DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JAN 17 2006

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 North Carolina for State Fiscal Years 1998 Through 2002 (A-07-04-04038)

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

Our objective was to determine whether North Carolina's inpatient hospital cost outlier payments were budget neutral.

North Carolina's inpatient hospital cost outlier payments were not budget neutral. Outlier payments consistently exceeded the 7.2-percent reduction in diagnosis-related group (DRG) payments. Specifically, (1) the State's outlier formula allowed inpatient hospitals that dramatically increased charges to receive outlier payments for high charges rather than high costs, and (2) the State did not have adequate policies and procedures in place to monitor cost outlier payments.

As a result, cost outlier payments increased at a significantly faster rate than Medicaid base payments. From State FY 1998 through State FY 2003, the average cost outlier payment per discharge increased by 128.1 percent, whereas the average DRG base payment per discharge increased by only 14.3 percent. If the State had modified its outlier payment reimbursement policy to achieve budget neutrality, the State could have saved approximately $89.4 million in State FYs 1998 through 2003.

We recommend that North Carolina revise its current Medicaid outlier payment policy to ensure that future outlier payments achieve budget neutrality. Specifically, North Carolina should consider:

- increasing the amount of the 7.2-percent DRG rate reduction,
- raising the outlier thresholds, and/or
- limiting outlier payments on certain DRGs with high levels of Medicaid utilization.

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

- monitoring DRG and outlier payments to ensure budget neutrality,
- reviewing cost reports to identify hospitals with significant decreases in cost-to-charge ratios,
- reviewing the charge structure of hospitals with high levels of outlier payments to identify possible measures to limit outliers to exceptionally costly cases, and/or
- performing targeted medical reviews of cost outlier claims on a routine basis to determine whether procedures are medically necessary and to identify duplicate and other incorrect charges.

North Carolina disagreed that it (1) intended for inpatient hospital outlier payments to be budget neutral and (2) should develop policies and procedures to more closely monitor outlier payments.

We agree that the State Medicaid plan did not use the specific term "budget neutrality." However, the State's fiscal impact statement, completed prior to the adoption of the DRG and outlier payment system, stated that the new system was projected to be budget neutral and would not result in additional costs or savings. We also continue to believe that North Carolina should revise its policies and procedures because of increasing average cost 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 Patrick J. Cogley, Regional Inspector General for Audit Services, Region VII, at (816) 426-3591, extension 274. Please refer to report number A-07-04-04038.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

JAN 20 2006

Report Number: A-07-04-04038

Ms. Carmen Hooker Odom
Secretary, Department of Health and Human Services
Adams Building
101 Blair Drive
Raleigh, North Carolina 27603

Dear Ms. Odom:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General (OIG) final report entitled "Medicaid Hospital Outlier Payments in North Carolina for 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 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).

If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, extension 274, or contact Raylene Mason, Audit Manager, at (816) 426-3591, extension 227 or through e-mail at Raylene.Mason@oig.hhs.gov. Please refer to report number A-07-04-04038 in all correspondence.

Sincerely,

Patrick J. Cogley
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mr. Roger Perez
Acting Regional Administrator
Centers for Medicare & Medicaid Services
Sam Nunn Atlanta Federal Center
61 Forsyth Street, SW., Suite 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID HOSPITAL OUTLIER PAYMENTS IN NORTH CAROLINA FOR STATE FISCAL YEARS 1998 THROUGH 2002

Daniel R. Levinson
Inspector General

JANUARY 2006
A-07-04-04038

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 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 HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts management and program evaluations (called inspections) that focus on issues of concern to HHS, 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. OEI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Investigations

The 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. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. 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

North Carolina Medicaid Payments

As part of the Medicaid program, North Carolina pays hospitals predetermined per discharge rates referred to as diagnosis-related group (DRG) payments. Although DRG payments vary by category of inpatient Medicaid cases, the payments for each category of cases are fixed. Under this system, hospitals have a financial incentive to avoid extremely costly cases. To counter this incentive and promote access to hospital care for high-cost patients, the State makes additional payments called 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. Cost outlier payments compensate hospitals for extremely costly cases, whereas day outlier payments compensate hospitals for exceptionally long stays.

In 1995, North Carolina revised its Medicaid inpatient hospital reimbursement regulations to establish a prospective payment system comprising DRG base payments and outlier payments. Also in 1995, in accordance with its regulations, North Carolina reduced DRG rates by 7.2 percent to "account for" outlier payments.

During State fiscal year (FY) 2003, North Carolina paid hospitals $722 million in Medicaid DRG payments, $67.9 million in Medicaid cost outlier payments, and $14.3 million in Medicaid day outlier payments.

Medicare Outlier Payments

North Carolina's Medicaid cost outlier reimbursement policy was similar to the policy that the Centers for Medicare & Medicaid Services (CMS) used in the Medicare program. However, in 2003, CMS adopted new regulations to address program vulnerabilities that resulted in excessive payments to certain hospitals that were aggressively increasing charges. Because of the charge increases, CMS's outlier formula had overestimated the hospitals' costs, and CMS reported that it paid approximately $9 billion in excessive Medicare outlier payments between Federal FYs 1998 and 2002 for cases that should not have qualified as exceptionally costly cases.

OBJECTIVE

Our objective was to determine whether North Carolina's inpatient hospital cost outlier payments were budget neutral.

SUMMARY OF FINDINGS

North Carolina's inpatient hospital cost outlier payments were not budget neutral. Outlier payments consistently exceeded the amount that we calculated for the 7.2-percent reduction in DRG base payments. Specifically, (1) the State's outlier formula allowed inpatient hospitals that

dramatically increased charges to receive outlier payments for high charges rather than high costs, and (2) the State did not have adequate policies and procedures in place to monitor cost outlier payments.

