DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

MAY 12 2006

Report Number: A-04-04-00009

Ms. Carie Summers
Chief Financial Officer
Georgia Department of Community Health
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

Dear Ms. Summers:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Georgia's Medicaid Cost Outlier Payments." A copy of this report will be forwarded to the action official noted below for his 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.

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If you have any questions or comments about this report, please do not hesitate to call me or have your staff contact Peter Barbera, Audit Manager at (404) 562-7758 or through e-mail at peter.barbera@oig.hhs.gov. To facilitate identification, please refer to report number A-04-04-00009 in all correspondence.

Sincerely,

Lori S. Pilcher
Regional Inspector General
for Audit Services, Region IV

Enclosures

Direct Reply to HHS Action Official:

Mr. Renard L. Murray, D.M.
Associate Regional Administrator
Division of Medicaid and Children's Health
U.S. Department of Health and Human Services
61 Forsyth Street, S.W., Suite 4T20
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF GEORGIA'S MEDICAID COST OUTLIER PAYMENTS

Daniel R. Levinson
Inspector General

MAY 2006
A-04-04-00009

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Georgia Medicaid Payments

The Georgia Department of Community Health (the State agency) pays hospitals for Medicaid inpatient services through a hybrid diagnosis-related group (DRG) prospective payment system. Most cases are reimbursed using a DRG per case rate. 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 agency 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 Georgia Medicaid outlier policy is similar to the initial Medicare outlier policy. However, the Medicare program adopted new regulations in 2003 to address vulnerabilities that resulted in excessive payments to certain hospitals that were aggressively increasing charges. Because of these increases, the Centers for Medicare & Medicaid Services (CMS) outlier formula overestimated the hospitals' costs, and CMS paid approximately $9 billion in excessive Medicare outlier payments from 1998 through 2002 for cases that should not have qualified as extraordinarily high-cost cases.

OBJECTIVE

Our objective was to determine whether Georgia's method of computing inpatient hospital cost outlier payments effectively limited outlier payments to high-cost cases.

SUMMARY OF FINDINGS

Georgia's method of computing inpatient hospital cost outlier payments did not effectively limit outlier payments to high-cost cases. Instead of applying a current cost-to-charge ratio (costs divided by charges) to current billed charges from July 1998 through December 2002, the State agency applied an outdated cost-to-charge ratio to current billed charges, thus increasing cost outlier payments.

The calculation of inpatient cost outlier payments includes applying the cost-to-charge ratio to current billed charges. During the audit period, actual cost-to-charge ratios steadily declined as current billed charges increased, which should have resulted in lower outlier payments. However, except for making an adjustment in 2002, the State agency kept outlier payments artificially high by not updating cost-to-charge ratios at a pace commensurate with increasing hospital charges.

The State agency relied on historical cost-to-charge ratios because its State plan amendments required the use of audited cost report data to calculate cost-to-charge ratios. Audited cost reports typically run about 4 years behind the current year. Thus, the State agency relied on outdated cost-to-charge ratios in determining outlier payments.

If the State agency continues to use outdated cost-to-charge ratios, it is likely that cost outlier payments will continue to increase as hospitals increase charges faster than costs. Had the State agency applied current cost-to-charge ratios to convert billed charges to costs, it could have saved approximately $22.7 million in cost outlier payments between 1998 and 2002 at the three hospitals reviewed. We believe that additional savings exist at other hospitals.

RECOMMENDATION

We recommend that the State agency amend its Medicaid State plan to require that the data for calculating cost-to-charge ratios be based on submitted cost reports instead of audited cost reports.

STATE COMMENTS

The State will begin using submitted cost reports to calculate its cost-to-charge ratios as of October 1, 2006. The State will amend its Medicaid State plan to reflect this change. The State's complete response is included as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

We agree with the State's proposed changes and revisions.

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INTRODUCTION

BACKGROUND

Medicaid Program

Title XIX of the Social Security Act established Medicaid in 1965 as a joint Federal and State program. Medicaid provides medical assistance to low-income persons who are age 65 or over, blind, or disabled; to 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 that the Centers for Medicare & Medicaid Services (CMS) approves. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.

The Georgia Department of Community Health (the State agency) administers the State's Medicaid program.

