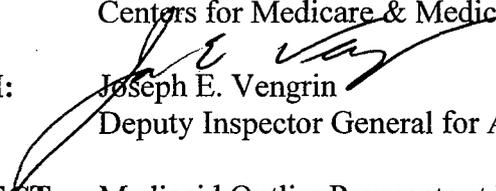




MAY 15 2006

TO: Wynethea Walker
Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

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

SUBJECT: Medicaid Outlier Payments at Inpatient Hospitals in Texas (A-06-04-00051)

Attached is an advance copy of our final report on Medicaid outlier payments at inpatient hospitals in Texas. We will issue this report to Texas within 5 business days. This is one of a series of reports on Medicaid outlier payments to inpatient hospitals.

Our objective was to determine whether the State agency limited cost outlier payments to exceptionally high-cost cases.

The State agency did not limit cost outlier payments to exceptionally high-cost cases. Specifically, the State agency (1) did not use current cost-to-charge ratios (costs divided by charges), (2) used noncovered charges in calculating the outlier payments, and (3) did not have sufficient policies and procedures in place to monitor cost outlier payments.

If the State agency had applied current cost-to-charge ratios instead of 2-year-old ratios, it could have saved approximately \$4.6 million during State fiscal years 2000, 2002, and 2003 at the four hospitals reviewed.¹ We believe that the State agency would realize additional savings if it were to apply current cost-to-charge ratios at other hospitals. The State agency could realize further savings if it calculated payments using only covered charges and monitored cost reports to identify hospitals that significantly increased charges.

We recommend that the State agency revise its method of computing cost outlier payments. At a minimum, the State agency should:

- reconcile outlier payments at the time of final cost report settlement if a hospital's final cost-to-charge ratio has significantly changed from the ratio used during that period to make outlier payments and
- calculate outlier payments using only covered charges.

¹We excluded 2001 data from the recalculation of the outlier payment because the State agency could not provide all the information necessary to perform the recalculation for all 2001 claims. However, our sampled items at each hospital included a review of individual 2001 claims.

We also recommend that the State agency develop policies and procedures to more closely monitor outlier payments. Specifically, the State agency should:

- review the charge structure of hospitals with high levels of outlier payments to identify possible measures to limit outliers to exceptionally high-cost cases and
- review cost reports to identify hospitals with significant changes in cost-to-charge ratios.

In written comments on the draft report, Texas disagreed with our recommendation to revise its method of computing outlier payments. Regarding our second recommendation, Texas agreed to review and update its procedures for identifying hospitals with significant changes in their cost-to-charge ratios. After discussion with the State agency, we amended our first recommendation to focus on those hospitals whose cost-to-charge ratios at the time of final cost report settlement have changed significantly from the ratios used to make outlier payments. We continue to believe that the State agency's edits are not sufficient to ensure that noncovered charges are removed from the outlier calculation.

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 Gordon L. Sato, Regional Inspector General for Audit Services, Region VI, at (214) 767-8414. Please refer to report number A-06-04-00051.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

Report Number: A-06-04-00051

MAY 18 2006

Mr. Albert Hawkins
Executive Commissioner
Health and Human Services Commission
P.O. Box 13247
Austin, Texas 78711

Dear Mr. Hawkins:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Medicaid Outlier Payments at Inpatient Hospitals in Texas." A copy of this report will be forwarded to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. 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), OIG reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-06-04-00051 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures

cc: Mr. David Griffith
Internal Audit Director
Health and Human Services Commission
P.O. Box 13247
Austin, Texas 78711

Direct Reply to HHS Action Official:

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

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICAID OUTLIER PAYMENTS
AT INPATIENT HOSPITALS IN
TEXAS**



Daniel R. Levinson
Inspector General

MAY 2006
A-06-04-00051

Office of Inspector General

<http://oig.hhs.gov>

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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

Texas Medicaid Payments

As part of the Medicaid program, the Texas Health and Human Services Commission (the State agency) pays hospitals other than children's hospitals for inpatient stays using predetermined per discharge rates referred to as diagnosis-related group (DRG) rates. Although DRG payments vary by category of inpatient Medicaid cases, the payments for each category of cases are fixed. Under this system, hospitals have a financial incentive to avoid exceptionally costly cases. To counter this incentive and promote access to hospital care for high-cost patients, the State agency makes additional payments called day and cost outlier payments. Day outlier payments compensate hospitals for exceptionally long stays, whereas cost outlier payments compensate hospitals for extremely costly cases. Outlier payments can be viewed as insurance against the large losses that hospitals can incur from exceptionally expensive cases.

