MAY - 9 2005

TO: Dennis G. Smith
Director, Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services

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

SUBJECT: Medicaid Hospital Outlier Payments in Illinois for the Period of State Fiscal Years 1998 Through 2002 (A-07-04-04031)

Attached is an advance copy of our final report on Medicaid hospital outlier payments in Illinois for the period of State fiscal years (FYs) 1998 through 2002. We will issue this report to Illinois within 5 business days. This audit is one of a series of reports of State Medicaid agencies' outlier payments made to inpatient hospitals.

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

Illinois's method of computing inpatient hospital cost outlier payments did not result in reasonable payments. Specifically, the State (1) used an out-of-date factor to convert billed charges to costs and (2) did not have adequate policies and procedures in place to monitor cost outlier payments.

As a result, cost outlier payments increased significantly; in fact, they increased at a faster rate than other types of Medicaid payments. From FYs 1998 through 2002, the average cost outlier payment per admission increased by 60.4 percent, whereas during the same period the average diagnosis-related group base payment per admission declined by 4.6 percent, and total Medicaid payments per admission increased by 6.2 percent. Furthermore, if the State does not address the outlier policy deficiencies, including the out-of-date cost-to-charge ratio, it is likely that cost outlier payments will continue to increase as hospitals increase charges faster than costs. Finally, if the State had applied a more current factor to convert billed charges to costs, it could have saved approximately $56.5 million between 1998 and 2002 for the three hospitals reviewed. We believe that additional potential savings exist at other hospitals.

We recommended that Illinois revise its method of computing cost outlier payments to ensure that payments are reasonable. At a minimum, the State agency should work with the State legislature to revise the policy requiring the use of an outdated cost-to-charge factor in computing cost outlier payments.

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

- review cost reports to identify hospitals with significant changes in cost-to-charge ratios,

- review the charge structure of those hospitals with high levels of outlier payments to identify possible measures to limit outliers to extraordinarily high-cost cases, and

- perform targeted medical reviews of cost outlier claims on a routine basis to determine if procedures were medically necessary and to identify duplicate and other types of incorrect charges.

ILLINOIS'S COMMENTS

Illinois acknowledged that cost outlier payments have increased significantly. However, Illinois stated the appropriateness of the increase must be viewed in the context of the current inpatient hospital rate freeze. The purpose of the cost outlier payments, which is assuring access for the most costly Medicaid recipients, also "takes on additional significance given the rate freeze" and should be considered.

To address the increase in outlier payments, Illinois stated that the State FY 2006 proposed budget includes increasing the threshold amount in order to hold cost outlier payments at their FY 2005 levels. In addition, Illinois stated it will continue to review medical necessity and quality assurance through the current peer review process. Illinois did not address the recommendation to revise the policy requiring the use of an outdated cost-to-charge factor in computing cost outlier payments.

OFFICE OF INSPECTOR GENERAL RESPONSE

We commend Illinois on its efforts to address cost outlier payment issues. However, we urge Illinois to focus its efforts on ensuring that cost outlier payments are made for the correct cases. Specifically, cost outlier payments should be associated with cases in which hospitals have incurred extraordinarily high costs, not cases in which hospitals have billed high charges.

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. Aasmundstad, Regional Inspector General for Audit Services, Region VII at (816) 426-3591, ext. 225.

Please refer to report number A-07-04-04031 in all correspondence.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region VII
601 East 12th Street, Room 284A
Kansas City, MO 64106
(816) 426-3591

MAY 12 2005

Report Number: A-07-04-04031

Mr. Barry S. Maram
Director
Illinois Department of Public Aid
201 South Grand Avenue East
Springfield, Illinois 62763

Dear Mr. Maram:

Enclosed are two copies of the Department of Health and Human Services, Office of Inspector General (OIG) final report entitled "Medicaid Hospital Outlier Payments in Illinois for the Period of State Fiscal Years 1998 Through 2002." 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 named below will make final determination as to actions taken on all matters in the reported. We request that you respond to the HHS action official within 30 days. 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 members of the press and general 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-07-04-04031 in all correspondence.

Sincerely,

James P. Aasmundstad,
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Jackie Garner
Regional Administrator, Region V
Centers for Medicare & Medicaid Services
Department of Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID HOSPITAL OUTLIER PAYMENTS IN ILLINOIS FOR THE PERIOD OF STATE FISCAL YEARS 1998 THROUGH 2002

May 2005

A-07-04-04031

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. The OEI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

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

Illinois Medicaid Payments

Illinois pays hospitals predetermined per-discharge rates referred to as diagnosis-related groups (DRGs). While 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 extremely costly cases. To counter this incentive and promote access to hospital care for high-cost patients, the State makes additional payments called cost outlier payments. Outlier payments can be viewed as a form of insurance for hospitals against the large losses that could result from extremely expensive cases.

Medicare Outlier Payments

The Illinois Medicaid outlier policy initially was similar to the Medicare outlier policy. In 2003, the Medicare program 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, 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 Illinois's method of computing inpatient hospital cost outlier payments resulted in reasonable payments.

SUMMARY OF FINDINGS

Illinois's method of computing inpatient hospital cost outlier payments did not result in reasonable payments. Specifically, the State (1) used an out-of-date factor to convert billed charges to costs and (2) did not have adequate policies and procedures in place to monitor cost outlier payments.

As a result, cost outlier payments increased significantly; in fact, they increased at a faster rate than other types of Medicaid payments. From State fiscal years (FYs) 1998 through 2002, the average cost outlier payment per admission increased by 60.4 percent, whereas during the same period the average DRG base payment per admission declined by 4.6 percent, and total Medicaid payments per admission increased by 6.2 percent. Furthermore, if the State does not address the outlier policy deficiencies, including the out-of-date cost-to-charge ratio, it is likely that cost outlier payments will continue to increase as hospitals increase charges faster than costs. Finally, if the State had applied a more current factor to convert billed charges to costs, it could have saved approximately $56.5 million between 1998 and 2002 for the three hospitals reviewed. We believe that additional potential savings exist at other hospitals.

RECOMMENDATIONS

We recommend that Illinois revise its method of computing cost outlier payments to ensure that payments are reasonable. At a minimum, the State agency should work with the State legislature to revise the policy requiring the use of an outdated cost-to-charge factor in computing cost outlier payments.

