DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUN 14 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 Hospital Outlier Payments in New York for State Fiscal Years 1998 Through 2002 (A-02-04-01022)

Attached is an advance copy of our final report on Medicaid hospital outlier payments in New York for State fiscal years 1998 through 2002. We will issue this report to the New York State Department of Health within 5 business days. This review was part of a multistate audit of Medicaid outlier payments to inpatient hospitals.

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

With one exception, New York's method of computing inpatient hospital cost outlier payments generally resulted in reasonable payments. New York (1) used a hospital-specific factor, which it updated annually, to convert billed charges to costs and (2) monitored cost outlier payments by submitting each outlier claim for medical review. However, New York did not use the most accurate cost-to-charge ratios to convert billed charges to costs.[1] Had it done so, New York could have saved approximately $21.5 million ($10.75 million Federal share) in cost outlier payments between State fiscal years 1998 and 2002 at the three hospitals that we reviewed. We believe that New York could achieve additional savings at other hospitals.

We recommend that New York amend its State plan to require retroactive adjustments of interim cost outlier payments based on cost report data for the year in which the inpatient discharge occurred.

In its comments on our draft report, New York concurred with our recommendation, but stated that implementation would require changes in State regulations as well as the State plan. We believe that New York should take all necessary steps to implement our recommendation.

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[1]New York used data from the most recently filed cost reports to determine the ratio of costs to charges, the factor used to convert current charges to costs in the outlier payment calculation. The most recently filed cost reports were usually for 2 years before the rate year. As a result, 2-year-old cost-to-charge data were generally used to calculate outlier payments.

If you have any questions or comments about this report, please do not hesitate to 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 James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620. Please refer to report number A-02-04-01022.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES
Region II
Jacob K. Javits Federal Building
New York, New York 10278
(212) 264-4620

JUN 19 2006

Report Number: A-02-04-01022

Dr. Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner
New York State Department of Health
Corning Tower
14th Floor, Room 1408
Empire State Plaza
Albany, New York 12237

Dear Dr. Novello:

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 New York for State Fiscal Years 1998 through 2002." A copy of this report will be forwarded to the HHS action official noted on the next 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-02-04-01022 in all correspondence.

Sincerely,

James P. Edert

James P. Edert
Regional Inspector General
for Audit Services

Enclosures

**Direct Reply to HHS Action Official:**

James T. Kerr
Regional Administrator
Centers for Medicare & Medicaid Services–Region II
26 Federal Plaza, Room 3811
New York, New York 10278

Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# MEDICAID HOSPITAL OUTLIER PAYMENTS IN NEW YORK FOR STATE FISCAL YEARS 1998 THROUGH 2002

Daniel R. Levinson
Inspector General

June 2006
A-02-04-01022

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http://oig.hhs.gov

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## OAS FINDINGS AND OPINIONS

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

# EXECUTIVE SUMMARY

## BACKGROUND

### New York Medicaid Payments

As part of the Medicaid program, the New York State Department of Health pays hospitals a preestablished amount for each discharge based on a diagnosis-related group (DRG) code. Although hospitals' costs can vary significantly among patients within a specific DRG, the DRG payment is fixed. Under this system, hospitals have a financial incentive to avoid extremely costly cases. To counter this incentive and promote access to hospital care for high-cost patients, New York makes additional payments called cost outlier payments.

### Medicare Outlier Payments

New York's Medicaid outlier policy is similar to the initial Medicare outlier policy. However, the Medicare program adopted new regulations in 2003 to address vulnerabilities that resulted in excessive payments to certain hospitals that aggressively increased charges. Because of these increases, the Centers for Medicare & Medicaid Services (CMS) outlier formula overestimated the hospitals' costs, and CMS reported that it paid approximately $9 billion in excessive Medicare outlier payments from 1998 to 2002 for cases that should not have qualified as extraordinarily high-cost cases.