The State agency makes outlier payments to hospitals for admissions that meet the criteria for exceptionally high costs or exceptionally long stays for clients younger than 21 on the date of admission. If an admission qualifies as both a day and a cost outlier, the State agency pays only the outlier resulting in the higher payment.

Medicare Outlier Payments

The Medicare outlier policy authorizes the Centers for Medicare & Medicaid Services (CMS) to make outlier payments to hospitals for exceptionally high-cost cases. In 2003, CMS adopted new regulations to address program vulnerabilities that resulted in excessive payments to certain hospitals that were aggressively increasing charges. Because of the charge increases, CMS's outlier formula overestimated the hospitals' costs, and CMS reported that it paid approximately \$9 billion in excessive Medicare outlier payments nationwide between 1998 and 2002 for cases that should not have qualified as exceptionally high-cost cases.

OBJECTIVE

Our objective was to determine whether the State agency limited cost outlier payments to exceptionally high-cost cases.

SUMMARY OF FINDINGS

The State agency did not limit cost outlier payments to exceptionally high-cost cases. Specifically, the State agency (1) did not use current cost-to-charge ratios (costs divided by charges), (2) used noncovered charges in calculating the outlier payments, and (3) did not have sufficient policies and procedures in place to monitor cost outlier payments.

If the State agency had applied current cost-to-charge ratios instead of 2-year-old ratios, it could have saved approximately \$4.6 million during State fiscal years 2000, 2002, and 2003 at the four hospitals reviewed.¹ We believe that the State agency would realize additional savings if it were to apply current cost-to-charge ratios at other hospitals. The State agency could realize further savings if it calculated payments using only covered charges and monitored cost reports to identify hospitals that significantly increased charges.

RECOMMENDATIONS

We recommend that the State agency revise its method of computing cost outlier payments. At a minimum, the State agency should:

- reconcile outlier payments at the time of final cost report settlement if a hospital's final cost-to-charge ratio has significantly changed from the ratio used during that period to make outlier payments and
- calculate outlier payments using only covered charges.

We also recommend that the State agency develop policies and procedures to more closely monitor outlier payments. Specifically, the State agency should:

- review the charge structure of hospitals with high levels of outlier payments to identify possible measures to limit outliers to exceptionally high-cost cases and
- review cost reports to identify hospitals with significant changes in cost-to-charge ratios.

STATE'S COMMENTS

In its written comments on our draft report, Texas disagreed with our recommendation to revise its method of computing cost outlier payments. Texas stated that it used the most current cost-to-charge ratios available to calculate outlier payments and that it did not retroactively adjust outlier payments. Texas stated that “. . . analysis of historical data indicates that only negligible differences exist between tentative and final ratios.” Additionally, Texas stated that “. . . the current audit and edit check process for ensuring only covered charges are included in the outlier payment calculation is appropriate and accurate, and ensures that non-covered charges reported by hospitals are not used as a basis for outlier payment calculations.”

Regarding our second recommendation, Texas agreed to review and update its procedures for identifying hospitals with significant changes in their cost-to-charge ratios.

¹We excluded 2001 data from the recalculation of the outlier payment because the State agency could not provide all the information necessary to perform the recalculation for all 2001 claims. However, our sampled items at each hospital included a review of individual 2001 claims.

Texas's comments are included in their entirety in the appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We agree that only a negligible difference would exist between tentative and final ratios. Therefore, after discussion with the State agency, we amended our first recommendation to focus on those hospitals whose cost-to-charge ratios at the time of final cost report settlement have changed significantly from the ratios used to make outlier payments. The State agency should be able to identify the hospitals that fall into this category through appropriate changes in its policies and procedures.

We continue to believe that the State agency should use only the covered charges that providers identify to calculate outlier payments. The State agency's edits are not sufficient to ensure that noncovered charges are removed from the outlier calculation.

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APPENDIX

STATE'S COMMENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Title XIX of the Social Security Act established Medicaid in 1965 as a joint Federal and State program. Medicaid provides medical assistance to low-income persons who are age 65 or over, blind, or disabled; members of families with dependent children; and qualified children and pregnant women. Each State administers its Medicaid program in accordance with a State plan approved by the Centers for Medicare & Medicaid Services (CMS), which is responsible for the program at the Federal level. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. The Health and Human Services Commission (the State agency) administers the Medicaid program in Texas.

Outlier Payments and the Prospective Payment System

The State agency pays hospitals other than children's hospitals for Medicaid inpatient stays using a prospective payment system that includes a preestablished amount based on a diagnosis-related group (DRG) code. Between Texas State fiscal years (FYs) 2000 and 2003, the State agency paid approximately \$6.4 billion in DRG payments to hospitals for inpatient services. Although a hospital's costs can vary significantly among patients within a specific DRG, the DRG payment is fixed.