As a result, cost outlier payments increased at a significantly faster rate than Medicaid base payments. From State FY 1998 through State FY 2003, the average cost outlier payment per discharge increased by 128.1 percent, whereas the average DRG base payment per discharge increased by only 14.3 percent. If the State had modified its outlier payment reimbursement policy to achieve budget neutrality, the State could have saved approximately $89.4 million in State FYs 1998 through 2003.

RECOMMENDATIONS

We recommend that North Carolina revise its current Medicaid outlier payment policy to ensure that future outlier payments achieve budget neutrality. Specifically, North Carolina should consider:

- increasing the amount of the 7.2-percent DRG rate reduction,
- raising the outlier thresholds, and/or
- limiting outlier payments on certain DRGs with high levels of Medicaid utilization.

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

- monitoring DRG and outlier payments to ensure budget neutrality,
- reviewing cost reports to identify hospitals with significant decreases in cost-to-charge ratios,
- reviewing the charge structure of hospitals with high levels of outlier payments to identify possible measures to limit outliers to exceptionally costly cases, and/or
- performing targeted medical reviews of cost outlier claims on a routine basis to determine whether procedures are medically necessary and to identify duplicate and other incorrect charges.

NORTH CAROLINA'S COMMENTS

North Carolina disagreed with our findings and recommendations and stated that it "believe[s] that the OIG [Office of Inspector General] audit report is based on flawed assumptions." North Carolina stated that it did not intend for inpatient hospital outlier payments to be budget neutral and that it had not attempted "to limit or restrict the total amount of outlier payments to the 7.2-percent calculation." North Carolina commented that the State Medicaid plan made no

mention of "budget neutrality." North Carolina acknowledged that hospitals were escalating charge amounts and said that it would consider revising the Medicaid plan to increase the 7.2-percent factor and the outlier thresholds.

Regarding our second recommendation, North Carolina disagreed that it should develop policies and procedures to more closely monitor outlier payments because it believed that the current monitoring/reviewing process was adequate and effective. According to North Carolina, in State FY 2003, it began updating hospital cost-to-charge ratios annually to reflect the most current cost report data; however, the State noted that it did not do so during most of our audit period.

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

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We continue to believe that our findings and recommendations are valid. We based our findings and recommendations on information that North Carolina provided to us during the audit, as well as Federal regulations and other criteria.

We agree that the State Medicaid plan did not use the specific term "budget neutrality." However, the State's fiscal impact statement, completed prior to the adoption of the DRG and outlier payment system, stated that the new system was projected to be budget neutral and would not result in additional costs or savings. Outlier payments accounted for 5.5 percent of DRG base payments in State FY 1998 and increased to an average of 9.3 percent in subsequent years. We continue to recommend that North Carolina revise its Medicaid outlier payment policy.

North Carolina's monitoring activities did not target hospitals that received high levels of outlier payments or restrict outlier payments to exceptionally high-cost cases. We continue to believe that North Carolina should revise its policies and procedures because the average cost outlier payment per discharge increased by 128.1 percent from State FY 1998 through 2003, whereas the average DRG base payment per discharge increased by only 14.3 percent.

TABLE OF CONTENTS

APPENDIXES

INTRODUCTION

BACKGROUND

Medicaid Program

In 1965, Title XIX of the Social Security Act established Medicaid 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 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 North Carolina Division of Medical Assistance administers the State's Medicaid program.

Outlier Payments and the Prospective Payment System

North Carolina 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 a hospital's cost can vary significantly among patients within a specific DRG, the DRG payment is fixed.

Under the Medicare program, Congress established outlier payments for situations in which the cost of treating a Medicare patient is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. The State similarly pays hospitals outlier payments to compensate for significantly high Medicaid costs. The outlier policy promotes access to care for extremely costly patients who would otherwise be financially unattractive. Cost outlier payments compensate hospitals for extremely costly cases, whereas day outlier payments compensate hospitals for exceptionally long stays. During State fiscal year (FY) 2003, North Carolina paid hospitals $722 million in Medicaid DRG payments, $67.9 million in Medicaid cost outlier payments, and $14.3 million in Medicaid day outlier payments.

In 1995, North Carolina revised its Medicaid inpatient hospital regulations to establish a prospective payment system comprising DRG base payments and outlier payments. The State's fiscal impact statement (completed prior to the adoption of the prospective payment system) said that the change from cost reimbursement to a prospective payment system was designed to be budget neutral, i.e., it would not result in additional costs or savings to the Medicaid program. In 1995 and in each subsequent year, pursuant to its State plan, North Carolina reduced DRG rates by 7.2 percent to "account for" 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 whether a claim qualifies as exceptionally costly. The State calculates the cost-to-charge ratio by dividing a hospital's total estimated costs by its total charges. Total charges are derived from

claims submitted to the State during the calendar year. The State calculates the estimated costs by multiplying the charges by the cost-to-charge ratio as contained in the hospital's cost report. The cost outlier payment amount is equal to 75 percent of the difference between the total estimated cost for the stay (billed charges multiplied by the cost-to-charge ratio) and the DRG-specific threshold amount. The cost outlier threshold is the greater of $25,000 or the mean cost for the DRG plus 1.96 standard deviations.

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 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 vulnerability, 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 ratio from the tentatively settled cost report reduces the timelag for updating the 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 North Carolina's inpatient hospital cost outlier payments were budget neutral.

Scope

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

Between State FYs 1998 and 2003, North Carolina paid approximately $3.6 billion in DRG base payments to hospitals for inpatient services. During the same period, the State paid $288.7 million in cost outlier payments to hospitals for inpatient services. We used the State FY 1998 through 2002 Medicaid cost reports and other statistical information 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 selected providers for onsite reviews based on high cost outlier payments and a high percentage increase in outlier payments. To determine how specific hospitals received higher levels of outlier payments, we reviewed claims from four hospitals for State FYs 2000 through 2003.