## OBJECTIVE

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

## SUMMARY OF FINDINGS

With one exception, New York's method of computing inpatient hospital cost outlier payments generally resulted in reasonable payments. New York (1) used a hospital-specific factor, which it updated annually, to convert billed charges to costs; and (2) monitored cost outlier payments by submitting each outlier claim for medical review. However, New York did not use the most accurate cost-to-charge ratios to convert billed charges to costs.[1] Had it done so, New York could have saved approximately $21.5 million ($10.75 million Federal share) in cost outlier payments between State fiscal years 1998 and 2002 at the three hospitals that we reviewed. We believe that New York could achieve additional savings at other hospitals.

[1]New York used data from the most recently filed cost reports to determine the ratio of costs to charges, the factor used to convert current charges to costs in the outlier payment calculation. The most recently filed cost reports were usually for 2 years before the rate year. As a result, 2-year-old cost-to-charge data were generally used to calculate outlier payments.

## RECOMMENDATION

We recommend that New York amend its State plan to require retroactive adjustments of interim cost outlier payments based on cost report data for the year in which the inpatient discharge occurred.

## NEW YORK'S COMMENTS

In its comments on our draft report, New York concurred with our recommendation, but stated that implementation would require changes in State regulations and the applicable State plan. The full text of New York's comments is presented as Appendix C.

## OFFICE OF INSPECTOR GENERAL'S RESPONSE

We believe that New York should take all necessary steps to implement our recommendation.

## TABLE OF CONTENTS

# 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 New York State Department of Health administers the State's Medicaid program.

### Outlier Payments and the Medicaid Prospective Payment System

New York 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 hospitals' costs can vary significantly among beneficiaries within a specific DRG, the DRG payment is fixed. New York implemented its DRG payment rates in 1988 based on 1987 hospital costs adjusted to the year when the beneficiary is discharged. Under this fixed payment system, hospitals have a financial incentive to avoid extremely costly cases.

To address such concerns in the Medicare program, Congress established outlier payments for situations in which the cost of treating a Medicare beneficiary is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. New York makes similar outlier payments to compensate hospitals when they incur significantly high costs for Medicaid beneficiaries.

Because hospitals cannot calculate the exact cost for each beneficiary, New York must convert billed charges to estimated costs, using an established cost-to-charge ratio, to determine whether a claim qualifies as an extraordinarily high-cost case. New York calculates the cost-to-charge ratio by dividing a hospital's total inpatient costs by its total inpatient charges. The State uses cost and charge data from each hospital's most recently filed Medicaid cost report in its calculation.

Although hospitals report their costs on a calendar year basis, they are not required to file their cost reports until June of the following year. The cost report data, moreover, are not available to calculate outlier payments until the start of the next calendar year. As a result, an outlier claim for a beneficiary discharged in 2000 would be computed using a 2-year-old cost-to-charge ratio based on data from the hospital's 1998 cost report. The outlier payment is calculated as the difference between estimated costs (i.e., charges converted to costs by use of the cost-to-charge ratio) and New York's payment threshold.

New York does not make cost outlier payments if the estimated costs are less than the threshold amount. In addition, New York City municipal hospitals and certain other hospitals may not claim

cost outlier payments because they had not established ancillary and routine charge schedules when New York developed the cost base for DRG payment rates.

Although New York's procedures are similar to those initially used by Medicare to calculate cost outlier payments, New York did not modify its procedures when CMS revised the Medicare outlier payment policy in 2003 to allow for retroactive recalculations of outlier payments.

**Processes and Controls for Outlier Payments**

For each cost outlier claim, New York first compares the hospital's estimated costs against a payment threshold, which is the greater of the hospital's DRG payment for the beneficiary times 2 or the hospital's average DRG payment times 6. Claims that meet or exceed the threshold amount are eligible for cost outlier payments.

New York next requires hospitals to provide detailed billing and medical records for each cost outlier claim that exceeds the threshold. New York forwards these records to an independent peer review organization for medical review. The peer review organization evaluates the beneficiary's condition and treatment and the procedures performed to determine the appropriateness of both the DRG payment and the cost outlier claim. Once New York receives the results of this review, it manually computes the cost outlier payment.