The State agency pays hospitals an additional amount, called an outlier payment, for situations in which the length of stay or cost of treating a Medicaid patient who is younger than 21 on the date of admission is exceptionally high in relation to the average length of stay or average cost of treating comparable conditions or illnesses. Day outlier payments compensate hospitals for exceptionally long stays, whereas cost outlier payments compensate hospitals for extremely costly cases. If an admission qualifies as both a day and a cost outlier, the State agency pays only the outlier resulting in the higher payment. The outlier policy promotes access to care for exceptionally costly patients who would otherwise be financially unattractive.

The State agency uses a hospital's cost-to-charge ratio to calculate cost outlier payments. The State agency calculates the cost-to-charge ratio by dividing the hospital's total inpatient costs by its total inpatient charges. The State agency calculates the hospital-specific cost-to-charge ratio and makes current-year outlier payments using the hospital's final or tentatively settled cost report from 2 years earlier.

Calculating a cost outlier payment is a three-step process. The State agency first estimates the cost of care provided to a patient by multiplying the hospital's charges for services rendered to the patient by the hospital's cost-to-charge ratio. The State agency then compares the estimated cost of treating the patient with a threshold amount established by the State agency. If the estimated cost exceeds the threshold amount, the

hospital qualifies for an outlier payment. Finally, the State agency calculates the payment, which is equal to the difference between the estimated cost and the threshold amount multiplied by 70 percent.¹

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, if a hospital dramatically increases its charges relative to costs and the State agency does not routinely update the cost-to-charge ratio, the estimated costs will not be reliable or reflective of current conditions. Using a substantially inflated cost-to-charge ratio will yield higher outlier payments than would be appropriate because the outlier payments could be triggered by higher charges rather than higher costs.

Nationally, hospitals have steadily increased charges in relation to costs since the mid-1980s. The increase in charges during this period caused the average cost-to-charge ratio to decrease from approximately 80 percent to less than 50 percent of the difference between the total estimated cost for the stay and the DRG amount plus a hospital-specific threshold amount.² In addition, CMS determined that hospital charges had increased at a higher rate 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. The original CMS outlier computation overestimated costs for hospitals that raised charges faster than costs, resulting in unnecessary outlier payments. As a result, CMS reported that it overpaid approximately \$9 billion in outlier payments nationwide from 1998 through 2002.

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 recently settled or tentatively settled cost report. Using the cost-to-charge ratio from the tentatively settled cost report reduces the timelag for updating the cost-to-charge ratio by a year or more. In addition, outlier payments are now subject to adjustment when a hospital's cost report is settled and the actual cost-to-charge ratio is determined. This adjustment should ensure that the outlier payment appropriately reflects the hospital's true costs of providing care.

¹For admissions that occurred before September 1, 2001, the difference was multiplied by 75 percent.

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

³CMS determined that hospital charges increased 7.63 percent and 10 percent in 2000 and 2001, respectively, and that these 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 the State agency limited cost outlier payments to exceptionally high-cost cases.

Scope

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

Between State FYs 2000 and 2003, the State agency paid \$310.5 million in outlier payments to hospitals for inpatient services. We used the 2000 through 2003 hospital cost reports to identify trends in hospital charges and costs and reviewed claims from four hospitals that received a higher percentage of outlier payments compared with other hospitals.⁴ Because hospital cost-to-charge ratios do not directly 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 excluded 2001 data from the recalculation of the outlier payments because the State agency could not provide all of the information necessary to perform the recalculation for all 2001 claims. However, our sampled items at each hospital included a review of individual 2001 claims.

For all years, we were not able to determine whether a day outlier should have been paid instead of a cost outlier because the State agency did not provide all the information needed to compute the day outlier for each claim. For example, the information did not include the threshold days and the mean length of stay for a DRG.

We did not perform a detailed review of State agency or provider internal controls because the audit objective did not require us to do so. The State agency provided the Medicaid payment data used in this report. To validate the accuracy of these data, we reconciled 124 electronic claims from the State agency to detailed claim documentation at 4 hospitals.

We performed the audit at the State agency in Austin, Texas, and at four Texas inpatient hospitals.

Methodology

State Agency

We interviewed State agency officials and reviewed documentation to determine how the State agency calculated and monitored outlier payments. Using a State-provided list of

⁴We calculated the percentage by dividing total outlier payments to a hospital by total inpatient payments to the hospital.

hospitals that received outlier payments, we identified four providers that received a high percentage of outlier payments.