We did not perform a detailed review of State or provider internal controls because our objectives did not require us to do so. The State provided the Medicaid payment data used in this report. To validate these data, we reconciled 120 electronic claims to detailed claim documentation at the 4 hospitals.

We performed fieldwork at the North Carolina Division of Medical Assistance in Raleigh, NC, and at four North Carolina inpatient hospitals. We also interviewed and obtained documentation from officials at Myers and Stauffer, L.C., the State's contractor, in Leawood, KS.

Methodology

North Carolina Division of Medical Assistance

We interviewed North Carolina Division of Medical Assistance staff and reviewed documentation to determine how the State calculated and monitored outlier payments. North Carolina provided a listing of hospitals that received DRG base and outlier payments during State FYs 2000 through 2003. We used this listing to identify four providers that received a high percentage of outlier payments and showed high growth in the payments. We analyzed the cost outlier and DRG base payments for State FYs 1998 through 2003 to determine trends. (See Appendix A for a listing of cost outlier and DRG payments.)

To determine the fiscal impact of not restricting outlier payments to the 7.2-percent reduction in total DRG payments, we calculated what the DRG payments would have been without the reduction. We then determined the aggregate difference between the actual outlier payments and the reduced DRG payments. The result was the amount of outlier payments in excess of the 7.2-percent level.

Inpatient Hospital Providers

We reviewed 30 claims with high outlier payments at each of the 4 selected hospitals to determine whether the State paid cost outlier payments only for exceptionally costly cases and why certain hospitals received significantly higher outlier payments. At each hospital, we reviewed the board of directors' meeting minutes and interviewed department managers to determine how the hospital set charges. We determined the ratio of increase by comparing the charges for procedures that triggered the largest outlier payments with the hospital's historical charges. Next, we compared the charges for procedures billed by hospitals that had significantly increased charges with charges for procedures billed by competitive hospitals to determine whether the market had influenced the increase. Finally, we compared the percentage of charges that Medicaid paid for specific DRGs with the percentage that other insurers paid for the same DRGs.

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

FINDINGS AND RECOMMENDATIONS

North Carolina's inpatient hospital cost outlier payments were not budget neutral. Actual outlier payments consistently exceeded the amount that we calculated for the 7.2-percent reduction in DRG base payments. Specifically, (1) the State's outlier formula allowed inpatient hospitals that dramatically increased charges to receive outlier payments for high charges rather than high costs, and (2) the State did not have adequate policies and procedures in place to monitor cost outlier payments.

As a result, cost outlier payments increased at a significantly faster rate than Medicaid base payments. From State FY 1998 through State FY 2003, the average cost outlier payment per discharge increased by 128.1 percent, whereas the average DRG base payment per discharge increased by only 14.3 percent. If North Carolina had modified its outlier payment reimbursement policy to achieve budget neutrality, the State could have saved approximately $89.4 million in State FYs 1998 through 2003.

STATE OUTLIER PAYMENT REQUIREMENTS

The North Carolina Administrative Rule, subchapter 22G, section .0202(g), and the North Carolina Medicaid State plan, Attachment 4.19-A(d)(3), state that cost outlier payments are additional payments for exceptionally costly services made at the time a claim is processed.

The North Carolina Administrative Rule, subchapter 22G, section .0202(d), entitled "Hospital Inpatient Reimbursement Plan," and the North Carolina Medicaid State plan, Attachment 4.19-A(g), state that the hospital DRG rate is reduced by 7.2 percent to "account for" outlier payments. The State's contractor used 1993 claims data and "as submitted" cost report information to calculate the original DRG hospital payment rates, which it reduced by 7.2 percent to account for outlier payments pursuant to the Medicaid State plan and State regulations.[1]

OUTLIER PAYMENTS AND HOSPITAL CHARGES

Outlier Payments Exceeded Reduction in Diagnosis-Related Group Base Payments

North Carolina made outlier payments in excess of the 7.2-percent reduction in DRG base payments. The State annually reduced the DRG payments by 7.2 percent in accordance with the Medicaid State plan and State regulations. However, during State FYs 1998 through 2003, outlier payments exceeded the reduction in DRG payments by an average of 2.13 percent. (See Table 1 on the next page.) Therefore, the State did not achieve budget neutrality.

[1] Although North Carolina has occasionally adjusted the DRG hospital rates for inflation, the State has continued to reduce DRG payments by 7.2 percent each year in accordance with the State's regulation. To illustrate, the State paid $4,193 on a DRG claim with a discharge date of August 2002 because of the 7.2-percent reduction. The State would have paid $4,518 on this claim if it had not reduced the DRG rate.

Table 1: Percentage of Outlier Payments Exceeding Reduction in DRG Payments

State FY	Reduction of DRG Payments To Account for Outliers	Actual Cost and Day Outlier Payments Percentage	Percentage of Outlier Payments Exceeding Reduction in DRG Payments
1998	7.2%	5.50%	–1.70%
1999	7.2%	8.65%	1.45%
2000	7.2%	10.56%	3.36%
2001	7.2%	9.91%	2.71%
2002	7.2%	10.81%	3.61%
2003	7.2%	10.57%	3.37%
Average		**9.33%**	**2.13%**

Increased Charges Raised 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. 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 the outlier payment. In such cases, the higher outlier payments reflect higher charges, not necessarily higher costs.

