



Office of Audit Services – Region III  
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Philadelphia, PA 19106-3499

February 9, 2007

Report Number: A-03-04-00212

Patrick W. Finnerty, Director  
Department of Medical Assistance Services  
600 East Broad Street  
Richmond, Virginia 23219

Dear Mr. Finnerty:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled “Medicaid Hospital Outlier Payments in Virginia for State Fiscal Years 2001 Through 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.

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If you have any questions or comments about this report, please do not hesitate to contact me at (215) 861-4470 (e-mail [Stephen.Virbitsky@oig.hhs.gov](mailto:Stephen.Virbitsky@oig.hhs.gov)), or your staff may contact Bernard Siegel, Audit Manager, at (215) 861-4484 (e-mail [Bernard.Siegel@oig.hhs.gov](mailto:Bernard.Siegel@oig.hhs.gov)). Please refer to report number A-03-04-00212 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephen Virbitsky", with a long horizontal line extending to the right.

Stephen Virbitsky  
Regional Inspector General  
for Audit Services

Enclosures—as stated

cc:

Scott Crawford  
William Lessard  
Charles Lawver

**Direct reply to HHS Action Official:**

Nancy B. O'Connor  
Regional Administrator  
Centers for Medicare & Medicaid Services, Region III  
Public Ledger Building, Suite 216  
150 South Independence Mall West  
Philadelphia, PA 19106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICAID HOSPITAL OUTLIER  
PAYMENTS IN VIRGINIA FOR  
STATE FISCAL YEARS  
2001 THROUGH 2003**



Daniel R. Levinson  
Inspector General

February 2007  
A-03-04-00212

# ***Office of Inspector General***

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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 are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

## **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**

#### **Virginia Medicaid Payments**

Virginia 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, Virginia makes additional payments called cost outlier payments. Cost outlier payments can be viewed as a form of insurance for hospitals against the large losses that could result from extremely expensive cases that would otherwise be financially unattractive.

#### **Medicare Outlier Payments**

Virginia's Medicaid outlier policy was designed to be similar to the Medicare outlier policy. 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 Virginia's method of computing inpatient hospital cost outlier Medicaid payments resulted in reasonable payments.

### **SUMMARY OF FINDING**

Virginia's method did not result in reasonable cost outlier payments. 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 discharge basis from State fiscal year (FY) 2001 to 2003, for cases that received a cost outlier payment, cost outlier payments increased by 16 percent, DRG base payments decreased by about 5 percent, and total Medicaid payments decreased by about 3 percent. If Virginia had applied a more current cost-to-charge ratio to convert billed charges to costs, it could have saved approximately \$5.8 million (\$3.0 million Federal share) during State FYs 2001 through 2003 at the three hospitals reviewed. Additional potential savings may exist at other hospitals. If Virginia 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 Virginia should consider revising the State Medicaid outlier policy to:

- use the cost-to-charge ratio from the most recently settled (tentative or final) cost report and
- retroactively adjust provider payments for each year based on the actual cost-to-charge ratio calculated for that year.

## **VIRGINIA AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In its comments, Virginia stated that it did not disagree with our finding but did not concur with the specific recommendations. Virginia stated that it did not concur with the first recommendation but will consider changes in the future. In accordance with its State plan, Virginia would present the recommendation to the Hospital Payment Policy Advisory Council charged with evaluating and recommending policy changes. It did not concur with the second recommendation because it would be administratively burdensome and would be applied to providers selectively.

In its comments, the CMS Region III office stated that the report “never reviewed or explained the ceilings affect on the total outlier payments” and that CMS would pay more if Virginia uses current cost-to-charge ratios. It also stated that the second recommendation would be administratively burdensome and would outweigh the potential savings.

Virginia’s comments are included as Appendix A and CMS’s comments are included as Appendix B.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

Although Virginia’s actions differ from the audit recommendations, the State has taken administrative steps to reduce the possibility of using cost-to-charge ratios with material misstatements in its rebasing. These actions are positive and in line with our recommendations. The CMS Region III office should address its concerns with Virginia when CMS reviews any changes to the Virginia State plan. We continue to recommend that Virginia consider implementing a retroactive payment adjustment system that parallels the Medicare system, especially for providers that materially misstate their costs or charges.