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

- review cost reports to identify hospitals with significant changes in cost-to-charge ratios,
- review the charge structure of those hospitals with high levels of outlier payments to identify possible measures to limit outliers to extraordinarily high-cost cases, and
- perform targeted medical reviews of cost outlier claims on a routine basis to determine if procedures were medically necessary and to identify duplicate and other types of incorrect charges.

ILLINOIS'S COMMENTS

Illinois acknowledged that cost outlier payments have increased significantly. However, Illinois stated that the appropriateness of the increase must be viewed in the context of the inpatient hospital rate freeze. The purpose of the cost outlier payments, which is assuring access for the most costly Medicaid recipients, also "takes on additional significance given the rate freeze" and should be considered.

To address the increase in outlier payments, Illinois stated that the State FY 2006 proposed budget includes a provision to increase the threshold amount in order to hold cost outlier payments at their FY 2005 levels. In addition, Illinois said it will continue to review medical necessity and quality assurance through the current peer review process. However, Illinois did not address the recommendation to revise the policy requiring the use of an outdated cost-to-charge factor in computing cost outlier payments.

Illinois's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

We commend Illinois on its efforts to address cost outlier payment issues. However, we urge Illinois to focus its efforts on ensuring that cost outlier payments are made for the correct cases. Specifically, cost outlier payments should be associated with cases in which hospitals have incurred extraordinarily high costs, not cases in which hospitals have billed high charges.

TABLE OF CONTENTS

Page

INTRODUCTION 1

BACKGROUND 1
Medicaid Program 1
Outlier Payments and the Prospective Payment System 1
Potential Problems With the Cost-to-Charge Ratio 1
Excessive Medicare Outlier Payments 2

OBJECTIVE, SCOPE, AND METHODOLOGY 2
Objective 2
Scope 2
Methodology 3

FINDINGS AND RECOMMENDATIONS 4

STATE REQUIREMENTS 4
Cost Outlier Payments 4
Frozen Cost-to-Charge Ratio 5

COST OUTLIER PAYMENTS NOT LIMITED 5
Influence of Increased Charges on Cost Outlier Payments 5
Increases in Average Medicaid Charge Per Admission and Cost Outlier Payments 6

REASONS FOR INCREASED COST OUTLIER PAYMENTS 7
Use of Outdated Information 7
Ineffective Monitoring of Cost Outlier Payments 7

EFFECT OF NOT LIMITING COST OUTLIER PAYMENTS TO EXTRAORDINARILY HIGH-COST CASES 8
Cost Outlier Payments Increased Significantly Over Time 8
Cost Outlier Payments Are Likely to Increase in the Future 9
Illinois Can Save Money by Applying a More Current Cost-to-Charge Ratio 9

RECOMMENDATIONS 10

ILLINOIS'S COMMENTS 11

OFFICE OF INSPECTOR GENERAL RESPONSE 11

APPENDIXES
A – COST OUTLIER PAYMENTS BY HOSPITAL
B – ILLINOIS'S COMMENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Medicaid was established in 1965 under Title XIX of the Social Security Act as a joint Federal and State program. Medicaid provides medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children and to qualified pregnant women and children. 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 Illinois Department of Public Aid administers the State's Medicaid program.

Outlier Payments and the Prospective Payment System

The State pays hospitals for Medicaid inpatient stays using a prospective payment system that includes a pre-established amount for each discharge based on a diagnosis-related group (DRG) code. Although a hospital's costs can vary significantly among patients within a specific DRG, the DRG payment is fixed. In 1995, Illinois froze the DRG base payments, as well as certain outlier payment components. Congress established Medicare outlier payments for situations where the cost of treating a Medicare patient is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. To compensate hospitals when they incur significantly high costs for Medicaid patients, the State similarly pays hospitals outlier payments to help cover these extra costs. The outlier policy promotes access to care for extremely costly patients who would otherwise be financially unattractive.

Historically, Illinois used a formula similar to the Medicare formula to calculate Medicaid cost outlier payments. Because hospitals cannot calculate the exact cost for each admission, the State must convert billed charges to estimated costs, using an established cost-to-charge ratio, to determine if a claim qualifies as an extraordinarily high-cost case. The cost-to-charge ratio is calculated by dividing the hospital's total costs by its total charges. In 1995, the State froze the hospital-specific cost-to-charge ratios, which were based on 1989 cost report information.

The cost outlier payment amount is equal to 80 percent of the difference between the total estimated cost for the stay (billed charges times the cost-to-charge ratio) and the DRG amount plus a hospital-specific threshold amount. Illinois froze the thresholds from 1995 to December 2001. The hospital-specific thresholds ranged from $15,135 to $19,743. In December 2001, the State increased the thresholds by 22 percent.

Potential Problems With the Cost-to-Charge Ratio

As long as hospital costs and charges change at roughly the same rate, the estimate of costs, using the hospital-specific cost-to-charge ratio produces a reliable result. Over time, the cost-to-charge ratio will reflect the changes in the costs and charges. When a hospital dramatically

increases its charges relative to costs and the State does not routinely update the cost-to-charge ratio, the estimated cost will not be reliable or reflective of current conditions. Using an unrepresentative cost-to-charge ratio can yield higher outlier payments than would be appropriate because the cost outlier payment could be triggered by higher charges and not by higher costs.

On a national basis, hospitals have steadily increased charges in relationship 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.[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. From Federal fiscal years (FYs) 1998 to 2002, CMS reported that it paid approximately $9 billion more in outlier payments than intended because its outlier computation overestimated costs for hospitals that raised charges faster than costs. As a result, hospitals that dramatically increased their charges received outlier payments for cases with high charges rather than high costs. Upon discovering the vulnerabilities of the Medicare outlier policy, CMS revised the formula to use the cost-to-charge ratio from the latest cost reporting period; i.e., the most recent settled or tentatively settled cost report. Using the cost-to-charge ratios from tentatively settled cost reports reduces the timelag for updating the cost-to-charge ratio by a year or more. In addition, outlier payments are now subject to adjustment when the hospital's cost report is settled and the actual cost-to-charge ratio is determined. This adjustment will ensure that the outlier payment appropriately reflects the hospital's costs of providing care.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

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

Between Illinois State FYs 1998 and 2002, the State paid approximately $2.9 billion in DRG base payments to hospitals for inpatient services. During the same period, the State paid $616.1 million in cost outlier payments to hospitals for inpatient services and made total

[1]MedPac analysis of data from the American Hospital Association annual survey of hospitals from 1985 to 2001.
[2]Federal Register, Volume 67, No. 148, page 50124, dated August 1, 2002: CMS determined that hospital charges increased 7.63 percent and 10 percent in 2000 and 2001, respectively. CMS determined that these rates of hospital charge increases were higher than rates of hospital cost increases.