The four North Carolina hospitals that we reviewed received significantly higher Medicaid cost outlier payments by increasing charges for selected procedures. For example, one hospital (identified as hospital A in Appendix A) received $202,705 in additional Medicaid cost outlier payments by increasing the charge for a single procedure. The hospital increased its daily per patient charge for the nursery intensive care unit from $1,995 to $2,594, a 30-percent increase. If the charge had been limited to an average increase of 4 percent[2] annually (per discharge), the hospital would have received $202,705 less in cost outlier payments during 2001 and 2002.

Some of the other specific charges that increased at the individual hospitals included:[3]

- charges for an insert portable ventilator, which increased 346 percent from $73.50 to $328;
- charges for anendotracheal procedures, which increased 269 percent from $16.25 to $60;
- charges for a Heartmate implantable pneumatic device–left vent system, which increased 247 percent from $45,000 to $156,000;

[2]To calculate the annual rate of inflation, we used the 1998 through 2003 annual Consumer Price Index for Medical Care Services. The annual rate ranged from 3.36 to 5.06 percent.

[3]The hospitals implemented these increases individually (not over a period of time). Over time, the hospitals further increased these charges.

- charges for an anesthesia operating room procedure, which increased 312 percent from $101 to $416; and

- charges for a mounting stand–pedestal style warming blanket, which increased 323 percent from $99 to $419.

By significantly increasing charges for specific procedures that Medicaid patients often use, the hospitals received high levels of Medicaid cost outlier payments. However, the increases did not necessarily have a similar impact on non-Medicaid claims. For example, after hospital A significantly increased charges for specific procedures, the hospital received Medicaid cost outlier payments totaling 22.4 percent of total DRG base payments, compared with 7.6 percent for Medicare cost outlier payments. North Carolina paid the hospital $35.7 million in Medicaid DRG base payments and $10.3 million in Medicaid outlier payments for inpatient services provided in 2001. During the same period, the hospital received $140.3 million in Medicare DRG payments and $11.5 million in Medicare outlier payments.

CAUSES OF EXCESSIVE OUTLIER PAYMENTS

Formula Allowed Hospitals To Receive Higher Outlier Payments

North Carolina's outlier formula allowed hospitals that dramatically increased charges to receive outlier payments for high charges rather than high costs. The formula was intended to convert billed charges to estimated costs. The State estimated the costs of each case by multiplying current charges by a historical cost-to-charge ratio. If the charges multiplied by the hospital cost-to-charge ratio exceeded the outlier threshold, the hospital received an outlier payment. When hospitals dramatically increased charges without a corresponding increase in costs, the formula did not operate as designed. The use of the formula overstated costs and thereby triggered outlier payments for high-charge cases instead of high-cost cases.

On a per discharge basis, DRG base payments increased by only 14.3 percent from State FY 1998 through State FY 2003, while cost outlier payments grew by 128.1 percent. During the same period, total DRG payments grew by only 56.2 percent, while total cost outlier payments increased by 211.6 percent. (See Table 2 on the next page.)

Table 2: Increases in DRG and Cost Outlier Payments

State FY	DRG Payments Amount	DRG Payments Increase Over 1998	Cost Outlier Payments Amount	Cost Outlier Payments Increase Over 1998
1998	$462,234,037		$21,800,549	
1999	557,245,150	20.6%	38,130,208	74.9%
2000	474,335,375	2.6%	38,465,337	76.4%
2001	645,245,418	39.6%	55,109,076	152.8%
2002	692,794,160	49.9%	67,240,755	208.4%
2003	721,799,152	56.2%	67,923,039	211.6%

State Did Not Monitor Outlier Payments

North Carolina did not monitor outlier payments to ensure that they were limited to exceptionally costly cases and to the 7.2-percent reduction in DRG base payments.

Cost outlier payments are intended for exceptionally costly cases, not cases in which hospitals have billed high charges. However, the State did not review outlier payments to determine the reason for the significant increases. Specifically, the State did not review hospital cost reports to identify hospitals whose cost-to-charge ratios had decreased significantly. In addition, the State did not review each hospital's increased charges to identify why particular hospitals had higher levels of outlier payments. Finally, the State did not routinely conduct medical reviews of outlier claims to determine whether procedures were medically necessary and to identify duplicate and other incorrect charges. If the State had monitored these items, it might have identified payment trends demonstrating the need to change the outlier payment policy to limit such payments to exceptionally costly cases.

Furthermore, North Carolina did not attempt to limit outlier payments to the 7.2-percent reduction in DRG base payments. Without such a limit, the State could not attain budget neutrality as its fiscal impact statement projected. Because it did not systematically compare actual outlier payments with the reduction in DRG base payments, the State could not determine whether its methodology effectively limited cost outlier payments to 7.2 percent of DRG base payments.

AMOUNT OF EXCESSIVE OUTLIER PAYMENTS

Because North Carolina did not effectively limit Medicaid cost outlier payments to the 7.2-percent reduction in DRG base payments, outlier payments increased significantly, and the State did not achieve budget neutrality. As a result, the State incurred a total of $89.4 million in additional outlier payments for 5 of the 6 years audited. (See Table 3 on the next page.)