**TABLE OF CONTENTS**

**Page**

**INTRODUCTION**.....1

**BACKGROUND** .....1

        Medicaid Program.....1

        Virginia’s Cost Outlier Payments and the Prospective Payment System.....1

        Potential Problems With the Cost-to-Charge Ratio .....1

        Excessive Medicare Outlier Payments.....2

**OBJECTIVE, SCOPE, AND METHODOLOGY** .....2

        Objective.....2

        Scope.....2

        Methodology.....3

**FINDING AND RECOMMENDATIONS**.....4

**VIRGINIA’S COST OUTLIER PAYMENT REQUIREMENTS** .....4

**INFLUENCE OF INCREASED CHARGES ON COST OUTLIER PAYMENTS** ....4

**REASONS FOR INCREASED COST OUTLIER PAYMENTS** .....5

        Use of Outdated Information .....5

        Ineffective Monitoring of Cost Outlier Payments .....5

**EFFECT OF NOT LIMITING COST OUTLIER PAYMENTS**.....6

**RECOMMENDATIONS** .....6

**VIRGINIA AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS** .....7

**OFFICE OF INSPECTOR GENERAL RESPONSE** .....7

**APPENDIXES**

A—VIRGINIA COMMENTS

B—CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

# 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 Virginia, the Department of Medical Assistance Services (Virginia) administers the Medicaid program.

### Virginia's Cost Outlier Payments and the Prospective Payment System

Virginia 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. To compensate hospitals when they incur significantly high costs for Medicaid patients, Virginia makes Medicaid cost outlier payments. A cost outlier payment is equal to 80 percent of estimated cost (total billed charges multiplied by the hospital specific cost-to-charge ratio) that exceed a hospital-specific threshold. The outlier threshold is calculated each time the State recalibrates and rebases its DRG payment system (every 1 to 3 years) and updated annually for inflation during interim years.

Virginia converts billed charges to estimated costs using a cost-to-charge ratio to determine if a case qualifies as an extraordinarily high-cost case. The cost-to-charge ratio is calculated from financial data that providers submit annually. When Virginia recalibrates and rebases every 1 to 3 years, the ratio used for the State fiscal year (FY) generally comes from the Medicaid cost report from the most recent financial data, generally from 3 years earlier.<sup>1</sup> Once the cost-to-charge ratio is determined, Virginia does not retroactively adjust payments for cases 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. 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

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<sup>1</sup>Virginia State FY ends on June 30 of the calendar year (e.g., State FY 2001 runs from July 1, 2000, through June 30, 2001).

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, CMS determined that hospitals have steadily increased charges in relationship to costs since the mid-1980s.<sup>2</sup> In addition, CMS found that hospital charges have continued to increase faster than hospital costs.<sup>3</sup>

## **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.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

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

### **Scope**

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

During State FYs 2001 through 2003, Virginia paid approximately \$702 million for inpatient hospital services under the DRG system: \$642 million for DRG base payments and \$60 million for cost outlier payments.

To determine whether specific hospitals received disproportionately higher levels of cost outlier payments, we reviewed cases paid to three hospitals during State FYs 2001 through 2003. We selected providers for onsite reviews based on high cost outlier payments. The three hospitals

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<sup>2</sup>MedPac analysis of data from the American Hospital Association annual survey of hospitals from 1985 to 2001.

<sup>3</sup>CMS determined that hospital charges increased 7.63 percent and 10.00 percent in 2000 and 2001, respectively, and that those rates were higher than rates of hospital cost increases (67 Federal Register 50124 (August 1, 2002)).

reviewed received \$208.7 million for hospital inpatient services—\$174.9 million for DRG base payments and \$33.8 million for cost outlier payments—for 18,851 discharges.

Virginia provided the Medicaid payment data used in this report. To validate the accuracy of this data, we calculated the DRG base amount and any applicable cost outliers for all cases with outlier payments. Of the 18,851 discharges, 748 included cost outlier payments and the remaining 18,103 were not eligible for a cost outlier payment. In addition, we reconciled 90 cases paid by the State to detailed case documentation at three hospitals. This report does not duplicate potential savings identified in our draft report “Virginia Recalibration and Rebase Procedures Used to Calculate Medicaid Rates for State Fiscal Years 2001 Through 2003,” (A-03-05-00205) in computing the potential savings presented in this report.

