Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

THE REDUCED OUTLIER THRESHOLD APPLIED TO TRANSFER CLAIMS DID NOT SIGNIFICANTLY INCREASE MEDICARE PAYMENTS TO HOSPITALS

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Office of Inspector General

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Report in Brief
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

The Reduced Outlier Threshold Applied to Transfer Claims Did Not Significantly Increase Medicare Payments to Hospitals

Why OIG Did This Audit

The Medicare program pays hospitals for inpatient hospital services based on a Medicare severity diagnosis-related group (DRG) rate per discharge. To protect hospitals from excessive losses due to unusually high-cost cases, the Medicare program supplements the DRG rate payment by making outlier payments. To avoid giving hospitals an incentive to transfer patients to another health care setting early in a patient's stay, while still receiving the full DRG rate, Congress established the transfer policy. Medicare payment for transfer claims differs from Medicare payment for discharge claims in two ways. First, under the transfer policy, CMS uses a graduated per diem rate payment (transfer rate payment), which is less than the full DRG rate payment, to pay a hospital that transfers an inpatient to another health care setting. Second, CMS decreases the outlier threshold (reduced outlier threshold) applied to determine the eligibility for, and the amount of, outlier payments for transfer claims.

Our objective was to assess the financial impact that Medicare's transfer policy and reduced outlier threshold have on Medicare total payments for transfer claims compared with what hospitals would have been paid if the beneficiary had been discharged instead of transferred.

How OIG Did This Audit

During fiscal years 2011 through 2017, Medicare paid approximately $776 million in outlier payments for transfer claims. We reviewed 5,303 transfer claims with outlier payments totaling $66 million from 30 hospitals. Specifically, using Medicare claim data and information obtained from CMS for the 7-year period, we calculated DRG rate amounts and outlier payment amounts without applying the transfer policy for these 5,303 transfer claims, and we compared the results with the actual payments that Medicare made for these transfer claims.

What OIG Found

Medicare's reduced outlier threshold for transfer claims did not have a significant impact on the total Medicare payments to the 30 hospitals we audited. Of the 5,303 transfer claims, the total Medicare payments for 3,668 transfer claims were less than what Medicare would have paid the hospitals if they had discharged the beneficiaries. However, the total Medicare payments for the remaining 1,635 transfer claims were $2.9 million more than what Medicare would have paid the hospitals if they had discharged the beneficiaries. Specifically, under the transfer policy, Medicare decreased DRG rate payments by $10.8 million but, because of the reduced outlier threshold, Medicare increased outlier payments by $13.7 million, resulting in a net increase of $2.9 million in total Medicare payments compared to what hospitals would have been paid if they had discharged the beneficiaries.

The $2.9 million net increase in total Medicare payments for these 1,635 transfer claims occurred because the outlier payment increase using the reduced outlier threshold was greater than the DRG payment decrease under the transfer policy.

What OIG Recommends

Medicare's reduced outlier threshold for transfer claims does not have a significant enough impact for us to recommend a policy change. Therefore, we do not have any recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program and pays hospitals for inpatient hospital services using a rate per discharge that depends on the Medicare Severity Diagnosis Related Group (DRG) to which a beneficiary's hospital stay is assigned (DRG rate), regardless of the actual cost the hospital incurred in rendering those services.[1] The Medicare program intended the DRG rate to provide payment in full to hospitals for all inpatient services associated with a diagnosis, regardless of the length of the inpatient stay.

The Social Security Act (the Act), section 1886(d)(5)(A), requires CMS to make outlier payments to protect hospitals from excessive losses due to unusually high-cost cases and to ensure that seriously ill patients have access to high-quality inpatient care. A hospital is qualified for an outlier payment for any situation in which "charges, adjusted to cost" (cost-adjusted charges) for an inpatient stay exceed an outlier threshold (the Act § 1886(d)(5)(A)(ii)).