Outlier Payments and the Prospective Payment System

The State agency pays hospitals for Medicaid inpatient stays using a hybrid prospective payment system that includes a preestablished 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 base payment is fixed. Congress established Medicare 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. To compensate hospitals when they incur significantly high costs for Medicaid patients, the State agency similarly pays outlier payments to help defray these extra costs. The outlier policy promotes access to care for extremely costly patients who would otherwise be financially unattractive.

Historically, the State agency used a formula similar to the Medicare formula to calculate Medicaid cost outlier payments. The formulas are similar in that both begin with a DRG payment, both have thresholds that must be met, and both allow outlier payments for high-cost cases. If the total cost for services rendered on a claim exceeds the threshold amount, the claim is eligible for an outlier payment. The Medicaid cost outlier payment is normally equal to 90 percent of the unreimbursed allowable costs after the base payment.

The outlier determination depends on the cost of services. Because hospitals cannot calculate the exact cost for each admission, the State agency must convert billed charges to estimated costs using a predetermined cost-to-charge ratio to determine whether 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.

Potential Problems With the Cost-to-Charge Ratio

As long as hospital costs and charges change at roughly the same rate, estimating costs using the hospital-specific cost-to-charge ratio produces a reliable result. Over time, the cost-to-charge

ratio will reflect the changes in the costs and charges. However, when a hospital dramatically increases its charges relative to costs and the State agency does not routinely update the cost-to-charge ratio, the estimated costs may not reflect actual operating costs. Using a substantially inflated cost-to-charge ratio will yield higher outlier payments than would be appropriate because the outlier payments could be triggered by higher charges and not by higher costs.

Nationally, hospitals have steadily increased charges in relation to costs since the mid-1980s. The increase in charges 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 been increasing 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 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 recently settled or tentatively settled cost report. Using the cost-to-charge ratios from tentatively settled cost reports reduces the time lag 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 potential adjustment could ensure that the outlier payment appropriately reflects the hospital's true costs of providing care.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Georgia's method of computing inpatient hospital cost outlier payments effectively limited outlier payments to high-cost cases.

Scope

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

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

[2]CMS determined that hospital charges increased 7.63 percent and 10 percent in 2000 and 2001, respectively, and that these rates were higher than rates of hospital cost increases (Federal Register, volume 67, No. 148, page 50124, dated August 1, 2002).

We limited our review to the 93 Georgia hospitals that received cost outlier payments (see Appendix A). Our audit period covered outlier payments made from July 1998 through December 31, 2002. During this period, the State agency paid the 93 hospitals about $4.8 billion in DRG base payments and $245.9 million in cost outlier payments.

We used hospital cost reports for fiscal years (FYs)1998 through 2003 and other statistical information from the State agency to identify trends in hospital charges, costs, and outlier payments. We judgmentally selected three hospitals for onsite reviews on the basis of high cost outlier payments, type of hospital, and percentage increase in cost outlier payments. We also selected two other hospitals that had similar attributes and requested certain information from the hospitals. We made no site visits to these two other hospitals.

We did not perform a detailed review of State agency or provider internal controls because the audit objectives did not require us to do so. The State agency provided a report of the Medicaid outlier paid claims used in our review. The State agency extracted these paid-claims data from its files. To validate the accuracy of the data, we reconciled 90 electronic claims from the State agency to detailed claim documentation at the 3 hospitals that we visited.

We performed the audit at the State agency in Atlanta, Georgia, and at three Georgia hospitals.

Methodology

We conducted interviews and reviewed documentation at the State agency to determine how the State agency calculated and monitored cost outlier payments. The State agency provided a list of hospitals receiving DRG base and cost outlier payments. We used this list to identify three hospitals that received a high percentage of, and showed high growth in, cost outlier payments. We also reviewed the meeting minutes of the hospitals' boards of directors and interviewed department managers to determine how the hospitals set procedure charges.

To quantify the effect of high charges on cost outlier payments at the three hospitals, we recalculated each outlier payment using the cost-to-charge ratio from the hospitals' Medicaid "as submitted" cost reports. Specifically, we replaced the cost-to-charge ratio in the cost outlier formula with the cost-to-charge ratio from the cost report pertaining to the discharge date. For example, for a cost outlier payment with a discharge date of September 1, 2000, we recomputed the cost outlier payment using the cost-to-charge ratio from the hospital's cost report period that included the date of discharge instead of the historical cost-to-charge ratio (from the 1994 cost report) that the State agency used.

