CALIFORNIA DEPARTMENT OF CORRECTIONS

More Expensive Hospital Services and Greater Use of Hospital Facilities Have Driven the Rapid Rise in Contract Payments for Inpatient and Outpatient Care

Audit Highlights . . .

Our review of the California Department of Corrections' (Corrections) contracts for medical services revealed the following:

- ☑ *Corrections' hospital payments have risen $59.4 million from fiscal years 1998–99 through 2002–03, growing at an average rate of 21 percent per fiscal year.*
- ☑ *Inpatient hospital payments increased by $38.5 million from fiscal years 1998–99 through 2002–03, primarily driven by increased payments per hospital admittance.*
- ☑ *Outpatient hospital payments increased by $12.7 million from fiscal years 1998–99 through 2002–03, driven by both increased payments per hospital visit and increased numbers of hospital visits.*
- ☑ *Two institutions attributed their inpatient hospital payment increases, among other reasons, to changes in contract terms resulting in hospital payments that were three times as much as they would have paid previously for the same inpatient stay.*

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California Department of Corrections' response as of February 2005[1]

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) review the California Department of Corrections' (Corrections) contracts for medical services, including contracts with Tenet Healthcare Corporation (Tenet). Specifically, the audit committee asked the bureau to identify any trends and, to the extent possible, reasons for the trends in the costs Corrections is paying for contracted inpatient and outpatient health care services and costs for similar services among hospitals as well as hospital systems. Further, the audit committee asked the bureau to compare the costs Corrections is paying Tenet for inpatient and outpatient health care services to the costs paid for similar services at other hospitals and, to the extent possible and permissible, publicly report the results and reasons for an differences. Our review revealed the following:

Finding #1: Corrections did not have detailed analysis to explain the reasons behind the overall increase in its hospital payments.

We found that, overall, Corrections' payments for hospital services have risen an average of 21 percent annually since fiscal year 1998–99. The reasons for the growth can primarily be attributed to a combination of more expensive health care and Corrections' increased use of contracted hospital facilities. Although Corrections agreed that the growth in hospital payments occurred, it did not explain with supporting analysis the reasons behind the dramatic overall increase in its payments to hospitals.

[1] As of December 23, 2005, Corrections had not submitted a complete one-year response reporting on whether its pending actions were implemented or what, if any, benefits were achieved; therefore, the reported actions are from its February 2005 six-month response to our audit.

- ☑ *Corrections paid some hospitals amounts that were from two to eight times the amounts Medicare would have paid the same hospitals for the same inpatient services, including a hospital operated by Tenet Healthcare Corporation, which was paid eight times the amount Medicare would have paid.*
- ☑ *One institution's outpatient hospital payments increased by $821,000 primarily because its average payment per emergency room visit, which are paid at a percentage of the hospital bill without a maximum limit, increased from less than $950 per visit to more that $3,300 per visit.*
- ☑ *Corrections' outpatient payment amounts averaged two and one-half times the amount Medicare would have paid for the same services.*
- ☑ *A lack of key data being entered into Corrections' database limits analyses behind causes of increased payments and utilization, such as the extent to which case severity is a cause.*

To understand the reasons behind the rising trend in its inpatient and outpatient hospital payments, Corrections should do the following:

- Enter complete and accurate hospital-billing and medical procedures data in its health care cost and utilization program (HCCUP) database for subsequent comparison and analysis by the Health Care Services Division (HCSD) and correctional institutions of the medical procedures that hospitals are performing and their associated costs.
- Perform regular analysis of its health care cost and utilization data, monitor its hospital payment trends, and investigate fully the reasons why its costs are rising for the purpose of implementing cost containment measures.
- Investigate the significant and sudden increase in its inpatient hospital payments, beginning in fiscal year 2000–01, for the purpose of determining whether renegotiating contract payment rates, reducing the length of stay in contract hospital beds, or other cost containment measures can most effectively reduce its contract hospital costs.
- Complete its analysis of high-cost cases to determine why the number of high-cost inpatient cases and more-expensive outpatient visits are rising so that it can identify cost-effective solutions to its increasing health care costs. For example, Corrections should fully investigate the extent to which each of the potential cost drivers it has identified as part of its analysis of high-cost impatient cases is increasing its hospital inpatient costs.
- Follow up with all institutions using new hospital contracts to determine if renegotiated contract payment terms are resulting in significantly higher costs, as they did for the two institutions that informed us of the significant effect on their inpatient hospital costs for high-cost cases.