To avoid giving hospitals an incentive to transfer patients to another health care setting early in a patient's stay, while still receiving the full DRG rate, Congress established the transfer policy. Medicare payment for transfer claims differs from Medicare payment for discharge claims in two ways. First, under the transfer policy, CMS uses a graduated per diem rate payment (transfer rate payment), which is less than the full DRG rate payment, to pay a hospital that transfers an inpatient to another health care setting. Second, CMS decreases the outlier threshold (reduced outlier threshold) applied to determine the eligibility for, and the amount of, outlier payments for transfer claims. This decrease in the outlier threshold results in an increase in both the number of transfer claims eligible for outlier payments and the amount of the outlier payments for transfer claims. We performed this audit to determine the financial impact of the increase in outlier payments on total Medicare payments for the transfer claims.

OBJECTIVE

Our objective was to assess the financial impact that Medicare's transfer policy and reduced outlier threshold have on Medicare total payments for transfer claims compared with what hospitals would have been paid if the beneficiary had been discharged instead of transferred.

[1] Each DRG is defined by a particular set of patient attributes that include principal diagnosis, specific secondary diagnoses, procedures, sex, and discharge status.

BACKGROUND

Medicare Prospective Payment System

Under Title XVIII of the Act, the Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. CMS administers the program and uses the inpatient prospective payment system (IPPS) for hospital inpatient services. CMS uses Medicare administrative contractors (MACs) to, among other things, process and pay Medicare claims submitted for medical services.

Under the IPPS, payments to hospitals for inpatient services are based on a rate per discharge that varies based on the DRG to which a beneficiary's hospital stay is assigned, regardless of the actual cost hospitals incur in rendering those services (the Act § 1886(d)). CMS intended the DRG rate to provide payment in full to hospitals for all inpatient services associated with a diagnosis regardless of the length of that inpatient stay.[2] Generally, the earlier a beneficiary leaves the hospital, either through discharge or transfer to another health care setting, the higher the financial benefit to the hospital.

Outlier Payments

The Act, section 1886(d)(5)(A), requires CMS to make outlier payments to protect hospitals from excessive losses due to unusually high-cost cases. A hospital qualifies for an outlier payment if the cost-adjusted charges for an inpatient stay exceed the outlier threshold.[3, 4, 5] The outlier payment amount for a claim is 80 percent of the cost-adjusted charges that exceed

[2] If a hospital treats a high percentage of low-income patients, CMS makes an add-on payment, known as disproportionate share hospital (DSH) adjustment, to the DRG rate (the Act § 1886(d)(5)(F)). If a hospital has resident physicians in an approved graduate medical education (GME) program, CMS makes another add-on payment, known as indirect medical education (IME) adjustment, to the DRG rate (the Act § 1886(d)(5)(B)). The IME adjustment is in addition to the direct GME payment that Medicare makes based on the hospital's allowable cost of GME.

[3] MACs determine the cost-adjusted charges for inpatient stays by multiplying two values: (1) the hospital's total charges for the inpatient stay and (2) its cost-to-charge ratio (68 Fed. Reg. 34494, 34495 (June 9, 2003)). They determine a hospital's cost-to-charge ratio annually by dividing the hospital's yearly overall Medicare costs by its yearly charges for services provided to Medicare patients (42 CFR § 412.84(h); *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 3, Inpatient Hospital Billing,§ 20.1.2.1).

[4] The term "charges" is defined as the "regular rates established by the provider for services rendered to both beneficiaries and to other paying patients" (*The Provider Reimbursement Manual – Part 1*, Pub. No. 15–1, part I, chapter 22, § 2202.4). Charges should be related consistently to the cost of the services and uniformly applied to all inpatients and outpatients. Medicare does not dictate to a hospital what its charges or charge structure should be.

[5] The Act § 1886(d)(5)(A)(ii) defines the outlier threshold as "the sum of the applicable DRG prospective payment rate plus any [DSH adjustment and IME adjustment] amounts payable . . . plus a fixed dollar amount determined by the Secretary."

the outlier threshold. For example, if the cost-adjusted charges for an inpatient stay are $31,000, and the outlier threshold is $30,000, then the outlier payment would be $800 (($31,000 –$30,000) x 80 percent).