Because we intentionally selected 3 hospitals that received high levels of outlier payments, the potential cost savings that we computed for these hospitals may not be representative of the 90 other hospitals in our review. Therefore, we did not project or extrapolate our results to those hospitals.

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

FINDINGS AND RECOMMENDATION

Georgia's method of computing inpatient cost outlier payments did not effectively limit outlier payments to high-cost cases. Instead of applying a current cost-to-charge ratio to current billed charges from July 1998 through December 2002, the State agency applied an outdated cost-to-charge ratio to current billed charges, thus increasing cost outlier payments.

The calculation of inpatient cost outlier payments includes applying the cost-to-charge ratio to current billed charges. During the audit period, actual cost-to-charge ratios steadily declined as current billed charges increased, which should have resulted in lower outlier payments. However, except for making an adjustment in 2002, the State agency kept outlier payments artificially high by not updating cost-to-charge ratios at a pace commensurate with increasing hospital charges.

The State agency relied on historical cost-to-charge ratios because its State plan amendments (SPAs) required the use of audited cost report data to calculate cost-to-charge ratios. Audited cost reports typically run about 4 years behind the current year. Thus, the State agency relied on outdated cost-to-charge ratios in determining outlier payments.

If the State agency continues to use outdated cost-to-charge ratios, it is likely that cost outlier payments will continue to increase as hospitals increase charges faster than costs. Had the State agency applied current cost-to-charge ratios to convert billed charges to costs, it could have saved approximately $22.7 million in cost outlier payments between 1998 and 2002 at the three hospitals reviewed. We believe that additional savings exist at other hospitals.

STATE REQUIREMENTS

State guidelines indicate that outlier payments are based on costs and are intended for high-cost cases:

- Georgia's SPAs 98-09 and 02-008 include provisions for cost outlier reimbursements. The SPAs specify the cost report as the source of data used to calculate outliers.

- The Georgia Department of Community Health "Policies and Procedures for Hospital Services Manual," part II, section 1001.8, "Reimbursement for Outlier Cases," states: "All outlier cases under the hybrid-DRG system are determined based on cost."

- The manual (section 1001.8A) also states that high-cost DRGs will be reimbursed a supplemental amount based on 90 percent of the cost differential between the DRG base rate and the actual cost of the case.

In addition, Georgia's SPAs 98-09 and 02-008 both state that audited cost reports should be the data source for calculating prospective payment rates.

COST OUTLIER PAYMENTS NOT LIMITED TO HIGH-COST CASES

Georgia did not effectively limit cost outlier payments to high-cost cases. The State applied a historical cost-to-charge ratio, which did not reflect recent increases in hospital charges, to current billed charges, thus increasing cost outlier payments. The State's method allowed the three hospitals that we reviewed to increase their outlier payments through increases in charges rather than costs (see Appendix B).

With only two exceptions, current cost-to-charge ratios at the three hospitals reviewed were lower than the historical ratios that the State used to determine outlier payments during our audit period. Table 1 compares the State's historical ratios with the ratios that we calculated using current cost report data.

Table 1: Historical Ratios Versus Current Ratios

Year	Hospital A		Hospital B		Hospital C	
	Historical Ratio	Current Cost Report Ratio	Historical Ratio	Current Cost Report Ratio	Historical Ratio	Current Cost Report Ratio
1999	54.0%	41.5%	52.8%	56.3%	51.2%	44.3%
2000	54.0%	24.3%	52.8%	50.0%	51.2%	38.5%
2001	54.0%	25.7%	52.8%	49.2%	51.2%	35.6%
2002	54.0%	17.9%	52.8%	50.7%	51.2%	36.9%
2003	48.5%	19.0%	56.7%	50.1%	44.9%	44.9%

As discussed later in this report, the use of historical cost-to-charge ratios resulted in significantly higher cost outlier payments than would have occurred if the State agency had used more current cost-to-charge ratios.