Table 3: Outlier Payments Exceeding Reduction in Aggregate DRG Payments

State FY	Actual DRG Payments	DRG Payments Before 7.2-Percent Reduction[4]	Actual Cost and Day Outlier Payments	Outlier Payments as 7.2 Percent of DRG Payments	Outlier Payments Exceeding 7.2 Percent
1998	$462,234,037	$498,097,022	$27,410,094	$35,862,986	$(8,452,892)
1999	557,245,150	600,479,688	51,936,624	43,234,538	8,702,087
2000	474,335,375	511,137,258	53,971,148	36,801,883	17,169,265
2001	645,245,418	695,307,563	68,888,761	50,062,145	18,826,617
2002	692,794,160	746,545,431	80,729,048	53,751,271	26,977,777
2003	721,799,152	777,800,810	82,198,944	56,001,658	26,197,286
Total	**$3,553,653,292**	**$3,829,367,771**	**$365,134,619**	**$275,714,480**	**$89,420,140**

RECOMMENDATIONS

We recommend that North Carolina revise its current Medicaid outlier payment policy to ensure that future outlier payments achieve budget neutrality. Specifically, North Carolina should consider:

- increasing the amount of the 7.2-percent DRG rate reduction,
- raising the outlier thresholds, and/or
- limiting outlier payments on certain DRGs with high levels of Medicaid utilization.

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

- monitoring DRG and outlier payments to ensure budget neutrality,
- reviewing cost reports to identify hospitals with significant decreases in cost-to-charge ratios,
- reviewing the charge structure of hospitals with high levels of outlier payments to identify possible measures to limit outliers to exceptionally costly cases, and/or
- performing targeted medical reviews of cost outlier claims on a routine basis to determine whether procedures are medically necessary and to identify duplicate and other incorrect charges.

[4]To determine the fiscal impact of not restricting outlier payments to 7.2 percent of total DRG payments, we calculated what the DRG payments would have been without the 7.2-percent reduction. We then determined the aggregate difference between the actual outlier payments and 7.2 percent of the estimated DRG payments; the result was the amount of outlier payments in excess of the 7.2-percent level.

NORTH CAROLINA'S COMMENTS

North Carolina disagreed with the findings and recommendations and stated that it "believe[s] that the OIG [Office of Inspector General] audit report is based on flawed assumptions." North Carolina's comments are included in their entirety as Appendix B.

Budget Neutrality Measures

North Carolina stated that it did not intend for inpatient hospital outlier payments to be budget neutral. North Carolina also stated that the State Medicaid plan made no mention of "budget neutrality" with regard to outlier payments, nor "does [it] limit or restrict the amount of outlier payments to the 7.2-percent reduction in the DRG base payment calculation." In addition, the State had not attempted "to limit or restrict the total amount of outlier payments to the 7.2-percent calculation."

North Carolina acknowledged that hospitals were escalating charge amounts and stated that it would consider revising the State Medicaid plan to increase the 7.2-percent factor and the outlier thresholds. According to North Carolina, it "does monitor high utilization services . . . and develops policies and State plan amendments accordingly . . . ."

Cost Outlier Payment Monitoring

North Carolina disagreed that it should develop policies and procedures to more closely monitor outlier payments. It stated that it monitored all Medicaid payments for all services and believed that the current monitoring/review process was adequate and effective. According to North Carolina, its monitoring activities included comparing budget amounts with actual expenditures, performing program reviews to identify fraud or billing abuse, and performing targeted medical reviews. North Carolina considered the number of targeted claim reviews to be adequate.

North Carolina stated that hospitals with significant decreases in cost-to-charge ratios were subject to audit. North Carolina also said that in State FY 2003, it began updating hospital cost-to-charge ratios annually to reflect the most current cost report data; however, the State noted that it did not do so during most of the audit period.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We continue to believe that our findings and recommendations are valid. We based our findings and recommendations on information that North Carolina provided to us during the audit, as well as Federal regulations and other criteria.

Budget Neutrality Measures

We agree that the State Medicaid plan did not use the specific term "budget neutrality." However, the State's fiscal impact statement, completed prior to the adoption of the DRG and outlier payment system, stated that the new system was projected to be budget neutral and would

not result in additional costs or savings. In its response, the State did not address the contents of its fiscal impact statement. Nevertheless, the State used the statement to demonstrate that the new payment system would be budget neutral. Therefore, we relied on the fiscal impact statement to make our determination about budget neutrality.

The Medicaid State plan and the North Carolina administrative rules required the State to reduce DRG rates by 7.2 percent to account for outlier payments starting in 1995. In State FY 1998, outlier payments accounted for 5.5 percent of DRG payments. However, in subsequent years, outlier payments increased to an average of 9.3 percent of DRG payments.

We continue to recommend that North Carolina revise its current Medicaid outlier payment policy to ensure that future outlier payments meet the objective of budget neutrality.

Cost Outlier Payment Monitoring

We agree that North Carolina allocated significant resources to detect fraud and abuse. However, its monitoring activities did not target hospitals that received high levels of outlier payments. The State did not review hospital cost reports to identify hospitals whose cost-to-charge ratios had decreased significantly.

North Carolina stated in its response that it considered the number of targeted claim reviews to be adequate. However, in its May 2005 response to a related audit entitled "Medicaid Hospital Outlier Payments in North Carolina–Compliance" (A-07-05-04049, issued in June 2005), the State acknowledged that its policies and procedures for monitoring payments "need to be enhanced to address outlier payments, specifically as to threshold amounts, DRG base calculations and outlier payment calculations." North Carolina stated that it planned to develop and implement revised policies and procedures during 2005.

We continue to believe that North Carolina should revise its policies and procedures because the average cost outlier payment per discharge increased by 128.1 percent from State FY 1998 through 2003, whereas the average DRG base payment per discharge increased by only 14.3 percent. Improved policies and procedures will help the State more closely monitor cost outlier payments to ensure that they are restricted to exceptionally high-cost cases.