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

We performed the audit at the Virginia Department of Medical Assistance in Richmond, Virginia, and at three Virginia acute care hospitals.

## **Methodology**

We reviewed applicable State requirements. We conducted interviews and reviewed documentation to determine how Virginia calculated and monitored outlier payments. Virginia provided a listing of hospitals receiving DRG base and outlier payments. We used that listing to identify three providers that received a high percentage of cost outlier payments. We analyzed the cost outliers made during State FYs 2001 through 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 Virginia used with the cost-to-charge ratio from the cost report that included the discharge date for each case. For example, we calculated the outlier payment for a case with a discharge date of June 1, 2001, using the cost-to-charge ratio from the hospital’s State FY 2001 cost report instead of the ratio that Virginia used from its State FY 1998 cost report.

We reviewed cases with high cost outlier payments at each of the three selected hospitals to determine why these hospitals received significantly higher cost outlier payments.

Because we intentionally selected hospitals that received high levels of cost outlier payments, the potential cost savings we calculated for the three hospitals may not be representative. Therefore, we did not project or extrapolate these results to all 95 Virginia hospitals.

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

## **FINDING AND RECOMMENDATIONS**

Virginia's method did not result in reasonable cost outlier payments. 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 discharge basis from State FY 2001 to 2003, for claims that received a cost outlier payment, cost outlier payments increased by 16 percent, DRG base payments decreased by about 5 percent, and total Medicaid payments decreased by about 3 percent. If Virginia had applied a more current cost-to-charge ratio to convert billed charges to costs, it could have saved approximately \$5.8 million (\$3.0 million Federal share) during State FYs 2001 through 2003 at the three hospitals reviewed. Additional potential savings may exist at other hospitals. If Virginia 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.

### **VIRGINIA'S COST OUTLIER PAYMENT REQUIREMENTS**

The Virginia State plan submitted to CMS under Title XIX of the Social Security Act includes specific sections of the Virginia Administrative Code. The Virginia Administrative Code identifies the specific criteria under which Virginia makes cost outlier payments for Medicaid inpatient hospital cases. Section 12VAC30-70-221, subsection C, defines the requirement for cost outlier payments as “. . . those DRG cases, including transfer cases, in which the hospital's adjusted operating cost for the case exceeds the hospital's operating outlier threshold for the case.”

Section 12VAC30-70-261, “Outlier operating payment,” defines the payment methodology for cost outlier payments as “[T]he hospital's total charges for the case times the hospital's operating cost-to-charge ratio, as defined in subsection C of 12VAC30-70-221, times the adjustment factor specified in 12VAC30-70-331 B.” The Virginia Administrative Code (12VAC30-70-261) requires that the State further adjust cost outlier payments based on an operating threshold for the case. The outlier operating fixed loss threshold is recalculated using base year data when the DRG payment system is recalibrated and rebased.

### **INFLUENCE OF INCREASED CHARGES ON COST OUTLIER PAYMENTS**

Virginia'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.

An analysis of the three hospitals demonstrated that all three hospitals reviewed increased charges more than the increases or decreases in costs. For example, from State FY 2002 to 2003 the three hospitals increased their total charges by 2 to 3 times the increase in total costs. One hospital increased total charges more than 30 percent in 1 year, although total costs in that year rose by less than 10 percent. Increased charges by the three hospitals resulted in higher than reasonable Medicaid cost outlier payments. Because the increased charges were not related to

comparable increases in costs or increased workload, the number and payment amounts of cost outliers increased based on higher charges and not on higher costs.

## **REASONS FOR INCREASED COST OUTLIER PAYMENTS**

### **Use of Outdated Information**

Generally, Virginia calculates hospital specific cost-to-charge ratios every 1 to 3 years using 3-year-old cost data. Those ratios remain in effect for up to 3 years or until the next rate-setting period. For State FYs 2001 to 2003, the cost-to-charge ratios used by the three hospitals reviewed were developed from State FY 1998 Medicaid cost reports. Consequently, those cost-to-charge ratios were based on data that was 3 to 6 years old.