OUTDATED COST-TO-CHARGE RATIOS

The State agency relied on historical cost-to-charge ratios because its SPAs required the use of audited cost report data, which run about 4 years behind the current year, to calculate the ratios. Thus, the State agency relied on outdated cost-to-charge ratios in determining outlier payments. For example, in 1998, the State agency updated its cost-to-charge ratios based on 1994 cost reports. The State agency used the resulting 1994 cost-to-charge ratios to calculate outlier payments from 1998 through June 2002. Thus, 1994 data were in use for 48 months of our 54-month audit period (1998–2002). This reliance on outdated cost-to-charge ratios created a loophole for hospitals to exploit by increasing charges.

EXCESSIVE OUTLIER PAYMENTS

The State agency's cost outlier payments increased significantly without assurance that the payments were directed toward high-cost cases. The State agency's methods allowed the three hospitals in our review to receive approximately $22.7 million in outlier payments that the hospitals would not have received had the State agency used current cost-to-charge ratios. Table 2 demonstrates the financial effect on the three hospitals after we revised the outlier payments to reflect updated cost-to-charge ratios.

Table 2: Financial Effect of Using Current Versus Historical Ratios

Provider	Total Number of Outlier Claims	Claims Ineligible for Outlier Payments	Claims Subject to Reduced Outlier Payments	Total Reduction in Outlier Payments
Hospital A	354	245	109	$16,514,433
Hospital B	560	26	534	1,296,306
Hospital C	147	55	92	4,934,109
Total	**1,061**	**326**	**735**	**$22,744,848**

Had the State agency used a current cost-to-charge ratio for the three hospitals, their outlier payments would have been reduced.

RECOMMENDATION

We recommend that the State agency amend its Medicaid State plan to require that the data for calculating cost-to-charge ratios be based on submitted cost reports instead of audited cost reports.

STATE COMMENTS

The State is rebasing its Medicaid DRGs with an implementation date of October 1, 2006. As part of this rebasing, the State will use FY 2004 cost report data, which will be based on submitted cost reports, to calculate cost-to-charge ratios. The State will amend the Medicaid State plan to reflect this change. The State's complete response is included as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

We agree with the State's proposed changes and revisions.

APPENDIXES

COST OUTLIER PAYMENTS BY HOSPITAL

July 1, 1998–December 31, 2002

Outlier Rank	Total Base Payment[1]	Total Cost Outlier	Total Medicaid Reimbursement[2]	Cost Outlier in Relation to Base Payment[3]	Type
1	$219,445	$76,037	$295,482	34.65%	Urban
2	27,176,019	7,866,955	35,042,974	28.95%	Urban
3	6,234,090	1,776,151	8,010,241	28.49%	Urban
4	48,687,015	12,844,747	61,531,762	26.38%	Urban
5	19,311,610	4,812,710	24,124,320	24.92%	Urban
6	36,364,199	8,295,708	44,659,907	22.81%	Urban
7	162,819,054	33,749,403	196,568,457	20.73%	Urban
8 (Hospital A)	121,548,047	21,233,022	142,781,069	17.47%	Urban
9 (Hospital B)	247,993,633	37,275,037	285,268,670	15.03%	Urban
10 (Hospital C)	75,548,353	10,598,461	86,146,814	14.03%	Urban
11	425,263	59,075	484,338	13.89%	Urban
12	9,708,823	1,236,250	10,945,074	12.73%	Urban
13	7,586,505	869,110	8,455,614	11.46%	Urban
14	10,240,016	976,378	11,216,394	9.53%	Urban
15	15,815,945	1,385,030	17,200,975	8.76%	Urban
16	55,319,922	4,740,990	60,060,912	8.57%	Urban
17	17,612,958	1,496,455	19,109,413	8.50%	Urban
18	19,950,988	1,630,702	21,581,690	8.17%	Urban
19	7,542,791	529,072	8,071,864	7.01%	Urban
20	1,997,423	137,982	2,135,405	6.91%	Urban
21	3,932,039	247,896	4,179,935	6.30%	Urban
22	10,435,822	649,179	11,085,001	6.22%	Urban
23	311,911,992	16,001,920	327,913,912	5.13%	Urban
24	103,230,285	5,226,100	108,456,385	5.06%	Urban
25	1,994,292	100,128	2,094,420	5.02%	Urban
26	78,801,902	3,638,034	82,439,936	4.62%	Urban
27	239,811,644	10,690,475	250,502,119	4.46%	Urban
28	134,296,892	5,576,035	139,872,927	4.15%	Urban
29	37,780,206	1,549,890	39,330,097	4.10%	Rural
30	6,927,596	268,395	7,195,990	3.87%	Urban
31	13,816,463	528,575	14,345,038	3.83%	Urban
32	95,367,026	3,515,373	98,882,400	3.69%	Urban
33	15,971,886	524,991	16,496,877	3.29%	Urban