Medicaid payments of approximately $5.2 billion to hospitals under the DRG system. Total Medicaid payments include DRG base payments, day outliers, cost outliers, disproportionate share hospital payments, and other add-ons. We used the State FYs 1998 to 2002 cost reports and other statistical information from the State to identify trends in hospital charges and costs. The State was not required to maintain any Medicaid DRG or outlier payment data prior to 1998; therefore, we used 1998 as the base year for our analysis. We were unable to include 2003 data in our analysis because hospitals had not submitted all of their 2003 claims. State personnel informed us that the payment data for 2003 were incomplete and would not yield reliable results.

We selected providers for onsite reviews on the basis of high cost outlier payments and the percentage increase in cost outlier payments. To determine how specific hospitals received higher levels of cost outlier payments, we reviewed claims from three hospitals for 2000 to 2003.

We did not perform a detailed review of State or provider internal controls because the audit objectives did not require us to perform these tests. The State provided the Medicaid payment data used in this report. To validate the accuracy of this data, we reconciled 90 electronic claims from the State to detailed claim documentation at 3 hospitals.

We performed the audit at the Illinois Department of Public Aid office in Springfield, IL, and at three Illinois inpatient hospitals.

Methodology

Illinois Department of Public Aid

We conducted interviews and reviewed documentation to determine how the State calculated and monitored cost outlier payments. The State provided a listing of hospitals receiving DRG base and cost outlier payments. We used this listing to identify three providers that received a high percentage of cost outlier payments and showed high growth in the cost outlier payments.

To quantify the impact of high charges on cost outlier payments at specific hospitals, we recalculated each outlier payment for the three hospitals using the cost-to-charge ratio from the hospitals' final and "as submitted" cost reports. Specifically, we replaced the frozen cost-to-charge ratio in the cost outlier formula with the cost-to-charge ratio from the cost report pertaining to the admission date. For 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 cost-to-charge ratio that the State froze in 1995. For some claims, the reduction or elimination of the cost outlier payment would have required the State to pay a day outlier payment. To compute this effect, we reduced the potential cost savings by the increase in day outlier payments that would have occurred.

Because we intentionally selected hospitals that received high levels of outlier payments, the potential cost savings computed for the 3 hospitals are not representative of the entire population of 210 hospitals. Therefore, we did not project or extrapolate these results to all Illinois hospitals.

Inpatient Hospital Providers

We reviewed claims with high cost outlier payments at each of the three selected hospitals to determine why the hospitals had significantly higher cost outlier payments. We reviewed board of directors meeting minutes and interviewed department managers to determine how hospitals set procedure charges. We determined the ratio of increase by comparing the charges for procedures that triggered the largest cost outlier payments with the hospital's historical charges for procedures. Next, we compared the procedures that had significantly increased charges with charges billed by competitive hospitals to determine if the market influenced the charge increase. Finally, we compared the percentage of Medicaid charges paid for specific DRGs with the percentage that other payers paid.

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

FINDINGS AND RECOMMENDATIONS

Illinois's method of computing inpatient hospital cost outlier payments did not result in reasonable payments. Specifically, the State (1) used an out-of-date factor to convert billed charges to costs and (2) did not have adequate policies and procedures in place to monitor cost outlier payments.

As a result, cost outlier payments increased significantly; in fact, they increased at a faster rate than other types of Medicaid payments. From State FYs 1998 through 2002, the average cost outlier payment per admission increased by 60.4 percent, whereas during the same period the average DRG base payment per admission declined by 4.6 percent, and total Medicaid payments per admission increased by 6.2 percent. Furthermore, if the State does not address the outlier policy deficiencies, including the out-of-date cost-to-charge ratio, it is likely that cost outlier payments will continue to increase as hospitals increase charges faster than costs. Finally, if the State had applied a more current factor to convert billed charges to costs, it could have saved approximately $56.5 million between 1998 and 2002 for the three hospitals reviewed. We believe that additional potential savings exist at other hospitals.

STATE REQUIREMENTS

Cost Outlier Payments

Illinois Administrative Code, Title 89, Chapter I, 149.105(c)(1), "Payments for Extraordinarily High Costs Cases," provides for outlier payments for extraordinarily high-cost cases. The regulation states that if hospital charges exceed the applicable threshold criterion, the State agency will make an additional payment to the hospital to cover those costs. Also, the Illinois Medicaid State plan, Attachment 4.19-A, V.4.C, "Payment for Extraordinarily High Cost Cases (Cost Outliers)," states that if hospital charges exceed the applicable threshold criterion, the State agency will make an additional payment to the hospital to cover those costs.

Frozen Cost-to-Charge Ratio

The Illinois State Legislature enacted statute 305, section 5, part 14.1(a), which states "For hospital inpatient services rendered on or after July 1, 1995, the Illinois Department shall reimburse hospitals using the relative weighting factors and the base payment rates calculated for each hospital that were in effect on June 30, 1995. . . . " State personnel informed us that the intent of the statute was to freeze every component of the DRG payment, including the cost-to-charge ratio. The State incorporated that policy in 89 Illinois Administrative Code, Chapter I, section 152.150 (f), which states, in part, that " . . . payment for outlier cases . . . shall be determined using the following factors that were in effect on June 30, 1995 . . . (4) the cost-to-charge ratio." The outlier payment amount is equal to 80 percent of the difference between the total estimated cost for the stay and the DRG amount plus a hospital-specific threshold amount.

The State promulgated the cost outlier computation in Provider Bulletin H-30, dated April 5, 1996. The bulletin specifies that if a hospital's charges, converted to costs using the cost-to-charge ratio, exceed the applicable threshold criterion, the State will make a cost outlier payment to the hospital.