To quantify the impact of high charges on cost outlier payments at specific hospitals, we recalculated each cost outlier payment for the four hospitals using the cost-to-charge ratios from the hospitals' submitted cost reports. Specifically, we replaced the 2-year-old cost-to-charge ratio used in the cost outlier formula with the cost-to-charge ratio from the cost report for the period including the admission date. As an example, for a cost outlier payment with an admission date of September 1, 2000, we recomputed the cost outlier payment using the cost-to-charge ratio from the hospital's 2000 cost report in lieu of the ratio from the 1998 cost report.

Because we intentionally selected hospitals that received high outlier payments, the potential cost savings that we computed for the 4 hospitals may not be representative of the entire population of 278 hospitals. Therefore, we did not project the results to all Texas hospitals.

Inpatient Hospitals

We reviewed claims with high outlier payments at each of four selected hospitals to determine why they received significantly higher levels of outlier payments. We reviewed board of directors' meeting minutes and interviewed department managers to determine how hospitals set inpatient charges. We determined the percentage increase in charges by comparing the charges for procedures that triggered the largest outlier payments with the hospitals' historical charges for those procedures. Next, we compared charges for those procedures at the selected hospitals with charges at competitive hospitals to determine whether the market had influenced the charge increases.

We conducted our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The State agency did not limit cost outlier payments to exceptionally high-cost cases. Specifically, the State agency (1) did not use current cost-to-charge ratios, (2) used noncovered charges in calculating the outlier payments, and (3) did not have sufficient policies and procedures in place to monitor cost outlier payments.

If the State agency had applied current cost-to-charge ratios instead of 2-year-old ratios, it could have saved approximately \$4.6 million during State FYs 2000, 2002, and 2003 at the four hospitals reviewed. We believe that the State agency would realize additional savings if it were to apply current cost-to-charge ratios at other hospitals. The State agency could realize further savings if it calculated outlier payments using only covered charges and monitored cost reports to identify hospitals that significantly increased charges.

If the State agency does not address the outlier policy deficiencies, including the nonrepresentative cost-to-charge ratios, cost outlier payments will probably continue to increase as hospitals increase charges faster than costs.

STATE REQUIREMENTS

Outlier Payments

The “Texas Medicaid Provider Manual,” section 24.2.2.4, states:

[The fiscal agent, Texas Medicaid Health Professionals] makes outlier payment adjustments to DRG hospitals for admissions that meet the criteria for exceptionally high costs or exceptionally long lengths of stay for clients younger than age 21 years as of the date of the inpatient admission. If a client’s admission qualifies for both a day and a cost outlier, the outlier resulting in the higher payment to the hospital is paid.

Also, the Texas Medicaid plan states:

. . . The state agency or its designee pays day or cost outliers for medically necessary inpatient services provided to recipients less than age 21 in all participating hospitals that are reimbursed under the prospective payment system. If an admission qualifies for both a day and a cost outlier, only the outlier resulting in the highest payment to the hospital is paid.

Reduction of the Outlier Percentage Amount

The Texas Medicaid plan lowered the percentage used to compute outlier payments from 75 percent to 70 percent for admissions on or after September 1, 2001 (State FY 2002), to reduce outlier payments to hospitals.

Covered Charges

The Texas Medicaid plan states: “The Medicaid program reimburses hospitals, except in-state children’s hospitals, for covered inpatient hospital services using a prospective payment system.”

COST OUTLIER PAYMENTS NOT LIMITED TO HIGH-COST CASES

The State agency did not ensure that it limited cost outlier payments to exceptionally high-cost cases. The State agency’s method of computing inpatient hospital outlier payments, which used current billed charges and 2-year-old cost-to-charge ratios to convert billed charges to estimated costs, resulted in excessive payments. The four hospitals reviewed increased charges at a significantly higher rate than costs; therefore, they were able to increase outlier payments based on the increased charges rather than the

higher costs. Additionally, the State agency made outlier payments using noncovered charges in the calculations.

Influence of Increased Charges on Cost Outlier Payments

Hospitals can increase cost outlier payments simply by raising charges because the outlier formula uses current billed charges and a historical cost-to-charge ratio to convert billed charges to estimated costs.

The four hospitals reviewed received significantly higher Medicaid cost outlier payments by increasing the charges for selected procedures and products. Increasing charges for just a few routine services, such as room charges, by significant amounts will significantly increase total charges and, therefore, outlier payments. In such cases, the higher outliers reflect higher charges, not necessarily higher costs. Increasing charges will decrease the cost-to-charge ratio, which will increase outlier payment amounts. Because the hospitals increased their charges and the State agency used 2-year-old cost-to-charge ratios, the hospitals received an additional \$4.6 million in outlier payments.

Some examples of the charges that increased at the four hospitals include:⁵

- Charges for a pediatric intensive care unit room increased by 62 percent from \$1,600 to \$2,588.
- Charges for phisderm regular (a type of supply) increased by 2,222 percent from \$0.35 to \$8.13.
- Charges for a Tefla pad increased by 1,621 percent from \$0.19 to \$3.27.
- Charges for blood component administration increased by 504 percent from \$72 to \$435.
- Charges for a dressing pad increased by 334 percent from \$0.46 to \$2.