[1]The total base payment includes regular Medicaid claims and disproportionate share hospital payments.

[2]Total Medicaid reimbursement equals total base payments plus outlier payments.

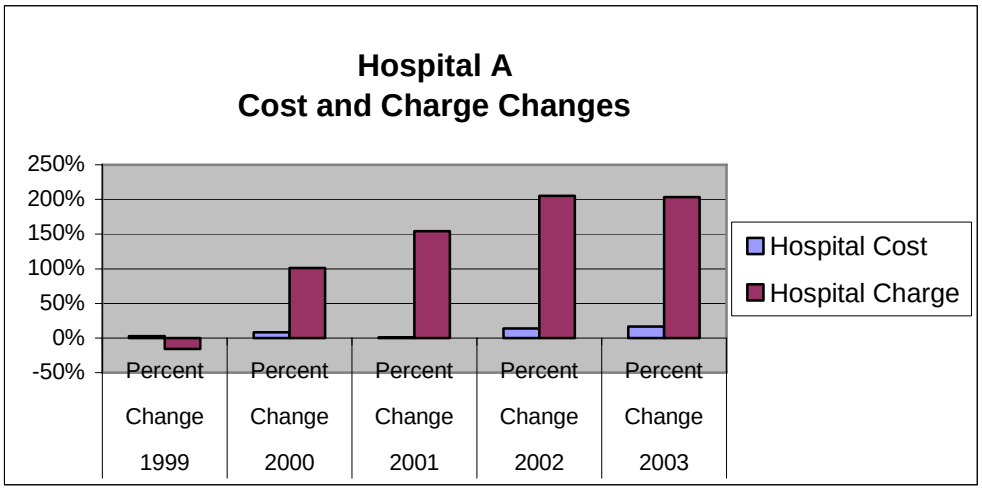
[3]The cost outlier in relation to base payment equals the total cost outlier divided by total Medicaid reimbursement.