APPENDIXES

COST OUTLIER PAYMENTS BY HOSPITAL

State Fiscal Year 1998–2003 Data			
Outlier Rank[1]	**Total DRG[2] Base Payments**	**Total Cost Outlier Payments**	**Cost Outlier Payments in Relation to DRG Base Payments[3]**
37	$15,565	$541,800	97.21%
106	4,594	41,719	90.08%
132	2,384	17,810	88.20%
118	3,973	27,814	87.50%
61	23,782	151,735	86.45%
103	7,161	43,923	85.98%
54	30,494	186,068	85.92%
75	18,599	109,568	85.49%
66	23,559	137,573	85.38%
129	3,499	19,430	84.74%
89	12,258	62,961	83.70%
67	27,096	134,851	83.27%
127	4,053	20,096	83.22%
43	68,723	312,446	81.97%
69	32,802	128,789	79.70%
86	21,615	69,205	76.20%
81	25,967	79,105	75.29%
33	200,010	602,175	75.07%
117	10,283	28,457	73.46%
131	6,779	18,189	72.85%
47	99,310	257,568	72.17%
135	7,405	17,302	70.03%
112	14,396	32,328	69.19%
123	11,432	23,679	67.44%
92	40,527	62,722	60.75%
107	26,363	38,136	59.13%
115	22,154	29,941	57.47%
163	6,145	8,214	57.21%
121	22,596	25,325	52.85%
59	146,889	161,598	52.38%

[1]Outlier rank represents the hospital name sorted in descending order by total cost outlier payments.

[2]Diagnosis-related group.

[3]The percentage is total cost outlier payments divided by the sum of total DRG base payments and total cost outlier payments.

State Fiscal Year 1998–2003 Data			
Outlier Rank	**Total DRG Base Payments**	**Total Cost Outlier Payments**	**Cost Outlier Payments in Relation to DRG Base Payments**
144	$12,871	$13,732	51.62%
148	13,852	13,352	49.08%
60	171,168	158,515	48.08%
25	994,895	892,698	47.29%
156	11,470	10,264	47.23%
175	4,959	4,206	45.89%
152	14,754	12,183	45.23%
46	324,248	262,145	44.70%
96	66,497	51,992	43.88%
64	197,694	146,679	42.59%
111	46,976	33,962	41.96%
98	68,725	49,313	41.78%
150	18,400	12,284	40.03%
100	75,531	45,272	37.48%
153	20,823	11,890	36.35%
58	297,599	165,202	35.70%
80	150,596	81,650	35.16%
36	1,032,213	546,801	34.63%
170	10,370	5,436	34.39%
52	425,170	222,240	34.33%
109	70,885	36,562	34.03%
134	34,534	17,360	33.45%
113	80,464	31,756	28.30%
183	7,250	2,728	27.34%
133	49,906	17,659	26.14%
126	60,238	20,267	25.17%
167	19,854	5,552	21.85%
49	962,935	256,300	21.02%
1	255,785,844	61,449,171	19.37%
2 (Hospital A)	227,126,708	50,043,328	18.06%
29	3,468,664	733,424	17.45%
108	176,158	37,213	17.44%
79	396,305	81,980	17.14%
72	572,749	117,062	16.97%
38	2,258,730	457,767	16.85%
191	8,591	1,662	16.21%
116	154,938	28,907	15.72%
179	16,720	3,068	15.50%

State Fiscal Year 1998–2003 Data			
Outlier Rank	**Total DRG Base Payments**	**Total Cost Outlier Payments**	**Cost Outlier Payments in Relation to DRG Base Payments**
90	$362,130	$62,816	14.78%
11	20,604,639	3,560,547	14.73%
55	1,057,257	181,373	14.64%
172	29,789	4,978	14.32%
110	209,717	34,383	14.09%
176	22,179	3,566	13.85%
3 (Hospital B)	314,245,229	46,283,371	12.84%
154	79,811	11,600	12.69%
97	362,157	50,782	12.30%
178	22,494	3,113	12.16%
139	121,124	15,866	11.58%
4	238,628,352	31,169,027	11.55%
185	18,658	2,426	11.51%
171	44,305	5,417	10.90%
165	62,247	7,574	10.85%
5	139,982,466	16,431,235	10.50%
197	5,463	639	10.47%
120	224,365	25,541	10.22%
166	81,553	7,426	8.35%
18	13,949,990	1,246,430	8.20%
13 (Hospital C)	31,307,092	2,629,755	7.75%
136	222,263	16,986	7.10%
159	130,264	9,372	6.71%
94	841,777	57,963	6.44%
23	15,376,020	950,575	5.82%
14	32,139,798	1,944,462	5.70%
7	144,714,043	8,345,956	5.45%
9	110,934,292	6,243,065	5.33%
34	10,227,607	566,641	5.25%
21	17,608,520	970,218	5.22%
15	30,668,723	1,663,262	5.14%
189	39,179	1,956	4.75%
30	13,323,014	663,687	4.75%
8	145,989,516	7,090,582	4.63%
6	268,056,205	12,560,706	4.48%
10	122,981,664	5,762,684	4.48%
27	20,094,786	846,534	4.04%

State Fiscal Year 1998–2003 Data			
Outlier Rank	**Total DRG Base Payments**	**Total Cost Outlier Payments**	**Cost Outlier Payments in Relation to DRG Base Payments**
48	$6,109,028	$257,295	4.04%
181	69,543	2,875	3.97%
20	27,802,307	1,070,043	3.71%
12	101,921,032	3,548,113	3.36%
45	8,526,944	276,968	3.15%
16 (Hospital D)	42,240,016	1,355,444	3.11%
40	12,386,908	385,215	3.02%
17	41,791,203	1,297,737	3.01%
93	1,954,612	59,156	2.94%
32	21,910,184	629,757	2.79%
169	205,509	5,492	2.60%
194	51,710	1,351	2.55%
22	38,820,014	968,027	2.43%
195	52,357	1,240	2.31%
168	240,105	5,519	2.25%
78	3,844,947	84,520	2.15%
31	29,533,243	638,073	2.11%
19	53,242,578	1,137,895	2.09%
180	143,986	2,946	2.00%
124	1,140,932	22,657	1.95%
73	5,890,328	113,949	1.90%
39	23,523,795	438,679	1.83%
193	74,516	1,389	1.83%
91	3,390,267	62,749	1.82%
26	47,464,365	856,135	1.77%
41	21,333,517	381,389	1.76%
24	50,513,489	898,758	1.75%
105	2,522,426	42,750	1.67%
63	8,895,757	149,805	1.66%
87	4,292,894	68,772	1.58%
161	544,555	8,537	1.54%
68	8,352,208	130,135	1.53%
122	1,523,404	23,693	1.53%
141	972,566	14,901	1.51%
50	16,820,480	250,796	1.47%
28	57,115,975	806,349	1.39%
200	21,059	289	1.35%