Corrections' Action: Pending.

Corrections stated that it continues to enter data from medical invoices and has established validation reports to ensure data is entered appropriately and will perform audits to ensure all available procedure data is entered. It also reported that it would establish a peer review program and develop training plans to improve data integrity. Additionally, Corrections stated that it hired analysts that are responsible for analyzing

health care cost and utilization data and established a workgroup to identify reasons for rising costs and to implement cost containment measures. Further, Corrections indicated that it revised its utilization management database to connect this data to its cost and utilization database, as well as add health care guidelines for reviewing patient treatment and placement, and would transmit reports from these data to each institution for review and action by appropriate staff. Corrections indicated it expects to begin reporting on its cost containment in July 2005.

Corrections also reported that it was gathering contract data and information on the impact of utilization and contract provisions. Further, it indicated that it would not investigate the significant increase in inpatient hospital payments beginning in fiscal year 2000–01 for the purpose of determining cost containment measures. Instead, due to limited resources, it stated it would prospectively analyze current hospital payments. Additionally, although it analyzed fiscal year 2002–03 high-cost inpatient cases and cited the impact of patient age on hospital costs as the most striking finding, its analysis did not first eliminate the effect of contracts renegotiated in 2001 that became disadvantageous to Corrections. Further, Corrections reported its analysis of cost and utilization data for three hospitals and noted increasing costs. However, it did not indicate whether it had each institution analyze their payments to hospitals, similar to the two that reported to us, to determine if renegotiated contract payment terms are resulting in the higher costs. Instead, Corrections indicated that due to limited resources, it would prospectively analyze current or existing hospital payments.

Finding #2: Certain contract provisions resulted in Corrections paying higher amounts for inpatient and outpatient health care.

Our review of inpatient hospital payments for selected hospitals revealed that the terms of some contracts resulted in payments that were significantly higher than those made by Medicare for similar hospital services. This effect appeared most pronounced for hospitals whose contracts include stop-loss provisions, which sets a dollar threshold for hospital charges per admittance. Typically, if the charges per admittance exceed the threshold, Corrections pays a percentage of the total charge, rather than a per diem or other rate. However, should hospital administrators inflate charges to take advantage of stop loss provision, Corrections could unknowingly pay higher amounts to hospitals than expected unless Corrections takes additional steps to monitor and investigate potentially inflated hospital charges. Similarly, Corrections' outpatient contract provisions base payments on a percentage of the hospitals' billed charges rather than costs and generally resulted in Corrections paying on average two to four times the amounts Medicare would have paid for the same outpatient services.

To control increases in inpatient and outpatient hospital payments caused by contract payment provisions, Corrections should do the following:

- Revisit hospital contract provisions that pay a discount on the hospital-billed charges and consider renegotiating these contract terms based on hospital costs rather than hospital charges. Corrections should also reassess hospital contract

provisions that require it to pay a percentage of hospitals' billed charges for outpatient visits, including emergency room outpatient visits. To renegotiate contract rates, Corrections should use either existing cost-based benchmarks, such as Medicare or Medi-Cal rates, or hospital cost-to-charge ratios to estimate hospital costs. Further, should Corrections renegotiate hospital contract payment terms, it should perform subsequent analysis to quantify and track the realized savings or increased costs resulting from each renegotiated contract.

- Obtain and maintain updated cost-to-charge ratios for each contracted hospital, using data from the Centers for Medicare and Medicaid Services, the Department of Health Services, or the Office of Statewide Health Planning and Development. It should use these ratios to calculate estimated hospital costs for use as a tool in contract negotiations with hospitals and for monitoring the reasonableness of payments to hospitals.