COST OUTLIER PAYMENTS NOT LIMITED

Illinois's method of computing inpatient cost outlier payments did not result in reasonable payments. By increasing charges faster than costs, the three hospitals reviewed were able to increase cost outlier payments on the basis of increased charges rather than higher costs:

- The hospitals dramatically raised the charges for specific procedures without a demonstrated increase in costs and, as a result, triggered Medicaid cost outlier payments.

- The hospitals' average Medicaid per admission charges increased significantly faster than their Medicaid per admission costs.

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 three Illinois hospitals reviewed received significantly higher Medicaid cost outlier payments by increasing the charges for selected procedures. Once a case exceeds the outlier threshold, any increase in charges will result in increased cost outlier payments. Increasing just a few routine services, such as room charges, by significant amounts will significantly increase total charges and therefore the outlier payment. In such cases, the higher outliers reflect higher charges, not necessarily higher costs.

One of the three hospitals received $3 million in additional Medicaid cost outlier payments by increasing the charge for a single procedure. The hospital increased its daily per patient charge for the neonatal intensive care unit from $1,675 to $2,675, a 60-percent increase. If the charge

increases had been limited to an average cost increase of approximately 4 percent[3] annually (per admission), the hospital would have received $3 million less in cost outlier payments.

Some of the other specific charges that increased at the individual hospitals include[4]:

- charges for continuous positive airway pressure daily procedures, which increased by 89 percent, from $516 to $974;

- charges for portable x-ray of the abdomen, which increased by 50 percent, from $193.50 to $290.50;

- charges for esophagogastroduodenoscopy diagnostic procedures, which increased by 46 percent, from $367.50 to $537.50; and

- charges for volume respirator pediatric procedures, which increased by 41 percent, from $936 to $1,318.

These increases were not always driven by commensurate cost increases. For example, one hospital indicated to us that "patient charge increases in 2001 were intended to provide additional revenue to attenuate lost income for proposed State of Illinois reimbursement reductions."

By significantly increasing charges for specific procedures that Medicaid patients often use, hospitals were able to receive high levels of Medicaid outlier payments. However, these charge increases did not necessarily have a similar impact on payments on non-Medicaid claims. To illustrate, after Hospital A significantly increased charges for specific procedures, the hospital received Medicaid cost outlier payments totaling 48.6 percent of total DRG base payments compared to 6.4 percent for Medicare. The State paid Hospital A $10.4 million in Medicaid DRG base payments and $9.8 million in total Medicaid cost outlier payments for inpatient services rendered in 2001. During the same period, Hospital A received $43.5 million in Medicare DRG base payments and $3 million in Medicare outlier payments.

Increases in Average Medicaid Charge Per Admission and Cost Outlier Payments

The three hospitals' average Medicaid charge per admission increased at a rate significantly greater than their average Medicaid cost per admission. To illustrate, from 2001 to 2002, costs increased from approximately 3 to 16 percent while charges increased from 7 to 24 percent, resulting in charge increases that exceeded cost increases by 45 to 143 percent.[5] As a result, the cost-to-charge ratio decreased between the 2 years. (See Table 1.) Because the State did not consider these changing ratios in computing outlier payments, some of the payments were not reasonable.

[3]To calculate the annual rate of inflation, we used the 1999 through 2004 annual Consumer Price Indexes - Medical Care Services. The annual rate of inflation ranged from 3.52 to 4.78 percent.

[4]Hospitals implemented these examples of charge increases as individual increases (not over a period of time). The hospitals added subsequent increases to these charges.

[5]We obtained the cost and charge information from the final and "as submitted" cost reports.

Table 1: Comparison of Average Cost, Average Charges, and Cost-to-Charge Ratios

	Average Medicaid per Admission Operating Costs			Average Medicaid per Admission Charges			Percentage of Average Charge Increases Exceeding Average Cost Increases	Cost-to-Charge Ratio		
Hospital	2001	2002	Increase	2001	2002	Increase		2001	2002	Decrease
A	$6,550	$6,730	2.8%	$16,629	$17,764	6.8%	143%	0.3939	0.3789	3.81%
B	$4,751	$5,531	16.4%	$13,441	$16,640	23.8%	45%	0.3534	0.3324	5.94%
C	$8,553	$8,982	5.0%	$18,041	$19,536	8.3%	66%	0.4961	0.4598	7.32%

REASONS FOR INCREASED COST OUTLIER PAYMENTS

Use of Outdated Information

The hospital-specific cost-to-charge ratios that the State used for reimbursements made during our audit period were frozen in 1995, and those ratios were calculated from statewide data collected in 1989. Consequently, the calculation used to convert charges to costs was based on cost report data that were more than 10 years old.

As shown in Table 2, the actual yearly cost-to-charge ratios at the three hospitals reviewed were lower than the frozen ratios used to calculate reimbursement payments. As we show later in this report, using the frozen cost-to-charge ratios resulted in significantly higher cost outlier payments than would have occurred had the State used the actual cost-to-charge ratios.

Table 2: Comparison of Frozen and Actual Cost-to-Charge Ratios

	Hospital A		Hospital B		Hospital C	
Year	Frozen	Actual	Frozen	Actual	Frozen	Actual
1998	0.7059	0.4104	0.5072	0.3394	0.5896	0.4939
1999	0.7059	0.3692	0.5072	0.3423	0.5896	0.5197
2000	0.7059	0.3887	0.5072	0.3610	0.5896	0.4846
2001	0.7059	0.3939	0.5072	0.3534	0.5896	0.4961
2002	0.7059	0.3789	0.5072	0.3324	0.5896	0.4598

Ineffective Monitoring of Cost Outlier Payments

In addition to using outdated cost-to-charge ratios, Illinois did not effectively monitor cost outlier payments. Although the State recognized that overall cost outlier payments were increasing, it did not monitor specific hospital activity to ensure that such payments were paid only for extraordinarily high-cost cases. The State did not review current cost reports to identify hospitals for which the cost-to-charge ratio decreased significantly. In addition, the State did not review each hospital's increased charges to identify why particular hospitals were able to achieve

higher levels of outlier payments. Finally, the State did not routinely conduct medical reviews of outlier claims to determine if procedures were medically necessary and to identify any duplicate and other incorrect charges. By conducting such monitoring, the State might have identified payment trends that would have enabled it to make necessary changes.

As cost outlier payments increased, the State responded by increasing the hospital-specific threshold by 22 percent effective December 2001. Increasing the threshold reduced cost outlier payments in the short term by making it more difficult for hospitals to qualify for an outlier payment.