Virginia’s cost-to-charge ratios resulted in significantly higher cost outlier payments than would have occurred had Virginia used more current cost-to-charge ratios. As shown in Table 1, the cost-to-charge ratio that Virginia used to calculate cost outlier payments for Hospital A was 33 percent greater than the actual cost-to-charge ratio from the final cost report for 2001 and 2002, and 58 percent greater for 2003. The inflated cost-to-charge ratio resulted in significantly higher payments for Hospital A. Although Hospitals B and C had less significant differences between the cost-to-charge ratios used and the final cost-to-charge ratio during 2001 and 2002, the differences did increase more significantly in 2003 using the outdated cost-to-charge ratio.

**Table 1: Comparison of Cost-to-Charge Ratios That Virginia Used and the Final Cost-to-Charge Ratio on Current Year’s Cost Report**

<b>State FY</b>	<b>Hospital A</b>			<b>Hospital B</b>			<b>Hospital C</b>		
	<b>Used<sup>4</sup></b>	<b>Final</b>	<b>Ratio<sup>5</sup></b>	<b>Used</b>	<b>Final</b>	<b>Ratio</b>	<b>Used</b>	<b>Final</b>	<b>Ratio</b>
<b>2001</b>	.6111	.4635	1.32	.5749	.5814	0.99	.4862	.5040	0.96
<b>2002</b>	.6111	.4588	1.33	.5749	.5656	1.02	.4862	.4822	1.01
<b>2003</b>	.6111	.3872	1.58	.5749	.5102	1.13	.4862	.4346	1.12

### **Ineffective Monitoring of Cost Outlier Payments**

Virginia did not monitor specific hospital outlier activity to ensure cost outlier payments were paid only for extraordinarily high cost cases. Virginia 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 higher cost-to-charge ratio the State used to calculate the cost outlier payments.

<sup>4</sup>The “Used” ratio is the cost-to-charge ratio used by Virginia during the review period.

<sup>5</sup>The “Ratio” represents the “Used” cost-to-charge ratio divided by the “Final” cost-to-charge ratio.

Virginia established a limit on the total percent of cost outlier payments made annually—5.1 percent of total operating payment—but it did not monitor total payments to ensure that it did not exceed the limit. During its recalibration and rebasing process every 1 to 3 years, Virginia established an outlier threshold, adjusted for inflation during the interim years, to limit total cost outlier payments. However, Virginia took no action to limit the payment of outliers during State FYs 2001 to 2003. As a result, cost outlier payments represented 7.98 to 9.56 percent of total operating payments. As shown in Table 2, on average and for all hospitals, cost outlier operating payments accounted for a greater percentage of total operating payments each year during our audit period.

**Table 2: Cost Outlier Payments as a Percent of Total Operating Payments  
(All Virginia Hospitals)**

<b>State FY</b>	<b>Total Payments</b>	<b>Cost Outlier Payments</b>	<b>Percent Cost Outliers</b>
<b>2001</b>	\$239,862,892	\$19,149,045	7.98
<b>2002</b>	\$229,657,722	\$18,697,072	8.14
<b>2003</b>	\$232,564,056	\$22,232,919	9.56

### **EFFECT OF NOT LIMITING COST OUTLIER PAYMENTS**

Because Virginia’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 \$5.8 million (\$3.0 million Federal share) during State FYs 2001 through 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.

### **RECOMMENDATIONS**

We recommend that Virginia should consider revising the State Medicaid outlier policy to:

- use the cost-to-charge ratio from the most recently settled (tentative or final) cost report and
- retroactively adjust provider payments for each year based on the actual cost-to-charge ratio calculated for that year.

## **VIRGINIA AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In its comments, Virginia stated that it did not disagree with our finding but did not concur with the specific recommendations. Virginia stated that it did not concur with the first recommendation but will consider changes in the future. In accordance with its State plan, Virginia would present the recommendation to the Hospital Payment Policy Advisory Council charged with evaluating and recommending policy changes. It did not concur with the second recommendation because it would be administratively burdensome and would be applied to providers selectively.