Transfer Policy and Reduced Outlier Threshold for Transfer Claims

To avoid incentivizing a hospital to transfer patients to another health care setting early in a patient's stay while it still receives the full DRG rate, Congress established the transfer policy.[6] Medicare payment for transfer claims differs from Medicare payment for discharge claims in two ways. First, under the transfer policy, CMS decreases the DRG rate payments for transfer claims. Specifically, CMS uses a transfer rate payment that is less than the full DRG rate payment to a hospital that transfers an inpatient to another health care setting. Second, CMS uses a reduced outlier threshold to determine the eligibility for, and the amount of, outlier payments for transfer claims under the transfer policy.[7]

HOW WE CONDUCTED THIS AUDIT

During fiscal years 2011 through 2017 (7-year period), Medicare paid $776 million in outlier payments for transfer claims. We selected the 30 hospitals that had the highest total outlier payments reported among all hospital cost reports in the country for fiscal year 2013.[8] For each of these 30 hospitals, we obtained inpatient claims from CMS's National Claims History file for the 7-year period. The 30 hospitals received a total of $66,305,618 in outlier payments for 5,303 transfer claims over the 7-year period.

We calculated the outlier payments for all 5,303 transfer claims without applying the transfer policy. We also calculated the DRG rate amounts (including disproportionate share hospital (DSH) and indirect medical education (IME) add-on payments if applicable) for all 5,303 transfer claims. For these calculations, we obtained from the PC Pricer hospital-specific data, such as cost-to-charge ratios used at the time of claim processing.[9]

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

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[6] The Act § 1886(d)(5)(J); see also, 42 CFR § 412.4(b), (c), and (f).

[7] CMS set forth a computation methodology at 42 CFR § 412.80(b) to reduce the outlier threshold.

[8] We identified these hospitals using information from our previous audit, *Hospitals Received Millions in Excessive Outlier Payments Because CMS Limits the Reconciliation Process* (A-05-16-00060). Total outlier payments reported on hospital cost reports include payments for both transfer and discharge claims.

[9] The PC Pricer is a tool used to estimate Medicare IPPS payments.

The Appendix contains the details of our audit scope and methodology.

FINDING

Medicare's reduced outlier threshold for transfer claims did not have a significant impact on the total Medicare payments to the 30 hospitals we audited. Of the 5,303 transfer claims, the total Medicare payments for 3,668 transfer claims were less than what Medicare would have paid the hospitals if they had discharged the beneficiaries. However, the total Medicare payments for the remaining 1,635 transfer claims were $2.9 million more than what Medicare would have paid the hospitals if they had discharged the beneficiaries. Specifically, under the transfer policy, Medicare decreased DRG rate payments by $10.8 million but, because of the reduced outlier threshold, Medicare increased outlier payments by $13.7 million, resulting in a net increase of $2.9 million in total Medicare payments compared to what hospitals would have been paid if they had discharged the beneficiaries.

MEDICARE PAID $2.9 MILLION MORE FOR 1,635 TRANSFER CLAIMS

For 1,635 transfer claims in fiscal years 2011 through 2017, Medicare paid 30 hospitals $2.9 million more than what it would have paid the hospitals if they had discharged the beneficiaries.

Of the 1,635 transfer claims, 372 would not have had outlier payments if they were processed as discharges. For these 372 claims, total reimbursement exceeded what would have been paid if Medicare had not applied the transfer policy and reduced outlier threshold.

> **Example 1:** For one transfer claim, Medicare would have made a DRG rate payment of $33,336 and no outlier payment if Medicare had not applied the transfer policy and reduced outlier threshold. However, because this was a transfer claim, Medicare made a transfer rate payment of $15,874 and an outlier payment of $21,457, resulting in a total Medicare payment of $37,331. As a result, the total Medicare payment for this transfer claim was $3,995 more than what Medicare would have paid the hospital if it had not applied the transfer policy and reduced outlier threshold.

Description	DRG or Transfer Rate, as Applicable	Outlier Payment	Total Payment
Claim as a discharge	$33,336	$0.00	$33,336
Claim as a transfer	15,874	21,457	37,331
Increase (decrease)	($17,462)	$21,457	$3,995

For the remaining 1,263 transfer claims, we determined Medicare would have made outlier payments if they were processed as discharges. For these 1,263 claims, the

reimbursement exceeded what would have been paid if Medicare had not applied the transfer policy and reduced outlier threshold.