**Potential Problems With the Cost-to-Charge Ratio**

As long as hospital costs and charges change at roughly the same rate, estimating costs using the hospital-specific cost-to-charge ratio produces a reliable result. Over time, the cost-to-charge ratio will reflect the changes in the costs and charges. However, when a hospital dramatically increases its charges relative to costs and the State does not routinely update the cost-to-charge ratio, the estimated costs may not reflect actual operating costs. Using an unrepresentative cost-to-charge ratio could yield higher outlier payments than would be appropriate because the payments could be triggered by higher charges and not by higher costs.

Nationally, hospitals have steadily increased charges in relation to costs since the mid-1980s. Charge increases during this period caused the average cost-to-charge ratio to decrease from approximately 0.8 to less than 0.5.[1] In addition, CMS determined that hospital charges have increased faster than hospital costs.[2]

**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. During Federal fiscal years (FYs) 1998–2002, CMS reported that it paid approximately $9 billion more in outlier payments than intended because

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

[2]CMS 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).

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

## OBJECTIVE, SCOPE, AND METHODOLOGY

### Objective

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

### Scope

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

Our audit covered State FYs 1998–2002 (April 1, 1997, to March 31, 2002). During this period, New York made approximately $17.4 billion in DRG base payments to hospitals for inpatient services. During the same period, New York made $270.1 million in cost outlier payments to hospitals for inpatient services and made total Medicaid payments of approximately $18.4 billion to hospitals reimbursed under the DRG system. Total Medicaid payments included DRG base payments, cost outliers, day outliers,[3] and other add-ons. We used cost reports and other statistical information from State FYs 1998–2002 to identify trends in hospital charges and costs.

To determine how specific hospitals received higher levels of cost outlier payments, we reviewed claims from three hospitals (Hospitals A, B, and C) for State FYs 1998–2002. We selected the hospitals for onsite review on the basis of several factors, including total cost outlier payments, the number of cost outlier claims, the average cost outlier payment per claim, and the ratio of cost outlier payments to total Medicaid payments. (See Appendix A for the cost outlier payments by hospital.)

We did not perform a detailed review of State or hospital internal controls because the audit objective did not require us to do so. We obtained Medicaid payment data from New York's Medicaid Management Information System (MMIS). To validate the accuracy of the data, we reconciled 90 claims from New York to detailed billing records at the 3 hospitals. The detailed

[3]In addition to cost outliers, New York paid day outliers on a per diem basis. We did not include day outliers in our audit.

billing records from Hospital A, however, did not match the information in either the MMIS or the hospital's claims. Further, we were unable to confirm the relationship between costs and significant increases in charges for certain items at Hospital A because the hospital did not provide adequate documentation of its costs. Therefore, we limited certain audit tests for this hospital to services listed on the detailed billing records.

We performed the audit at the New York State Department of Health, Office of Medicaid Management in Albany, New York, and at three inpatient hospitals in New York, New York.

**Methodology**

*New York State Department of Health*

We conducted interviews with New York officials and reviewed documentation to determine how New York calculated and monitored cost outlier payments. New York provided a listing of hospitals receiving DRG base and cost outlier payments. We used this listing to select the three hospitals for onsite review.

To quantify the impact of high charges on cost outlier payments at the three hospitals, we recalculated each outlier payment using the cost-to-charge ratio from the hospitals' Medicaid cost reports. Specifically, we replaced the 2-year-old cost-to-charge ratio in New York's cost outlier formula with the cost-to-charge ratio from the cost report for the period in which the beneficiary was discharged. For example, for a cost outlier payment with a discharge date of September 1, 2000, we recomputed the payment using the cost-to-charge ratio from the hospital's cost report for calendar year 2000 instead of 1998, the most recent year for which cost and charge data were available when the claim was processed.

Because we intentionally selected hospitals that received high levels of outlier payments, the potential cost savings computed for the 3 hospitals may not be representative of the entire population of 229 hospitals in the State. (See Appendix B.) Therefore, we did not project or extrapolate these results to all New York hospitals.