In its comments, the CMS Region III office stated that the report “never reviewed or explained the ceilings affect on the total outlier payments” and that CMS would pay more if Virginia uses current cost-to-charge ratios.<sup>6</sup> It also stated that the second recommendation would be administratively burdensome and would outweigh the potential savings.

Virginia’s comments are included as Appendix A and CMS’s comments are included as Appendix B.

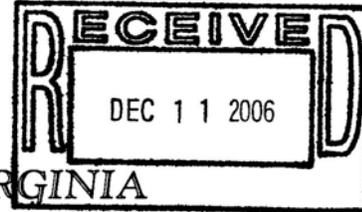
## **OFFICE OF INSPECTOR GENERAL RESPONSE**

Although Virginia’s actions differ from the audit recommendations, the State has taken administrative steps to reduce the possibility of using cost-to-charge ratios with material misstatements in its rebasing. These actions are positive and in line with our recommendations. The CMS Region III office should address its concerns with Virginia when CMS reviews any changes to the Virginia State plan. We continue to recommend that Virginia consider implementing a retroactive payment adjustment system that parallels the Medicare system, especially for providers that materially misstate their costs or charges.

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<sup>6</sup>The ceiling referred to by CMS Region III is a limit or threshold established by Virginia. As noted in the report, “Virginia established a limit on the total percent of cost outlier payments made annually—5.1 percent of total operating payment—but it did not monitor total payments to ensure that it did not exceed the limit.” This threshold does not limit (contain) costs as stated by CMS Region III.

# **APPENDIXES**



## COMMONWEALTH of VIRGINIA

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December 7, 2006

Mr. Stephen Virbitsky  
Regional Inspector General  
Department of Health and Human Services  
150 S. Independence Mall West, Suite 316  
Philadelphia, PA 19106-3499

Report Number: A-03-04-00212

Dear Mr. Virbitsky:

This letter is in response to your letter to Scott Crawford dated November 17, 2006, which enclosed a draft report entitled, "Medicaid Hospital Outlier Payments in Virginia for State Fiscal Year 2001 through 2003" (Report Number A-03-04-00212). You asked DMAS to provide written comments and a statement of concurrence or non-concurrence with each recommendation. For the reasons described below, DMAS does not concur with the recommendations though it may consider some of the changes in the future.

DMAS does not disagree with the findings on which the recommendation is based, and we do not disagree that the recommendations are appropriate for use by the Medicare program. However, we believe that they incorrectly assume that Virginia's problem is exactly similar to Medicare's problem. The most important consideration not taken into account is that Virginia Medicaid reimbursement for hospital services is much less generous than Medicare reimbursement. Virginia Medicaid policy is to include only 78% of the allowable cost when determining both regular operating prospective payments and outlier payments. So even if DMAS "overpays" for outliers, it still pays far less than costs. Virginia hospitals do not financially benefit from outlier payments. The hospitals who receive the most outlier payments are important safety net providers in the Commonwealth and it is important to the Commonwealth to insure the participation of these providers in Virginia Medicaid.

DMAS would also like to note that any excessive payments in Virginia are not the result of "certain hospitals aggressively increasing charges," which Medicare discovered in its program. In fact, the savings referred to in the report are based primarily on one hospital whose situation is not likely to occur again. Only one of the three hospitals reviewed by the OIG had a cost-to-charge ratio for outlier payments that was significantly higher than the cost-to-charge ratio used in all three years reviewed. The reason for the high cost-to-charge ratio for this one hospital was an error in filing the cost report and the time lag in auditing this cost report. As a result, a very high cost-to-charge ratio based on an as filed cost report was used at the time of rebasing. This has been noted in another draft OIG report, "Virginia Rebase Process Used to Calculate Medicaid Rates for State Fiscal Years 2001 through 2003." As was noted in the response to that draft, DMAS has taken administrative steps to reduce the possibility of using cost-to-charge ratios with material misstatements in its rebasing. Since this one aberration is unlikely to occur in the future, DMAS does not think that significant savings are likely to accrue from a change in the outlier policy. It is even possible that a policy change would increase costs in some cases

Report Number A-03-04-00212  
Mr. Stephen Virbitsky  
December 7, 2006

since the cost-to-charge ratio used in the outlier payment calculation was lower than the final cost report of the payment year in the first year for the other two hospitals.