However, a hospital intent on increasing or maximizing its cost outlier payments could simply increase its charges to exceed the higher threshold. Hospitals that were not aggressively increasing charges would be forced to absorb their higher costs, while those hospitals that aggressively increased charges could receive a disproportionate share of cost outlier payments.[6]

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

Because Illinois did not limit cost outlier payments to extraordinarily high-cost cases, Medicaid cost outlier payments increased significantly. In addition, if the State does not address the outlier policy deficiencies, it is likely that cost outlier payments will continue to increase at a much faster rate than base payments as hospitals increase charges further. Finally, if the State had applied a more current factor to convert billed charges to costs, the State could have saved approximately $56.5 million between State FYs 1998 and 2002 for the three hospitals reviewed. We believe that additional savings exist at other hospitals.

Cost Outlier Payments Increased Significantly Over Time

On a per admission basis, from State FYs 1998 to 2002, base payments actually decreased by 4.6 percent while cost outlier payments per admission grew by 60.4 percent and total Medicaid payments per admission increased by 6.2 percent.[7]

While total cost outlier payments increased about 91 percent between State FYs 1998 and 2002, total DRG payments grew by only 14 percent. Total Medicaid payments made to the hospitals increased by 26 percent during the same period. (See Table 3.)

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

[7]The per admission percentage accounts for the rise in the number of Medicaid patients annually.

Table 3: Increases in DRG, Cost Outlier, and Total Medicaid Payments

	DRG		Cost Outlier		Total Medicaid	
State FY	Amount	Increase Over 1998	Amount	Increase Over 1998	Amount	Increase Over 1998
1998	$554,199,105		$88,054,147		$952,405,674	
1999	551,091,542	-0.6%	98,654,211	12.0%	960,596,160	0.9%
2000	569,802,688	2.8%	118,082,467	34.1%	1,020,264,021	7.1%
2001	600,876,087	8.4%	143,163,108	62.6%	1,102,818,612	15.8%
2002	629,178,271	13.5%	168,104,573	90.9%	1,201,499,979	26.2%

Cost Outlier Payments Are Likely to Increase in the Future

Illinois cost outlier payments for inpatient hospital cases will continue to grow rapidly unless the State alters its payment policy. State officials said that cost outlier payments were estimated to rise to $250 million by State FY 2005. If additional hospitals dramatically increase charges and if the State does not correct the outlier policy, cost outlier payments will increase further.

Illinois Can Save Money by Applying a More Current Cost-To-Charge Ratio

For the three hospitals reviewed, cost outlier payments from State FYs 1998 through 2002 would have been $56.5 million lower[8] if the State had applied more current cost-to-charge ratios instead of using the frozen cost-to-charge ratios in the outlier formula.[9] (See Table 4.) Applying a cost-to-charge ratio based upon outdated cost and charge data does not yield a reasonable estimate of costs incurred in treating a patient and may result in significantly higher outlier payments than would have occurred if the State had used more current cost and charge data. We believe that additional potential savings exist at other hospitals.

[8]As stated in the "Methodology" section of this report, the three hospitals were not representative of all Illinois hospitals. Therefore, we did not project or extrapolate these results to all Illinois hospitals.

[9]In 2003, CMS changed its outlier policy to allow for a retroactive recalculation of Medicare outlier payments applying the current cost-to-charge ratio for hospitals with significant changes to their cost-to-charge ratios. Table 4 reflects the potential cost savings for the three hospitals if the State were to adopt a similar retroactive adjustment. We obtained cost and charge information used to calculate the current cost-to-charge ratio from the hospitals' FYs 1998 through 2002 cost reports.

Table 4: Potential Savings From Using More Current Cost-to-Charge Ratios

	Cost Outlier Payments					
Hospital	**1998**	**1999**	**2000**	**2001**	**2002**	**Totals**
A						
With Frozen Ratio (0.7059)	$6,635,122	$8,015,520	$8,640,176	$9,804,674	$13,674,492	$46,769,984
Current Ratio	0.4104	0.3692	0.3887	0.3939	0.3789	
Cost Outliers With Current Ratio	$2,363,401	$2,470,097	$3,115,527	$3,564,665	$5,046,129	$16,559,819
Day Outliers With Current Ratio[10]	$133,676	$195,430	$111,113	$102,367	$81,083	$623,669
Cost Savings	**$4,138,045**	**$5,349,993**	**$5,413,536**	**$6,137,642**	**$8,547,280**	**$29,586,496**
B						
With Frozen Ratio (0.5072)	$6,733,816	$6,109,512	$5,857,062	$7,139,655	$9,397,940	$35,237,985
Current Ratio	0.3394	0.3423	0.361	0.3534	0.3324	
Cost Outliers With Current Ratio	$2,680,294	$2,379,719	$2,500,132	$3,218,861	$3,745,224	$14,524,230
Day Outliers With Current Ratio	$585,700	$431,620	$451,510	$279,290	$146,213	$1,894,333
Cost Savings	**$3,467,822**	**$3,298,173**	**$2,905,420**	**$3,641,504**	**$5,506,503**	**$18,819,422**
C						
With Frozen Ratio (0.5896)	$2,506,783	$3,626,025	$4,965,496	$6,224,815	$7,223,680	$24,546,799
Current Ratio	0.4939	0.5197	0.4846	0.4961	0.4598	
Cost Outliers With Current Ratio	$1,617,434	$2,767,142	$3,209,754	$4,194,996	$4,085,750	$15,875,076
Day Outliers With Current Ratio	$39,246	$28,030	$141,448	$142,214	$277,035	$627,973
Cost Savings	**$850,103**	**$830,853**	**$1,614,294**	**$1,887,605**	**$2,860,895**	**$8,043,750**
Total Cost Savings						**$56,449,668**

RECOMMENDATIONS

We recommend that Illinois revise its method of computing cost outlier payments to ensure that payments are reasonable. At a minimum, the State agency should work with the State legislature to revise the policy requiring the use of an outdated cost-to-charge factor in computing cost outlier payments.

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

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

[10]The Medicaid State plan, amendment 4.19-A, states that the additional payment is greater of the day or cost outlier payment calculation. To compute the potential cost savings that could be generated from using the more current cost-to-charge ratio for the three hospitals, we determined, in some instances, that the day outlier payments would have increased as the cost outlier payments were decreased or eliminated. Accordingly, we included the increase in day outlier payments in the cost savings estimate.