- Require hospitals to include diagnosis related group (DRG) codes on invoices they submit for inpatient services to help provide a standard, along with hospital charges, by which Corrections can measure its payments to hospital as well as case complexity.

- Detect abuses of contractual stop-loss provisions by monitoring the volume and total amounts of hospital payments made under stop-loss provisions, which are intended to protect hospitals from financial loss in exceptional cases, not to become a common method of payment.

Corrections' Action: Pending.

Corrections reported that as hospital contracts are renegotiated, it is requesting the charge description master. Additionally, it stated that as staff negotiate contracts, they are requesting that rates be tied to a reimbursement benchmark such as Medicare. In cases where hospitals refuse, Corrections indicated it is pursuing per diem benchmarked by Medicare rates, as well as lower maximum caps on outpatient rates that are a percent of billed charges. Hospitals that insist on a percent of billed charges rate structure are asked to accept billed charges in line with their cost-to-charge ratio. If a hospital refuses all its rate proposals, Corrections indicated it would not contract with that hospital. According to Corrections, no hospital has agreed to its proposals. Corrections stated it would report on its progress in its one-year status report. Further, it reported obtaining hospital cost-to-charge ratios for use in contract negotiations and assessing the reasonableness of payments to hospitals.

Corrections further reported that it amended its hospital contract language to require hospitals to submit DRG codes on the hospital invoices for all inpatient admissions and would modify its database to capture these codes. It indicated that it is using the DRG code to determine what Medicare would have paid and assessing its payments to hospitals. Additionally, it stated that it identified those hospitals that have stop-loss provisions in their contracts and will renegotiate to tie rates to a

reimbursement benchmark such as Medicare. Corrections indicated that if a hospital refuses all its rate proposals, it would not contract with that hospital. For hospitals that provide emergency services, yet will not negotiate reasonable rates, Corrections pays Medicare rates per state law.

Finding #3: Increases in hospital admissions and visits contributed to Corrections' increased inpatient and outpatient hospital payments.

An increase in the number of hospital admissions contributed to 28.9 percent of the increase in inpatient hospital payments, while 45.7 percent of the increase in outpatient hospital payments was attributed to an increase in the number of hospital visits. More striking is the fact that outpatient hospital visits nearly doubled from 7,547 visits in fiscal year 1998–99 to 14,923 visits in fiscal year 2002–03, even though Corrections' inmate population remained relatively constant during this period.

To control rising inpatient and outpatient hospital payments caused by increases in the numbers of hospital admissions or visits, Corrections should do the following:

- Include in its utilization management quality control process, a review of how utilization management medical staff assess and determine medical necessity, appropriateness of treatment, and need for continued hospital stays.
- Investigate the reasons why the number of outpatient visits by inmates has nearly doubled even though the inmate population has remained relatively constant, and implement plans to correct the significant increase in outpatient hospital visits.
- Continue with its plan to analyze how mentally ill inmates are affecting inpatient costs and utilization at its institutions.

Corrections' Action: Pending.

➲ Corrections indicated that it plans to increase the number of utilization management staff. Further, Corrections stated that it has taken additional proactive measures to improve quality of services. It acquired recognized inpatient care guidelines to ensure standardized and consistent services. Using these guidelines, it will focus on conditions associated with unscheduled admissions, emergency department use, and high-cost/high-volume procedures. However, Corrections did not specifically indicate how it would review utilization management medical staff's assessments and determinations of medical necessity, appropriateness of treatment, and need for continued hospital stays to identify staff that are ineffective at containing costs while providing necessary medical services. Further, Corrections indicated that it formed a subcommittee to identify annual objectives for quality improvement and costs containment. According to Corrections, it believes program standardization and more oversight have increased the denial rate for outpatient services by 13 percent. However, due to limited resources, it indicated that it would not investigate why the number of outpatient visits nearly doubled, but instead

would analyze current outpatient hospital visits. Corrections also reported that it would refine its utilization management system to identify the impact of mental health crisis patients and their effect on cost and use of hospital beds. It stated that this analysis would be available by July 2005.