Stauffer

Enclosure

ACKNOWLEDGMENTS

This report was prepared under the direction of Stephen Virbitsky, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

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