The charge increases were not always driven by commensurate cost increases. For example, officials at one hospital indicated to us that during State FY 2003, the State agency cut funding by \$22 million, forcing the hospital to create ways to overcome the deficit. The hospital hired an outside firm to evaluate the pricing structure of teaching hospitals and to help it raise charges from the 50th percentile to the 90th percentile.

Noncovered Charges Used in Computing the Outlier Amount

The hospitals submitted uniform billing documents (UB-92s) that identified total charges, separating them into covered and noncovered charges. In some instances, the State

⁵The hospitals implemented these charge increases as individual increases (not over a period of time).

agency used total charges, which included noncovered charges, to compute the outlier amounts.

REASONS FOR INCREASED COST OUTLIER PAYMENTS

Medicaid cost outlier payments increased because the State agency used outdated factors to convert billed charges to costs and included noncovered charges. Additionally, the State agency did not monitor or identify hospitals that increased charges faster than costs.

Use of Outdated Information

Every year, the State agency recalculated the hospital-specific cost-to-charge ratios using final or tentatively settled cost reports that reflected the actual costs at the time. However, the State agency used 2-year-old cost-to-charge ratios to calculate cost outlier payments. For the four hospitals reviewed, the actual cost-to-charge ratios for the years reviewed were overall lower than the outdated ratios that the State agency used to calculate outlier payments. Because it used outdated cost-to-charge ratios, the State agency made excessive cost outlier payments.

Use of Noncovered Charges To Compute Outliers

The State agency did not use information from hospitals to determine covered charges when computing outlier payments. When a provider submits a claim to the State agency, the UB-92 identifies the total charges and separates them into covered and noncovered charges. However, the State agency determined what charges should be covered before calculating outlier payments. In some instances, the State agency converted the noncovered charges that the provider identified to covered charges and included them in the outlier calculation. By using noncovered charges, the State agency paid a higher amount than it would have paid had it included only covered charges.

For example, the State agency made an outlier payment of \$588,092 to one hospital. We removed the noncovered charges and recalculated the outlier amount. Based on the recalculation, the payment would have been \$272,744, saving the State \$315,348.

Ineffective Monitoring of Outlier Payments

The State agency did not review current cost reports to identify hospitals that significantly increased charges. In addition, the State agency did not review hospitals' charge structures to identify possible measures to limit outliers to exceptionally high-cost cases. Such monitoring might have helped the State agency identify outlier payment trends and make necessary changes.

A hospital intent on increasing or maximizing its cost outlier payments could simply increase its charges. Hospitals that did not aggressively increase charges were forced to

absorb the higher costs, while those hospitals that aggressively increased charges received a disproportionate share of cost outlier payments.⁶

EFFECT OF NOT LIMITING COST OUTLIER PAYMENTS TO EXCEPTIONALLY HIGH-COST CASES

If the State agency had applied a more current factor to convert billed charges to costs, it could have saved approximately \$4.6 million during State FYs 2000, 2002, and 2003 at the four hospitals reviewed. We believe that the State agency would realize additional savings if it were to apply current cost-to-charge ratios at other hospitals. The State agency could realize further savings if it calculated outlier payments using only covered charges and monitored cost reports to identify hospitals that significantly increased charges. If the State agency does not address the outlier policy deficiencies, outlier payments will probably continue to increase.

Potential Savings From Applying Current Cost-to-Charge Ratios

At the four hospitals reviewed, cost outlier payments during State FYs 2000, 2002, and 2003 would have been \$4.6 million lower if the State agency had used current cost-to-charge ratios. (See Table 1 on the next page.) Applying a cost-to-charge ratio based on outdated cost and charge data does not always yield a reasonable estimate of costs incurred in treating a patient and may result in significantly higher cost outlier payments. We believe that the State agency would realize additional savings if it were to apply current cost-to-charge ratios at other hospitals.

⁶To address disparate and excessive payments of Medicare outlier payments, the CMS Administrator testified before the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies 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.