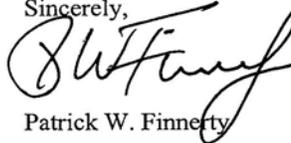
The first recommendation made by the report is to "use the cost-to-charge ratio from the most recently settled (tentative or final) cost report." DMAS does not concur with this recommendation but will consider changes in the future. Currently, DMAS uses the cost-to-charge ratio from the most recently available cost report year available at the time of rebasing. While DMAS can rebase more often, it usually rebases every three years. Technically, it would be feasible for DMAS to comply with this OIG recommendation through a State Plan Amendment and a state regulatory change. DMAS is willing to consider this change, but would first want to present this recommendation to the next meeting of the Hospital Payment Policy Advisory Council. The Hospital Payment Policy Advisory Council is authorized on p. 22 of Attachment 4.19-A of the State Plan and is charged with evaluating and recommending policy changes in areas that include, among other things, "the mechanisms and budget implications of recalibration and rebasing approaches."

The second recommendation made by the report is to "retroactively adjust provider payments for each year based on the actual cost-to-charge ratio calculated for that year." DMAS does not concur with this recommendation. Fully complying with this recommendation would require DMAS to reprocess claims that may have been processed more than a year ago. This is administratively burdensome. DMAS notes that Medicare's policy is to reprice hospital outlier claims only for hospital providers who exceed a threshold in terms of both payment dollars and differences in cost-to-charge ratios. As a result, it is only necessary for CMS to reprice Medicare hospital outlier claims for a few providers. While DMAS understands the reason for Medicare's threshold policy, DMAS is not comfortable with a policy that is applied to providers selectively.

DMAS would also point out that more than half of its payments for hospital services are through managed care contracts. MCOs may or may not use a hospital payment methodology similar to DMAS, but even when they do, they do not settle payments. Therefore, while the recommended action would be administratively burdensome to implement, the possible benefit is relatively small and diminishing over time.

Thank you for the opportunity to comment on the draft report. If there are any questions, please contact William Lessard, the Director of Provider Reimbursement at (804) 225-4593.

Sincerely,



Patrick W. Finnerty

PWF/wjl

cc. Scott Crawford  
William Lessard  
Charles Lawver



## Memorandum

Centers for Medicare & Medicaid Services

Region III

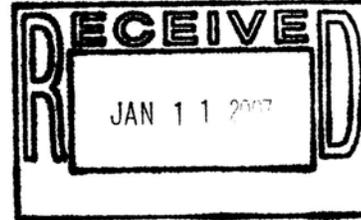
Suite 216, The Public Ledger Bldg  
150 S. Independence Mall West  
Philadelphia, PA 19106-3499

**Date:** JAN 9 2007

**To:** Regional Inspector General for Audit Services

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

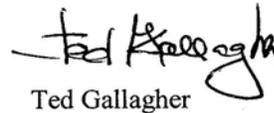
**Subject:** Draft Audit Report – VA #A-03-04-00212



We have reviewed the subject draft audit report and the recommendations contained therein and we have the following comments.

1. The report relies heavily on Medicare principles which differ from Medicaid regulations. The OIG never reviewed or explained the ceilings affect on the total outlier payments. It was mentioned in the report, but there was no analysis on how the ceiling contained costs.
2. If VA uses the current cost to charge ratio, CMS shall be paying more. Since VA has agreed to consider this option, the audit finding should be resolved. However, it will take some time for VA to change its regulations and it may not be in CMS's best interest to pay higher outlier costs.
3. The last issue is associated with whether the savings will outweigh the administrative burden to the State. The State contends that it will not be cost effective. If the costs outweigh the savings, then the OIG should remove the finding because the conclusion associated with the dollar savings is incorrect.

Thank you for giving us the opportunity to respond to your draft report. If you should have any questions regarding our comments, please contact Ginger Levesque at (215) 861-4645 or De Earhart at (804) 771-2905.

  
Ted Gallagher

# ACKNOWLEDGMENTS

This report was prepared under the direction of Stephen Virbitsky (RIGA). Other principal Office of Audit Services staff who contributed includes:

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For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.