*Inpatient Hospital Providers*

We reviewed 30 claims for cost outlier payments at each of the 3 selected hospitals. Specifically, we:

- interviewed officials and requested board of directors' meeting minutes to determine how hospitals set procedure and supply charges,

- determined the rate of increase in charges by comparing the charges that triggered the largest cost outlier payments with the hospital's historical charges, and

- compared significantly increased charges with competitive hospitals' charges to determine whether the market influenced the increase.

The three hospitals informed us that they did not discuss charges at their board of directors' meetings, and they did not provide us with the minutes.

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

## FINDINGS AND RECOMMENDATION

With one exception, New York's method of computing inpatient hospital cost outlier payments generally resulted in reasonable payments. New York (1) used a hospital-specific factor, which it updated annually, to convert billed charges to costs; and (2) monitored cost outlier payments by submitting each outlier claim for medical review. However, New York did not use the most accurate cost-to-charge ratios to convert billed charges to costs. Had it done so, New York could have saved approximately $21.5 million ($10.75 million Federal share) in cost outlier payments between State FYs 1998 and 2002 at the three hospitals that we reviewed. We believe that New York could achieve additional savings at other hospitals.

## STATE REQUIREMENTS

### Cost Outlier Payments

New York Compilation of Codes, Rules and Regulations (NYCRR), Title 10, section 86-1.52, states that hospitals may receive cost outlier payments in addition to DRG payments. Pursuant to 10 NYCRR § 86-1.55(c)(2), cost outlier payments represent the difference between estimated costs (i.e., total charges converted to costs by use of the cost-to-charge ratio) and New York's payment threshold.

### Cost-to-Charge Ratios

Pursuant to 10 NYCRR § 86-1.11(g)(ii)(g)(3), the factor used to convert current charges to costs in the outlier payment calculation is "the ratio of adjusted inpatient costs to inpatient gross charges." New York computes this hospital-specific factor using cost and charge data from the most recently filed cost report. New York updates cost-to-charge ratios annually after it receives hospital cost reports.

## INCREASED OUTLIER PAYMENTS

Cost outlier payments to the three selected hospitals increased because the hospitals raised their charges for certain procedures and because New York's cost-to-charge ratios were not based on cost and charge data for the period when the inpatient discharges occurred.

### Increased Charges

For each of the three hospitals, we identified instances in which outlier payments for certain procedures exceeded the statewide average rate of increase in outlier payments. Our analysis of the hospitals' billing records, claims, and payments also noted instances of significant charge increases for specific procedures or supplies. For example, in a single year:

- Hospital A increased its charges for left heart catheterization procedures by 367 percent, from $1,102 to $5,150.

- Hospital B increased its charges for pediatric ventilation procedures by 50 percent, from $1,000 to $1,495.

- Hospital C increased its charges for basic open-heart surgery supplies by 286 percent, from $1,563 to $6,029.

Although these charge increases raised Medicaid outlier payments, in each instance hospital officials attributed the charge increases to factors other than costs.

**Inaccurate Cost-to-Charge Ratios**

The hospital-specific cost-to-charge-ratios that New York used to calculate current-year outlier payments were generally based on cost report data for periods 2 years before the inpatient discharges occurred. As shown in Table 1, the actual cost-to-charge ratios at the three hospitals reviewed were almost always lower than the ratios used to calculate cost outlier payments.

**Table 1: Comparison of 2-Year-Old and Actual Cost-to-Charge Ratios**

| | Hospital A | | Hospital B | | Hospital C | |
|---|---|---|---|---|---|---|
| State FY | As Paid | Actual | As Paid | Actual | As Paid | Actual |
| 1998 | 0.6371 | 0.5559 | 0.5921 | 0.5098 | 0.7796 | 0.6949 |
| 1999 | 0.6024 | 0.5066 | 0.5503 | 0.4598 | 0.6978 | 0.7124 |
| 2000 | 0.5559 | 0.5050 | 0.5098 | 0.4257 | 0.6949 | 0.6818 |
| 2001 | 0.5066 | 0.4271 | 0.4598 | 0.3778 | 0.7124 | 0.6296 |
| 2002 | 0.5050 | 0.4478 | 0.4257 | 0.3535 | 0.6818 | 0.5314 |

The use of outdated cost-to-charge ratios can result in higher outlier payments if the outdated ratios are higher than the actual ratios.