Table 1: Potential Savings From Using Current Cost-to-Charge Ratios⁷

Cost Outlier Payments⁸	2000	2002	2003	Total
Hospital A				
Cost outliers with old ratio	\$4,973,338	\$2,894,384	\$6,260,992	\$14,128,714
Cost outliers with current ratio	4,222,224	3,377,359	4,988,870	12,588,454
Cost savings	\$751,114	(\$482,975)	\$1,272,122	\$1,540,260
Hospital B				
Cost outliers with old ratio	\$3,508,288	\$2,582,697	\$4,158,954	\$10,249,939
Cost outliers with current ratio	2,914,717	3,364,178	3,267,465	9,546,360
Cost savings	\$593,571	(\$781,481)	\$891,489	\$703,579
Hospital C				
Cost outliers with old ratio	\$3,474,743	\$2,924,137	\$4,235,626	\$10,634,506
Cost outliers with current ratio	3,538,122	2,675,087	3,832,221	10,045,430
Cost savings	(\$63,379)	\$249,050	\$403,405	\$589,076
Hospital D				
Cost outliers with old ratio	\$2,285,453	\$2,262,387	\$1,675,318	\$6,223,158
Cost outliers with current ratio	1,596,538	1,770,614	1,119,525	4,486,677
Cost savings	\$688,915	\$491,773	\$555,793	\$1,736,481
Total cost savings				\$4,569,396

Changes in Outlier Payments

The outlier method may have resulted in higher outlier payments than necessary because the State agency did not monitor the hospitals' increased charges identified in the cost reports. Because total charges increased, outlier payments to State hospitals increased from 2000 to 2001⁹ and 2002 to 2003. Outlier payments decreased from 2001 to 2002 because the State Medicaid plan reduced the outlier payment percentage. See Table 2 on the next page for the increase/decrease between years.

⁷The State was not able to provide enough information to determine whether any of the claims that had a reduction in the cost outlier would have resulted in the payment of a day outlier instead of a cost outlier.

⁸We computed the current cost-to-charge ratios for 2000 and 2002 using the final cost report. We computed the current cost-to-charge ratios for 2003 using the final or tentatively settled cost report.

⁹The State was able to provide enough documentation for 2001 to compute the changes in the DRG and outlier payments.

Table 2: Changes in Cost Outlier and DRG Payments

Statewide	2000	2001	Percent Increase/ (Decrease)	2002	Percent Increase/ (Decrease)	2003	Percent Increase/ (Decrease)
Outlier claims	1,339	1,364		1,036		1,260	
Outlier payments	\$52,958,536	\$60,354,254	13.96	\$42,795,853	(29.09)	\$52,437,930	22.53
Outlier payment per claim	\$39,551	\$44,248		\$41,309		\$41,617	
DRG payments	\$1,459,448,440	\$1,441,445,586	(1.23)	\$1,684,687,163	16.87	\$1,836,026,839	8.98

Texas’s outlier payments for inpatient hospital cases will continue to increase if hospitals dramatically increase charges and the State agency does not correct the outlier payment formula.

RECOMMENDATIONS

We recommend that the State agency revise its method of computing cost outlier payments. At a minimum, the State agency should:

- reconcile outlier payments at the time of final cost report settlement if a hospital’s final cost-to-charge ratio has significantly changed from the ratio used during that period to make outlier payments and
- calculate outlier payments using only covered charges.

We also recommend that the State agency develop policies and procedures to more closely monitor outlier payments. Specifically, the State agency should:

- review the charge structure of hospitals with high levels of outlier payments to identify possible measures to limit outliers to exceptionally high-cost cases and
- review cost reports to identify hospitals with significant changes in cost-to-charge ratios.

STATE’S COMMENTS

Texas disagreed with the first of our two recommendations because it is the State agency’s practice to use the most current cost-to-charge ratios to calculate outlier payments to hospitals. Texas stated that it did not retroactively adjust outlier payments. According to Texas: “. . . analysis of historical data indicates that only negligible differences exist between tentative and final ratios. In addition, the process improvements related to monitoring outlier payments [our second recommendation] will be designed to identify and address payments and ratios with variances outside of the norm.” Texas also stated that “The report suggests that the cost-to-charge ratio is the driving force behind the outlier calculation.” Texas noted that several additional

components influenced the outlier calculation: the relative weight of the DRGs, the standard dollar amount, and the universal mean.

Additionally, Texas stated that it monitored “. . . claims to ensure the outlier calculation, as well as payments, are derived from only allowable charges, not the billed charges per the provider.” Texas maintained that “. . . the current audit and edit check process for ensuring only covered charges are included in the outlier payment calculation is appropriate and accurate, and ensures that non-covered charges reported by hospitals are not used as a basis for outlier payment calculations.”

Texas agreed to review and update its procedures for identifying hospitals that have significant changes in their cost-to-charge ratios.

Texas’s comments are included in their entirety in the appendix.

OFFICE OF INSPECTOR GENERAL’S RESPONSE

We agree that only a negligible difference would exist between tentative and final ratios. Therefore, after discussion with the State agency, we amended our first recommendation to focus on those hospitals whose cost-to-charge ratios at the time of final cost report settlement have significantly changed from the ratios used to make outlier payments. The State agency should be able to identify the hospitals that fall into this category through appropriate changes in its policies and procedures.