- perform targeted medical reviews of cost outlier claims on a routine basis to determine if procedures were medically necessary and to identify duplicate and other types of incorrect charges.

ILLINOIS'S COMMENTS

Illinois acknowledged that cost outlier payments have increased significantly. However, Illinois stated the appropriateness of the increase must be viewed in the context of the inpatient hospital rate freeze. The purpose of the cost outlier payments, which is assuring access for the most costly Medicaid recipients, also "takes on additional significance given the rate freeze" and should be considered.

To address the increase in outlier payments, Illinois stated that the State FY 2006 proposed budget includes a provision to increase the threshold amount in order to hold cost outlier payments at their FY 2005 levels. In addition, Illinois said it will continue to review medical necessity and quality assurance through the current peer review process. However, Illinois did not address the recommendation to revise the policy requiring the use of an outdated cost-to-charge factor in computing cost outlier payments, identifying hospitals with significant changes in cost-to-charge factors, or reviewing the charge structure of hospitals with high levels of outlier payments.

Illinois stated that CMS approved the methodology for reimbursing cost outlier payments.

Illinois's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

We commend Illinois on its efforts to address cost outlier payment issues. However, we urge Illinois to focus its efforts on ensuring that cost outlier payments are made for the correct cases. Specifically, cost outlier payments should be associated with cases in which hospitals have incurred extraordinarily high costs, not cases in which hospitals have billed high charges.

We believe that Illinois's proposal to increase the threshold likely will not fix this problem unless it also addresses the outdated factor used in the cost outlier formula. As described in the Federal Register (Volume 68, Number 43), CMS's experience in the Medicare program beginning in the late 1990's has shown that increasing the threshold alone does not solve the overall problem. As Medicare outlier payments grew, CMS increased the outlier threshold significantly in an attempt to limit Medicare outlier payment growth. As a direct result, more hospitals were forced to absorb the costs of the complex cases while a relatively small number of hospitals increased charges, and thereby received a disproportionate share of the Medicare outlier payments. In 2003, CMS fixed the underlying formula problems, including the use of an outdated factor, which limited hospitals' ability to receive Medicare outlier payments simply by raising charges.

Moreover, we continue to recommend that Illinois needs to more closely monitor outlier payments to ensure that payments are limited to extraordinarily high-cost cases.

While CMS did approve Illinois's methodology for Medicaid cost outlier reimbursement as part of the Medicaid State plan, it granted approval prior to its discovery of problems related to the Medicare outlier payment methodology. Upon the completion of similar Medicaid cost outlier payment reviews in several other States, we plan to issue a consolidated report to CMS with our recommendations to address the Medicaid cost outlier problems.

APPENDIXES

COST OUTLIER PAYMENTS BY HOSPITAL

	1998 - 2002 State Data			
Outlier Rank	**Total DRG Base Payments**	**Total Cost Outlier Payments**	**Cost Outlier Payments in Relation to Base Payment [1]**	**Total Medicaid Reimbursement [2] [3]**
82	$1,157,623	$1,391,027	54.58%	$2,830,455
Hospital A 1	47,200,007	46,769,985	49.77%	99,122,047
143	136,454	133,259	49.41%	281,985
75	1,864,719	1,725,825	48.07%	4,077,842
66	2,657,856	2,125,017	44.43%	4,321,702
84	1,828,399	1,345,691	42.40%	3,058,453
7	29,936,402	16,987,668	36.20%	56,310,201
34	10,112,955	5,295,234	34.37%	15,502,159
19	18,209,422	9,426,556	34.11%	28,671,190
62	4,955,402	2,460,179	33.18%	9,066,184
58	5,201,663	2,575,343	33.11%	10,908,481
33	10,818,497	5,319,262	32.96%	16,963,873
5	48,339,995	23,301,593	32.53%	105,718,675
27	13,368,457	6,420,520	32.44%	23,198,377
78	3,506,250	1,677,139	32.36%	5,469,943
41	9,894,022	4,531,130	31.41%	16,643,744
17	22,359,432	9,865,279	30.61%	39,790,624
16	24,517,467	10,642,085	30.27%	38,047,498
128	616,891	262,873	29.88%	776,804
9	33,126,993	13,695,986	29.25%	52,519,160
8	37,259,669	15,190,014	28.96%	74,954,590
10	33,762,840	13,477,283	28.53%	50,160,670
43	10,246,724	4,045,310	28.30%	16,699,264
15	28,212,784	11,135,165	28.30%	46,624,054
25	19,657,014	7,506,985	27.64%	28,709,956
165	39,269	14,057	26.36%	61,751
14	32,377,335	11,554,728	26.30%	51,065,009
76	5,031,417	1,703,928	25.30%	7,440,910
87	3,750,567	1,256,489	25.09%	5,218,977
96	2,855,246	951,652	25.00%	4,516,097
51	9,684,165	3,220,365	24.96%	39,354,495
47	11,322,920	3,687,212	24.56%	16,681,910

[1]The Cost Outlier in Relation to DRG Base payment percentage is Total Cost Outlier payments divided by the result of Total DRG Base payments plus Total Cost Outlier payments.
[2]Total Medicaid reimbursement includes the following payments: DRG base, cost outliers, day outliers, disproportionate share, and other add-on payments.
[3]For those cases in which the DRG base plus Cost Outlier payments were greater than total Medicaid reimbursement, the State deducted a third-party liability payment.