State Fiscal Year 1998–2003 Data			
Outlier Rank	**Total DRG Base Payments**	**Total Cost Outlier Payments**	**Cost Outlier Payments in Relation to DRG Base Payments**
56	$14,387,978	$181,007	1.24%
42	30,701,021	380,137	1.22%
147	1,087,837	13,398	1.22%
51	18,564,755	224,783	1.20%
57	14,926,822	177,535	1.18%
53	17,818,033	194,251	1.08%
44	30,282,374	294,540	0.96%
71	12,482,224	121,142	0.96%
101	4,846,244	45,042	0.92%
35	61,363,536	547,654	0.88%
164	907,736	8,054	0.88%
77	11,114,613	84,555	0.76%
82	10,731,930	77,101	0.71%
85	10,164,658	70,249	0.69%
65	21,006,927	144,343	0.68%
83	10,412,448	71,450	0.68%
76	14,438,573	93,037	0.64%
70	20,091,634	124,068	0.61%
95	9,860,150	54,784	0.55%
62	27,195,337	150,648	0.55%
74	21,274,031	112,105	0.52%
201	47,473	248	0.52%
84	14,046,989	71,290	0.50%
137	3,491,143	16,464	0.47%
173	994,405	4,520	0.45%
88	14,661,154	65,734	0.45%
196	219,665	961	0.44%
158	2,223,277	9,621	0.43%
142	3,771,411	14,336	0.38%
104	13,106,604	42,933	0.33%
99	15,393,831	48,404	0.31%
188	775,669	2,173	0.28%
145	4,868,303	13,606	0.28%
114	11,297,364	30,124	0.27%
187	987,281	2,362	0.24%
119	11,503,989	26,141	0.23%
128	8,818,320	19,836	0.22%

State Fiscal Year 1998–2003 Data			
Outlier Rank	**Total DRG Base Payments**	**Total Cost Outlier Payments**	**Cost Outlier Payments in Relation to DRG Base Payments**
198	$204,023	$429	0.21%
143	6,772,022	13,909	0.20%
160	4,681,224	8,843	0.19%
138	8,777,114	16,328	0.19%
102	28,624,630	44,224	0.15%
151	8,246,928	12,207	0.15%
125	17,921,140	21,419	0.12%
130	16,081,976	18,476	0.11%
182	2,510,037	2,865	0.11%
184	2,550,871	2,697	0.11%
155	10,712,621	11,156	0.10%
146	13,085,295	13,547	0.10%
162	8,589,392	8,483	0.10%
140	17,673,543	15,855	0.09%
174	5,149,101	4,493	0.09%
199	400,264	337	0.08%
149	15,964,144	12,308	0.08%
177	4,407,994	3,166	0.07%
186	4,070,070	2,410	0.06%
157	20,670,977	9,969	0.05%
192	6,122,623	1,491	0.02%
190	7,899,648	1,689	0.02%
202–610[4]	36,513,774	0	0.00%
Total	**$3,553,653,292**	**$288,668,963**	

[4]Providers ranked 202 through 610 did not receive any cost outlier payments during State fiscal years 1998 through 2003. Therefore, we combined the DRG payments for these providers.

North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

November 1, 2005

Report Number: A-07-04-04038

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
US DHHS Office of Inspector General
601 East 12th Street, Room 284A
Kansas City, Missouri 64106

Dear Mr. Cogley:

We have received your October 7, 2005 letter and the draft report entitled "*Medicaid Hospital Outlier Payments in North Carolina*" [Audit# A-07-04-04038]. Our response to the findings is indicated in the following narrative.

NC DHHS Response

As stated on page one of the draft report, cost outlier payments provide a form of insurance for hospitals against large losses associated with expensive patients. We agree with the report that outlier payments promote access for extremely costly patients. In North Carolina, it is important to consider cost outlier payments within this context of assuring access for the most costly and most vulnerable Medicaid recipients. North Carolina has reviewed and adjusted its threshold amount for determining cost outlier payments in accordance with the CMS approved State Plan. The Department will continue to review medical necessity and quality assurance through our current peer review process. Hospitalization involving outlier payments are subject to post payment review through a sampling methodology. In addition, the methodology for reimbursing cost outlier payments is approved by CMS.

The report makes two recommendations to ensure that future outlier payments achieve budget neutrality. The report also indicates that the State could have saved approximately $89.4 million during the six-year period ending June 30, 2004 had the State modified its outlier reimbursement policy to achieve budget neutrality. In general, we believe that the OIG audit report is based upon flawed assumptions.