## POTENTIAL SAVINGS BY USING MORE ACCURATE RATIOS

New York could reduce Medicaid costs by using more accurate cost-to-charge ratios to convert billed charges to costs. For the three hospitals reviewed, cost outlier payments for State FYs 1998–2002 would have been approximately $21.5 million lower ($10.75 million Federal share) if New York had applied more accurate cost-to-charge ratios. (See Table 2 on the next page.) We believe that additional savings may exist at other hospitals.

**Table 2: Potential Savings for State FYs 1998–2002 by Using More Accurate Cost-to-Charge Ratios**

| | Total Outlier Payments Based on Ratios From Outdated Cost Reports (A) | Total Outlier Payments Based on More Accurate Ratios (B) | Potential Cost Savings (A – B) |
|---|---|---|---|
| Hospital A | $30,047,669 | $21,463,050 | $8,584,619 |
| Hospital B | 26,124,498 | 16,082,241 | 10,042,257 |
| Hospital C | 17,120,459 | 14,199,709 | 2,920,750 |
| **Total** | **$73,292,626** | **$51,745,000** | **$21,547,626**[4] |

## RECOMMENDATION

We recommend that New York amend its State plan to require retroactive adjustments of interim cost outlier payments based on cost report data for the year in which the inpatient discharge occurred.

## NEW YORK'S COMMENTS

In its comments on our draft report, New York concurred with our recommendation, but stated that implementation would require changes in State regulations and the applicable State plan.

The full text of New York's comments is presented as Appendix C.

## OFFICE OF INSPECTOR GENERAL'S RESPONSE

We believe that New York should take all necessary steps to implement our recommendation.

[4]$10,773,813 Federal share.

# APPENDIXES

## COST OUTLIER PAYMENTS BY HOSPITAL
## State Fiscal Years 1998–2002

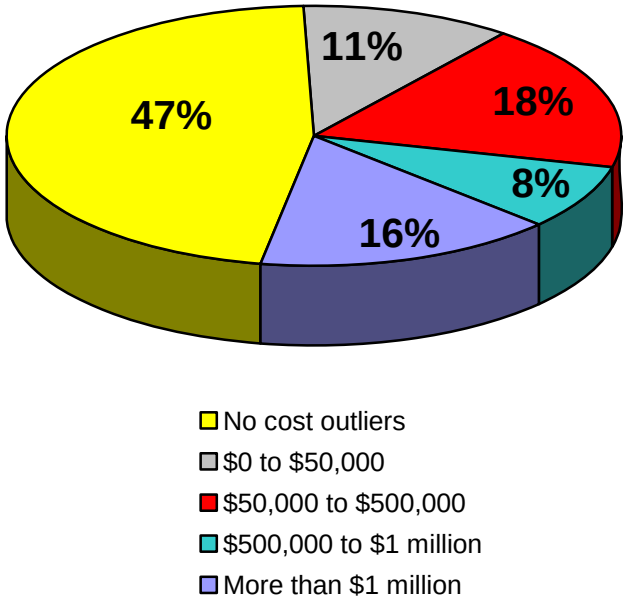
| Outlier Rank | Total DRG Base Payments[1] | Total Cost Outlier Payments | Total Medicaid Reimbursement[2] |
|---|---|---|---|
| 1 (Hospital A) | $677,096,566 | $30,602,034 | $721,883,694 |
| 2 | 494,761,036 | 29,888,319 | 536,322,062 |
| 3 (Hospital B) | 614,804,156 | 27,210,840 | 659,091,500 |
| 4 | 517,109,367 | 25,447,916 | 558,995,598 |
| 5 (Hospital C) | 545,397,121 | 17,652,605 | 579,600,444 |
| 6 | 286,478,178 | 12,536,045 | 306,191,105 |
| 7 | 100,549,286 | 11,814,292 | 115,509,005 |
| 8 | 197,239,144 | 8,986,050 | 211,149,083 |
| 9 | 313,842,726 | 7,943,168 | 330,502,805 |
| 10 | 171,640,944 | 7,831,469 | 184,404,714 |
| 11 to 229 | 13,528,956,585 | 90,152,176 | 14,167,479,439 |
| **Total** | **$17,447,875,109** | **$270,064,914** | **$18,371,129,449** |