> **Example 2:** For one transfer claim we audited, Medicare would have made a DRG rate payment of $21,854 and an outlier payment of $7,269 if Medicare had not applied the transfer policy and reduced outlier threshold. However, because this was a transfer claim, Medicare made a transfer rate payment of $10,407 and an outlier payment of $27,687, resulting in a total Medicare payment of $38,094. As a result, the total Medicare payment for this transfer claim was $8,971 more than what Medicare would have paid the hospital if it had not applied the transfer policy and reduced outlier threshold.

Description	DRG or Transfer Rate, as Applicable	Outlier Payment	Total Payment
Claim as a discharge	$21,854	$7,269	$29,123
Claim as a transfer	10,407	27,687	38,094
Increase (decrease)	($11,447)	$20,418	$8,971

The $2.9 million net increase in total Medicare payments for these 1,635 transfer claims occurred because the outlier payment increase using the reduced outlier threshold was greater than the DRG payment decrease under the transfer policy.

CONCLUSION

Medicare's reduced outlier threshold for transfer claims does not have a significant enough impact for us to recommend a policy change. Therefore, we do not have any recommendations.

We provided CMS with a draft report for review. CMS elected not to provide any formal comments.

APPENDIX: AUDIT SCOPE AND METHODOLOGY

SCOPE

During the 7-year period from 2011 through 2017, Medicare paid approximately $776 million in outlier payments for transfer claims. Of this $776 million, we performed a detailed review of $66,305,618 in outlier payments to 30 hospitals for 5,303 transfer claims. Our detailed review consisted of recalculating the outlier payment amounts without applying the transfer policy. We also calculated the payment reductions that CMS made through the transfer rate payments.

We conducted our audit from January 2019 through August 2021.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements and CMS guidance;
- selected 30 hospitals covered by our prior audit by performing the following steps:
    - obtained the acute care hospital cost report data from the CMS Healthcare Cost Report Information System database for 2013 cost reports (the 2013 cost report file),
    - extracted total outlier payments reported on the cost reports using the 2013 cost report file, and
    - selected the 30 hospitals that had received the highest outlier payments;
- determined the outlier payments and payment reductions made using the transfer rate payments to 30 hospitals for their 5,303 transfer claims during the 7-year period by performing the following steps:
    - obtained inpatient claim data from CMS's National Claims History file for the 30 hospitals for the 7-year period,[10]
    - separated transfer claims of these hospitals from other inpatient claims (the resulting database had a total of 227,125 transfer claims consisting of 221,822 transfer claims that did not qualify for outlier payments and 5,303 transfer claims that qualified for outlier payments, which totaled $66,305,618),

[10] We had the claim data for fiscal years 2011 through 2014 in a prior audit file. We made an additional claim data request for fiscal years 2015 through 2017 for this audit.

- obtained cost-to-charge ratios that CMS used for making outlier payments to the 30 hospitals during the 7-year period from the PC Pricer,

- calculated outlier payments for 5,303 transfer claims and verified that the outlier payments we calculated agreed with the outlier payments that CMS made,[11]

- recalculated outlier payments for the 5,303 claims by using the outlier threshold (not the reduced outlier threshold) for determining the outlier payment if the transfer policy was not applied,

- determined the difference between the outlier amounts by using the outlier threshold (not the reduced outlier threshold) and the outlier payments made for 5,303 claims,

- calculated transfer rate payments for transfer claims and verified that the transfer rate payments we calculated agreed with the transfer rate payments that CMS made for 5,303 claims,

- calculated the DRG rate amounts (including DSH and IME add-ons if applicable) for 5,303 transfer claims without applying the transfer policy,

- determined the difference between the transfer rate payment amounts and DRG rate amounts (including DSH and IME add-ons if applicable) for 5,303 transfer claims; and

- discussed the results of our audit with CMS officials.

We provided CMS with a draft report on June 6, 2022, for review. CMS elected not to provide any formal comments.

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

[11] We calculated outlier payments using the reduced outlier threshold for all 227,125 transfer claims, and the result showed outlier amounts for 5,303 transfer claims. For the remaining 221,822 transfer claims for which CMS did not make any outlier payments, our calculation also showed $0.00 outlier amounts.