We continue to believe that the State agency should use only the covered charges that providers identify to calculate outlier payments. The State agency’s edits are not sufficient to ensure that noncovered charges are removed from the outlier calculation. In some instances, the State agency converted provider-identified noncovered charges to covered charges. The State agency’s edit process allowed these charges because they were identified under an allowable revenue code. We believe that if a provider has identified noncovered charges, the State agency should not convert them to covered charges or include them in the outlier payment calculation.

We agree that several components influence the outlier calculation. However, our audit work centered on the cost-to-charge ratio and not the other components.

OTHER MATTERS

The Texas Medicaid plan makes the State agency responsible for monitoring and ensuring the accuracy of cost outlier payments. We identified two problems resulting from the State agency’s failure to monitor cost outlier payments. One hospital billed \$271,375 for a miscellaneous drug. Review of the claim showed that the amount should have been \$271.75. Hospital officials stated that a keying error had occurred. We recalculated the claim by correcting the keying error and determined that the State agency had overpaid the hospital \$69,131. Another hospital erroneously double-billed for

services performed or balances carried forward because it lacked a reconciliation process. As a result, the State agency overpaid \$39,304 to the hospital for two claims.

Both hospitals asserted that they had resubmitted the claims to the State agency. However, State agency records showed that only one of the three claims had been resubmitted. We provided information to the State agency regarding the two claims that had not been resubmitted.

APPENDIX



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

March 17, 2006

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

Reference Report Number A-06-04-00051

Dear Mr. Sato:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled "Medicaid Outlier Payments in Inpatient Hospitals" from the Department of Health and Human Services Office of Inspector General. The cover letter, dated January 27, 2006, requested that HHSC provide written comments, including the status of actions taken or contemplated in response to the report recommendations.

The report identified four recommendations in three areas: (1) use of current cost-to-charge ratios; (2) using covered charges in calculating outlier payments; and (3) policies and procedures for monitoring cost outlier payments. This management response includes comments for each of the recommendations in these areas and provides current status and actions planned, where applicable.

DHHS/OIG Recommendation: *We recommend that the State agency revise its method of computing cost outlier payments. At a minimum, the State agency should use the cost-to-charge ratio from the latest cost reporting period, either the most recent settled or tentatively settled cost report.*

HHSC Management Response

It is HHSC's practice to use the most current cost-to-charge ratios available to calculate outlier payments to hospitals. In accordance with the Centers for Medicare and Medicaid Services (CMS) approved Texas Medicaid State Plan and Texas Administrative Code regulations, when a

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facility files a Medicaid claim and the claim is eligible for a cost outlier payment, HHSC calculates the cost outlier payment using the most current cost-to-charge ratio available.

The cost-to-charge ratio is determined by using the most recently received cost report. Hospitals must submit their cost reports within six months after the end of their fiscal year. The Texas Medicaid Healthcare Partnership (TMHP) performs a review of the filed cost report. Once completed (the review process may take up to six months), a tentative cost-to-charge ratio is established in the claims processing system. HHSC uses this tentative ratio to process outlier payments. It may take 12 to 24 months or longer after the cost report is tentatively settled, depending on the type of review or audit, before the cost report becomes final and a final cost-to-charge ratio is developed. After the cost report is finalized, HHSC does not retroactively adjust outlier payments that it calculated using preliminary ratios because analysis of historical data indicates that only negligible differences exist between tentative and final ratios. In addition, the process improvements related to monitoring outlier payments (see page four) will be designed to identify and address payments and ratios with variances outside of the norm. By addressing the variances early on in the process, later differences between tentative and final ratios should not occur.

The report suggests that the cost-to-charge ratio is the driving force behind the outlier payment. There are, however, several additional components that significantly influence the day and cost outlier calculation.

- Relative Weight of the Diagnosis Related Groups (DRG) – An increase in the relative weight of a DRG will increase the payment amount.
- Standard Dollar Amount (SDA) – The SDA is a hospital specific payment amount calculated by the hospital's standardized average cost per Medicaid inpatient and adjusted by the hospital's case mix index. An increase in an SDA increases day outlier payments.
- Universal Mean – The universal mean is the average standard dollar amount for all hospitals. The universal mean had a substantial increase of 13.87 percent from state fiscal year 2001 (\$3,005.14) to state fiscal year 2002 (\$3,421.88), which influenced the payment calculation for cost outliers.