Pursuant to New York Compilation of Codes, Rules and Regulations, Title 10, sections 86-1.54(f)(3) and 86-1.55(c)(3), the statewide annual limit for cost outlier payments is 3 percent of inpatient costs for hospitals paid under the DRG system. If cost outlier payments exceed this limit, the payments must be suspended until New York reviews the hospital charge schedules. New York's method of computing inpatient hospital cost outlier payments limited such payments to 1.55 percent of DRG payments for State fiscal years (FYs) 1998–2002.

[1]A DRG is a diagnosis-related group.

[2]Total Medicaid reimbursement included DRG base payments, cost outliers, day outliers, and other add-on payments.

## HOSPITALS RECEIVING COST OUTLIER PAYMENTS STATEWIDE
### State Fiscal Years 1998–2002




Of the 229 hospitals in the State, 107 hospitals (47 percent) received no outlier payments during State FYs 1998–2002. However, 36 hospitals (16 percent), including the 3 hospitals reviewed, each received more than $1 million in outlier payments. The 36 hospitals accounted for 92 percent of the total outlier payments. By concentrating its efforts on the relatively few hospitals that account for the vast majority of outlier payments, New York could maximize the savings from using a more accurate factor to convert billed charges to costs.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
*Commissioner*

Dennis P. Whalen
*Executive Deputy Commissioner*

April 21, 2006

James P. Edert
Regional Inspector General for
Audit Services
DHHS OIG Office of Audit Services
26 Federal Plaza
Room 3900A
New York, New York 10278

Dear Mr. Edert:

Enclosed are the Department of Health's comments on the DHHS – OIG's Draft Audit Report (A-02-04-01022) on "Medicaid Hospital Outlier Payments in New York for State Fiscal Years 1998 through 2002."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

cc: Mr. Gahan
Mr. Griffin
Mr. Howe
Ms. O'Connor
Mr. Reed
Mr. Seward
Mr. Van Guysling
Mr. Wing
Mr. Wollner

# Department of Health
# Comments on the
# Department of Health and Human Services
# Office of Inspector General
# Draft Audit Report A-02-04-01022 on
# "Medicaid Hospital Outlier Payments in New York for State Fiscal Years 1998 through 2002"

The following are the Department of Health's (DOH) comments in response to the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) draft audit report (A-02-04-01022) on "Medicaid Hospital Outlier Payments in New York for State Fiscal Years 1998 through 2002."

**Recommendation #1:**

We recommend that the State amend its State plan to require retroactive adjustments of interim cost outlier payments based on cost report data for the year in which the inpatient discharge occurred.

**Response #1:**

Current regulations require DOH to use the cost-to-charge rates from the cost report two years prior to the rate period. Accordingly, hospitals benefit by the use of two year old data, since charges in the interim were significantly higher. DOH agrees with the recommendation; however, implementation requires change to existing regulations as well as the applicable State plan. Any proposed revisions require public vetting, which will delay any changes for a considerable period of time.

# ACKNOWLEDGMENTS

This report was prepared under the direction of James P. Edert. Other principal Office of Audit Services staff who contributed include:

Elliot Hirshon, *Audit Manager*
Jennifer Webb, *Senior Auditor*
Stephen Hobday, *Auditor*
Anita Sahoo, *Auditor*
Sarah Stein, *Auditor*

Technical Assistance
David Phillips, *Advanced Audit Techniques*

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