OIG Audit Recommendation #1: North Carolina should revise its current Medicaid outlier payment policy to ensure that future outlier payments meet the objective of budget neutrality as intended. To achieve budget neutrality, North Carolina should consider implementing one or more of the following remedies:

- Increasing the amount of the 7.2-percent DRG base payment reduction,
- Raising the cost outlier thresholds, or
- Limiting outlier payments on certain DRGs with high levels of Medicaid utilization

***NC Response**: The Department disagrees with this audit finding/recommendation.*

A. *The State Medicaid Plan makes no mention of "budget neutrality" with regard to outlier payments. As part of its annual budget and DRG rebasing process, the State estimates the amount of outlier payments and reduces DRG base payments by a corresponding amount. However, the amount is an estimate and by definition, an estimate normally varies from the actual amount paid. As a result, there is no attempt made to ensure "budget neutrality" is achieved and the State Medicaid Plan has no such requirement.*

B. *The State Medicaid Plan does <u>not</u> limit or restrict the amount of outlier payments to the 7.2-percent reduction in the DRG base payments calculation. In addition, there has been <u>no</u> attempt by North Carolina to limit or restrict the total amount of outlier payments to the 7.2-percent calculation.*

C. *Historically, approximately 13% of the outlier payments made during the audit period have been distributed to state-owned hospitals, for which all charges are cost-settled per the State Medicaid Plan. These outlier payments have no overall impact with regard to "budget neutrality". A reduction in outlier payments would result in an increase in the cost settlement amount and an increase in outlier payments would result in a decrease in the cost settlement amount. Thus, any recommendation insofar as these facilities are concerned is moot.*

With regard to the specific comments associated with Recommendation #1, the following should be noted:

a) The 7.2 percent DRG base payment reduction can not be changed without a State Plan Amendment. Although the State does revise the reduction of DRG base payment amounts annually as part of the DRG rebasing process, the revised estimate is not submitted to CMS as a State Plan Amendment. However, the Division will consider whether or not it would be prudent to increase the 7.2% factor in view of escalating charge amounts by hospitals. If the Division concludes that such an increase is advisable, it will submit a State Plan Amendment.

b) Cost outlier thresholds are established according to the methodology approved in the State Plan. These thresholds can not be arbitrarily raised (or lowered) without a State Plan Amendment. As a result of the trend of increasing outlier payments, the State Plan methodology will automatically increase the threshold amount for each DRG. Here too, the Division will consider whether outlier thresholds should be adjusted, and if so, it will submit a State Plan Amendment.

c) Limiting outlier payments to certain DRGs with high levels of Medicaid utilization would also require a change in Medicaid policy and a State Plan Amendment. The Department does monitor high utilization services on an on-going basis and develops policies and State Plan Amendments accordingly, on an as-needed basis.

OIG Audit Recommendation #2: The State should develop policies and procedures to more closely monitor cost outlier payments. Specifically, North Carolina could:

- Monitor DRG and outlier payments to ensure budget neutrality,
- Review cost reports to identify hospitals with significant decreases in cost-to-charge ratios,
- Review the charge structure of hospitals with high levels of outlier payments to identify possible measures to limit outliers to exceptionally costly cases, and
- Perform targeted medical reviews of cost outlier claims on a routine basis to determine whether procedures are medically necessary and to identify duplicate and other incorrect charges.

***NC Response**: The Department disagrees with this audit finding/recommendation.*

A. *The Department does monitor all Medicaid payments for all services, including DRG payments and outlier payments. The monitoring activities include, but are not limited to, the following:*

- *The Budget Management Section of the Division of Medical Assistance prepares budgets and forecasts for all Medicaid expenditures and compares/ monitors actual expenditures with budget/forecast amounts.*
- *The Program Integrity Section is staffed with 104 employees who conduct claim and program reviews to identify areas of error, incorrect payments, possible fraud or billing abuse, or follow-up where corrective action is required.*
- *The Attorney General's Office – Medicaid Investigations Unit, in cooperation with Program Integrity, monitors, investigates and prosecutes cases having suspected criminal activity.*
- *The Department contracts with Medical Review of North Carolina to perform targeted medical reviews of claims and medical charts, on a sample basis, to determine the propriety and allowability of selected claims.*
- *A system edit in MMIS flags all large dollar claims for manual review by MMIS contractor staff.*
- *The Office of the State Auditor reviews, on a sample basis, selected claims which may include cost outliers.*

Results of all these monitoring processes, with the possible exception of criminal investigations, are discussed by DHHS management and communicated, along with recommendations, to the State Legislature. Although most monitoring processes always can be improved, we believe that the monitoring/review process currently in place is adequate and effective.

B. *Hospitals with significant decreases in cost-to-charge ratios are subject to review and audit. The Division has taken steps to ensure that its cost-to-charge ratio information is kept current in the MMIS+ system. Beginning with the State fiscal year 2003, hospital cost-to-charge ratios used to process outlier claims are updated annually in the MMIS+ system to reflect the most current cost report data. It should be noted that this was not the case during most of the period under review. Further reviews are currently limited*

by budgetary constraints. For state-owned facilities, reviews of possible measures to limit outliers would not effect overall cost settlements for reasons indicated above. For the cost outliers of non-state owned facilities, there are already measures in place in accordance with the State Plan for determining thresholds.

C. The Department does perform targeted reviews of claims to determine medical necessity through its contractor, Medical Review of North Carolina, and the number of reviews currently being performed is considered adequate.

We trust that the foregoing responses address the report recommendations. If additional information is needed, please contact Dan Stewart, Assistant DHHS Secretary at (919) 733-4534 or Dan.Stewart@ncmail.net. Lastly, even though we disagree on several basic issues, we would like to state that the OIG staff were very professional to deal with and appreciate the review. We are always interested in studying various options to improve our Medicaid Program.

Sincerely,

Carmen Hooker Odom

CHO:ds

Cc: Dan Stewart, CPA
L. Allen Dobson Jr., M.D.
Mark Benton
Eddie Berryman, CPA
Laketha Miller, CPA
Honorable Les Merritt, CPA