	1998 - 2002 State Data			
Outlier Rank	Total DRG Base Payments	Total Cost Outlier Payments	Cost Outlier Payments in Relation to Base Payment	Total Medicaid Reimbursement
12	37,310,574	11,941,998	24.25%	58,191,737
22	27,304,897	8,113,149	22.91%	36,588,114
26	23,332,382	6,839,196	22.67%	33,944,608
11	46,053,955	13,292,035	22.40%	84,872,001
32	18,939,896	5,466,159	22.40%	27,711,570
Hospital C 4	86,158,065	24,546,799	22.17%	151,284,795
55	9,387,505	2,672,281	22.16%	13,607,450
57	9,411,169	2,626,865	21.82%	14,124,368
35	18,874,216	5,245,073	21.75%	32,689,971
131	901,862	248,767	21.62%	1,224,475
Hospital B 2	129,384,500	35,237,985	21.41%	361,291,360
28	23,347,396	6,342,492	21.36%	38,629,830
99	3,211,717	868,241	21.28%	4,503,132
3	111,338,480	29,947,658	21.20%	207,356,104
39	17,789,045	4,737,597	21.03%	23,959,844
6	79,050,973	20,852,019	20.87%	152,046,545
21	31,440,470	8,275,010	20.84%	43,239,236
23	30,552,700	8,021,071	20.79%	43,126,019
13	46,824,413	11,709,482	20.00%	70,088,269
44	16,210,778	4,014,036	19.85%	24,121,286
122	1,224,296	299,971	19.68%	1,576,402
81	5,949,112	1,415,401	19.22%	8,510,316
48	14,888,181	3,520,155	19.12%	20,519,598
114	1,841,539	429,581	18.91%	2,631,955
49	15,076,636	3,464,256	18.68%	30,217,164
120	1,587,764	347,939	17.97%	2,247,616
20	43,542,814	9,238,483	17.50%	59,220,765
79	7,790,795	1,646,833	17.45%	9,906,454
59	12,408,754	2,568,301	17.15%	17,792,795
30	26,912,022	5,567,120	17.14%	38,769,814
136	972,749	200,653	17.10%	4,724,631
95	4,708,279	965,544	17.02%	7,708,014
54	13,540,928	2,776,094	17.01%	17,163,498
42	23,031,504	4,416,165	16.09%	28,342,069
126	1,415,163	269,411	15.99%	1,713,604
112	2,342,589	435,372	15.67%	3,267,549
93	5,793,101	1,062,716	15.50%	6,843,433
117	2,129,559	382,920	15.24%	2,895,813
155	177,124	31,006	14.90%	401,835
52	17,981,778	3,121,776	14.79%	32,879,207

	1998 - 2002 State Data			
Outlier Rank	Total DRG Base Payments	Total Cost Outlier Payments	Cost Outlier Payments in Relation to Base Payment	Total Medicaid Reimbursement
24	47,197,270	7,995,881	14.49%	79,937,938
18	56,888,378	9,449,607	14.24%	120,897,478
86	8,005,794	1,273,056	13.72%	22,894,415
37	30,610,845	4,864,986	13.71%	38,212,800
111	3,003,816	472,258	13.59%	3,862,262
70	13,102,509	2,027,231	13.40%	16,434,643
108	3,449,129	520,609	13.11%	4,525,193
46	25,446,131	3,748,176	12.84%	46,461,804
60	17,719,020	2,563,745	12.64%	22,321,897
36	35,455,136	5,109,859	12.60%	46,327,035
64	16,092,773	2,242,092	12.23%	19,649,261
38	34,772,860	4,816,098	12.17%	51,814,740
74	13,149,240	1,806,565	12.08%	18,071,966
29	45,875,831	6,252,763	11.99%	55,864,291
68	15,391,281	2,094,646	11.98%	23,585,920
90	9,010,151	1,206,940	11.81%	13,164,687
125	2,043,752	271,644	11.73%	2,821,028
53	24,024,601	2,950,144	10.94%	34,112,602
103	5,588,394	680,941	10.86%	6,929,430
80	12,726,705	1,538,222	10.78%	28,513,494
31	48,600,412	5,559,811	10.27%	113,674,446
77	14,742,649	1,681,138	10.24%	17,970,584
67	18,630,267	2,115,448	10.20%	26,539,738
106	4,739,783	531,454	10.08%	6,707,528
69	18,467,901	2,053,430	10.01%	24,388,267
144	1,118,464	121,953	9.83%	1,339,718
72	18,240,040	1,953,487	9.67%	22,010,777
45	36,175,693	3,843,696	9.60%	48,723,160
92	11,154,687	1,165,882	9.46%	13,589,001
105	5,713,773	591,362	9.38%	8,295,272
124	2,710,625	273,623	9.17%	4,379,063
63	24,466,733	2,398,474	8.93%	33,282,835
100	9,312,397	855,588	8.41%	15,103,537
94	10,673,867	968,780	8.32%	16,075,159
110	5,313,491	476,117	8.22%	8,297,603
156	341,852	30,353	8.15%	414,531
85	14,572,161	1,274,738	8.04%	24,440,200
101	9,302,611	794,653	7.87%	14,226,994
115	4,974,167	422,146	7.82%	5,496,441
56	32,654,605	2,655,445	7.52%	41,714,567

	1998 - 2002 State Data			
Outlier Rank	Total DRG Base Payments	Total Cost Outlier Payments	Cost Outlier Payments in Relation to Base Payment	Total Medicaid Reimbursement
140	2,117,279	171,962	7.51%	3,252,751
40	56,494,547	4,582,969	7.50%	138,834,774
71	26,119,252	1,988,707	7.08%	103,522,547
50	45,027,191	3,313,838	6.86%	103,693,759
107	7,452,280	521,578	6.54%	10,131,578
146	1,832,777	119,925	6.14%	2,321,320
138	2,830,288	178,853	5.94%	3,823,206
89	20,248,484	1,251,670	5.82%	28,196,673
137	2,910,489	179,884	5.82%	5,896,259
88	20,931,105	1,256,161	5.66%	50,157,376
61	41,716,083	2,483,187	5.62%	60,976,307
153	673,921	39,076	5.48%	792,943
142	2,710,297	156,160	5.45%	4,073,713
97	16,002,220	911,669	5.39%	39,851,102
113	7,792,488	430,227	5.23%	10,149,627
73	33,821,729	1,827,741	5.13%	83,659,738
130	4,795,698	254,158	5.03%	6,851,383
98	17,300,058	900,433	4.95%	76,574,512
109	9,824,595	510,861	4.94%	13,577,597
83	26,603,545	1,379,563	4.93%	41,573,435
139	3,397,762	172,797	4.84%	4,507,878
91	23,916,956	1,176,063	4.69%	34,949,970
148	1,187,047	56,304	4.53%	1,442,025
65	47,249,175	2,201,774	4.45%	120,371,883
135	4,650,562	208,145	4.28%	7,371,354
123	6,376,237	280,482	4.21%	7,060,690
147	1,938,212	83,333	4.12%	2,864,642
119	8,628,635	366,799	4.08%	9,508,777
129	6,225,682	260,532	4.02%	8,134,173
121	8,407,000	324,605	3.72%	13,338,107
151	1,172,340	45,254	3.72%	1,462,126
150	1,516,906	52,046	3.32%	2,016,144
132	7,086,828	241,988	3.30%	8,920,331
133	7,406,884	217,033	2.85%	11,067,682
145	4,421,828	120,986	2.66%	8,209,066
163	627,546	16,644	2.58%	1,060,400
172	368,452	9,663	2.56%	463,335
154	1,283,305	31,818	2.42%	1,476,050
157	1,118,818	26,830	2.34%	1,266,609
159	934,700	21,776	2.28%	1,078,386