Table 2, Changes in Cost Outlier and DRG Payments, presents statistical data on the outlier claims paid during state fiscal years 2000-2003. The data in the table appears to support the report's assertion that costs will continue to increase if HHSC does not correct the outlier payment formula. While outlier payments over this period have increased, the presentation in Table 2 fails to acknowledge that much of the increase, and fluctuations in those amounts from year to year, can be attributed to significant variances in the number of outlier claims each year. The average outlier claim payment increased only about five percent from state fiscal year 2000-2003 period and less than one percent (.75 percent) from state fiscal year 2002 to 2003. In illustrating that outlier claims paid are increasing over time, a more comprehensive analysis of

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outlier trends would be to include percent changes in the number of outlier claims and the average outlier claim payment amount for each fiscal year:

	<u>2000</u>	<u>2001</u>	<u>Change</u>	<u>2002</u>	<u>Change</u>	<u>2003</u>	<u>Change</u>
Outlier Claims	\$1,339	\$1,264	(5.60%)	\$1,036	(18.00%)	\$1,260	21.60%
Outlier Payments			13.96%		(29.09%)		22.53%
Outlier Payment Per Claim	\$39,551	\$44,248	11.88%	\$41,309	(6.64%)	\$41,617	.75%

HHSC's current procedures address the concern that the longer the lag between the historical data and current charges, the more likely it is that the cost-to-charge ratio estimate will be inaccurate and allow hospitals to receive higher outlier payments than if a more current cost-to-charge ratio was used. Procedures address this by ensuring that only the most current tentatively settled or final cost report cost-to-charge ratio is used when calculating outlier payments to hospitals.

DHHS/OIG Recommendation: *We recommend that the State agency revise its method of computing cost outlier payments. At a minimum, the State agency should calculate outlier payments using only covered charges.*

HHSC Management Response

Providers are required to categorize and report both their covered and non-covered charges on the UB-92 Claim Form when submitting a claim for payment. When a claim is processed, all charges are subjected to a series of audit and edit checks that determine which charges are allowable in accordance with current rules and regulations. Charges that pass these edit checks are paid and are included in the outlier payment calculation. Conversely, charges that fail these edit checks are not paid, and are not included in the outlier payment calculation.

HHSC monitors claims to ensure the outlier calculation, as well as payments, are derived from only allowable charges, not the billed charges per the provider. Experience has shown that accepting provider-billing categorization from the UB-92 may result in non-covered charges being included in the outlier calculation. HHSC maintains that the current audit and edit check process for ensuring only covered charges are included in the outlier payment calculation is appropriate and accurate, and ensures that non-covered charges reported by hospitals are not used as a basis for outlier payment calculations.

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DHHS/OIG Recommendation: *We also recommend that the State agency develop policies and procedures to more closely monitor outlier payments. Specifically, the State agency should:*

- *Review the charge structure of hospitals with high level of outlier payments to identify possible measures to limit outliers to exceptionally high-cost cases and*
- *Review cost reports to identify hospitals with significant changes in cost-to-charge ratios.”*

HHSC Management Response

The Texas Medicaid Healthcare Partnership (TMHP) provides monthly outlier monitoring reports to HHSC covering the number of outlier claims, paid amount for each claim, average payment per claim, number of adjusted outlier claims, amount paid after adjustment and total outlier amount paid. In addition, HHSC is utilizing a similar report to track and monitor outlier payments on a continuing basis. Although HHSC monitors outlier payments, it does not have specific criteria or a formal policy in place to identify hospitals with significant increases in their cost-to-charge ratio and to determine how such increases may influence outlier payments.

Action Planned: HHSC will review its processes to determine how best to identify those hospitals that qualify for a high number of day and cost outlier payments and review their cost-to-charge inpatient ratio for significant changes in their interim rate from the previous year. Upon completion of this review, HHSC will update its formal policies to include any new or updated processes.

Estimated Completion Date: November 30, 2006

Title of Responsible Person: Director, Hospital Rate Analysis

The report also identified two instances in which outlier claims were submitted and paid inappropriately. As a result of the audit identifying these issues, recoupment has been received on one claim and a thorough review is underway on the other.

Action Planned: HHSC will conduct a thorough review of the outlier claim paid due to a keying error of \$271,375.

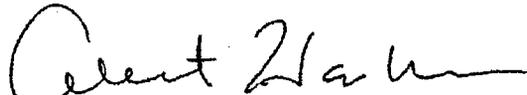
Estimated Completion Date: June 15, 2006

Title of Responsible Person: Director, Hospital Rate Analysis

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If you have any questions or require additional information, please contact David M. Griffith, CPA, CIA, Internal Audit Director. Mr. Griffith may be reached by telephone at (512) 424-6998 or by email at David.Griffith@hhsc.state.tx.us.

Sincerely,

A handwritten signature in cursive script, appearing to read "Albert Hawkins".

Albert Hawkins