	1998 - 2002 State Data			
Outlier Rank	Total DRG Base Payments	Total Cost Outlier Payments	Cost Outlier Payments in Relation to Base Payment	Total Medicaid Reimbursement
118	17,932,879	378,128	2.07%	20,071,565
162	918,174	19,149	2.04%	1,192,074
169	501,181	10,405	2.03%	560,974
149	2,769,162	54,723	1.94%	3,733,039
170	544,348	10,188	1.84%	639,421
127	14,920,974	264,508	1.74%	46,998,350
158	1,288,570	22,601	1.72%	1,661,516
104	37,190,645	615,414	1.63%	96,340,525
166	761,118	11,966	1.55%	974,636
161	1,282,699	19,459	1.49%	1,561,384
134	14,656,417	213,168	1.43%	24,405,080
141	12,456,128	166,193	1.32%	43,894,093
102	59,964,536	787,369	1.30%	119,333,895
116	31,813,474	416,934	1.29%	55,762,901
167	935,280	11,620	1.23%	1,103,736
164	1,325,188	15,143	1.13%	1,799,121
175	617,565	6,709	1.07%	770,786
176	727,269	6,652	0.91%	810,414
171	1,152,892	9,966	0.86%	1,785,756
160	2,452,655	19,763	0.80%	3,112,597
177	824,291	6,143	0.74%	1,091,953
183	613,251	4,106	0.67%	646,965
186	346,631	2,149	0.62%	422,834
152	7,678,833	42,636	0.55%	10,492,256
188	231,118	1,219	0.52%	264,825
173	1,723,143	8,026	0.46%	2,845,802
182	972,420	4,459	0.46%	1,193,295
178	1,301,539	5,744	0.44%	1,354,255
174	1,688,517	7,267	0.43%	8,747,536
168	3,281,760	11,480	0.35%	4,411,948
185	981,801	2,528	0.26%	1,074,751
181	2,638,308	5,185	0.20%	3,818,758
180	2,954,067	5,533	0.19%	3,955,734
179	3,014,458	5,618	0.19%	4,203,732
184	2,248,742	3,833	0.17%	6,056,253
187	1,555,593	1,676	0.11%	1,774,055
190	1,364,380	816	0.06%	1,821,959
189	3,253,386	1,043	0.03%	4,785,028
191	582,842	-	0.00%	896,894
192	2,603,158	-	0.00%	3,392,360

	1998 - 2002 State Data			
Outlier Rank	**Total DRG Base Payments**	**Total Cost Outlier Payments**	**Cost Outlier Payments in Relation to Base Payment**	**Total Medicaid Reimbursement**
193	701,982	-	0.00%	775,344
194	132,418	-	0.00%	143,429
195	124,176	-	0.00%	139,005
196	5,757	-	0.00%	19,449
197	152,435	-	0.00%	168,666
198	114,936	-	0.00%	141,919
199	1,715,357	-	0.00%	2,599,508
200	43,419	-	0.00%	51,471
201	440,185	-	0.00%	526,757
202	86,620	-	0.00%	103,446
203	3,077,752	-	0.00%	4,138,585
204	1,363,004	-	0.00%	3,837,072
205	107,555	-	0.00%	114,078
206	337,345	-	0.00%	434,886
207	558,850	-	0.00%	610,233
208	327,029	-	0.00%	382,250
209	853,017	-	0.00%	1,159,983
210	208,933	-	0.00%	222,443
Total Payments	**$2,905,147,693**	**$616,058,503**		**$5,237,584,439**

Rod. R. Blagojevich, Governor
Barry Maram, Director

Illinois Department of Public Aid

Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

E-mail: dpa_webmaster@state.il.us
Internet: http://www.dpaillinois.com/

April 8, 2005

James P. Aasmundstad,
Regional Inspector General for Audits
Office of the Inspector General
Department of Health and Human Services
601 East 12th Street, Room 284A
Kansas City, Missouri 64106

Dear Mr. Aasmundstad:

I write in response to your request for a formal response to your report entitled, "Medicaid Hospital Outlier Payments in Illinois."

I appreciate the work your auditors have done regarding outlier payments in Illinois. While cost outlier payments have increased significantly over the past several years, the significance or appropriateness of the increase must be viewed in the context of Illinois' current inpatient hospital rate freeze. As stated on page one of your report, cost outlier payments provide a form of insurance for hospitals against large losses associated with expensive patients. Your report also states that outlier payments promote access for extremely costly patients. The Department agrees with your description of the purpose of outlier payments. In Illinois, that purpose takes on additional significance given the rate freeze on base hospital payments. It is important to consider cost outlier payments within this context of assuring access for the most costly and most vulnerable Medicaid recipients.

In your report you recommend that the State; 1) identify hospitals with significant changes in cost-to-charge ratios, 2) review the charge structure of hospitals receiving large outlier payments and develop measures to limit outlier payments, and 3) perform reviews of outlier claims to determine medical necessity.

Illinois has reviewed and adjusted its threshold amount for determining cost outlier payments in 2001, as noted in your report. Governor Blagojevich's proposed budget for State fiscal year 2006 calls for increasing the threshold amount in order to hold cost outlier payment at their fiscal year 2005 levels. The Department will continue to review medical necessity and quality assurance through our current peer review process. The federally qualified Peer Review Organization reviews all admissions that are subject to the department's utilization review. Hospitalization admissions

involving outlier payments are subject to post payment review through a sampling methodology.

As you are aware, the methodology for reimbursing cost outlier payments is approved by CMS. We look forward to working with you on this issue.

Sincerely,

Barry S. Maram

Barry S. Maram
Director