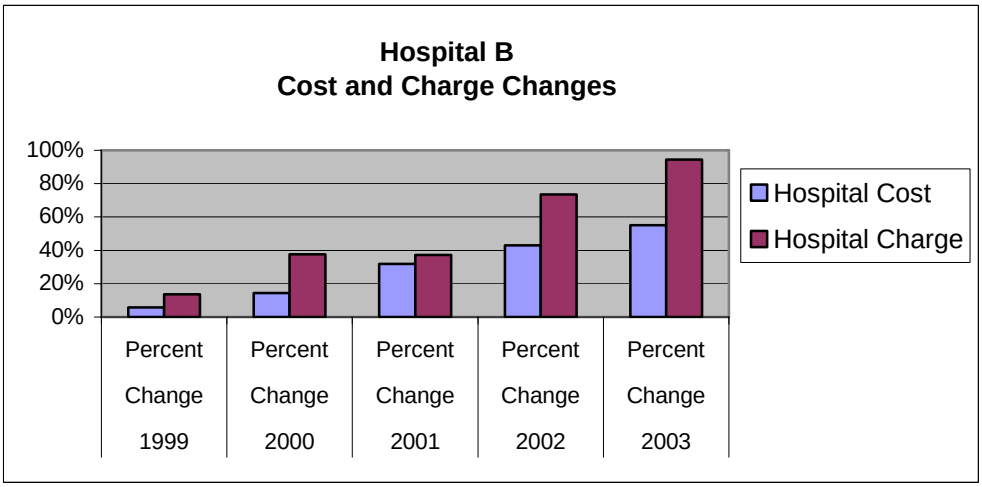
Outlier Rank	Total Base Payment[1]	Total Cost Outlier	Total Medicaid Reimbursement[2]	Cost Outlier in Relation to Base Payment[3]	Type
34	12,995,814	425,508	13,421,322	3.27%	Urban
35	10,939,519	336,728	11,276,248	3.08%	Rural
36	25,214,360	771,667	25,986,028	3.06%	Urban
37	51,123,435	1,412,543	52,535,978	2.76%	Urban
38	$18,219,754	$492,631	$18,712,385	2.70%	Urban
39	210,207,508	5,598,670	215,806,178	2.66%	Urban
40	23,952,170	635,473	24,587,643	2.65%	Urban
41	10,308,363	273,008	10,581,372	2.65%	Urban
42	16,149,409	403,306	16,552,715	2.50%	Urban
43	25,870,219	630,888	26,501,106	2.44%	Urban
44	2,634,189	58,243	2,692,432	2.21%	Urban
45	67,723,923	1,419,474	69,143,397	2.10%	Urban
46	830,607,087	16,802,647	847,409,735	2.02%	Urban
47	10,888,457	219,879	11,108,336	2.02%	Urban
48	74,880,650	1,507,725	76,388,375	2.01%	Rural
49	46,550,541	903,718	47,454,259	1.94%	Urban
50	5,380,820	103,030	5,483,850	1.91%	Urban
51	23,256,130	443,703	23,699,833	1.91%	Urban
52	36,332,561	678,518	37,011,079	1.87%	Urban
53	12,709,730	226,969	12,936,699	1.79%	Urban
54	91,361,558	1,555,402	92,916,960	1.70%	Urban
55	60,746,976	1,008,054	61,755,030	1.66%	Urban
56	17,254,099	272,192	17,526,290	1.58%	Urban
57	133,921,435	2,103,610	136,025,045	1.57%	Urban
58	6,441,156	98,977	6,540,132	1.54%	Urban
59	2,447,996	35,416	2,483,413	1.45%	Rural
60	2,394,721	34,355	2,429,076	1.43%	Urban
61	63,439,003	884,019	64,323,022	1.39%	Urban
62	25,422,360	334,952	25,757,312	1.32%	Urban
63	94,508,692	1,180,586	95,689,278	1.25%	Urban
64	38,345,243	470,177	38,815,420	1.23%	Rural
65	42,631,673	513,090	43,144,763	1.20%	Urban
66	52,632,041	592,687	53,224,728	1.13%	Urban
67	22,644,470	253,815	22,898,285	1.12%	Urban
68	5,104,185	50,927	5,155,112	1.00%	Urban
69	2,387,184	23,368	2,410,552	0.98%	Urban
70	3,097,192	29,398	3,126,590	0.95%	Rural
71	37,505,204	336,728	37,841,932	0.90%	Rural
72	3,183,186	27,268	3,210,453	0.86%	Urban
73	25,582,690	203,769	25,786,459	0.80%	Urban

Outlier Rank	Total Base Payment[1]	Total Cost Outlier	Total Medicaid Reimbursement[2]	Cost Outlier in Relation to Base Payment[3]	Type
74	$18,843,695	$148,516	$18,992,211	0.79%	Urban
75	16,472,403	126,545	16,598,947	0.77%	Rural
76	11,046,357	83,685	11,130,043	0.76%	Urban
77	63,063,000	469,997	63,532,997	0.75%	Rural
78	32,973,431	185,092	33,158,523	0.56%	Rural
79	17,242,347	80,291	17,322,639	0.47%	Urban
80	4,969,491	21,433	4,990,924	0.43%	Rural
81	9,526,711	30,242	9,556,953	0.32%	Rural
82	33,891,245	104,421	33,995,665	0.31%	Rural
83	11,563,580	33,583	11,597,163	0.29%	Rural
84	13,656,752	38,156	13,694,909	0.28%	Rural
85	29,962,774	75,776	30,038,550	0.25%	Rural
86	41,486,106	100,714	41,586,820	0.24%	Rural
87	25,926,995	61,383	25,988,378	0.24%	Rural
88	7,214,095	16,816	7,230,911	0.23%	Rural
89	21,462,988	46,570	21,509,558	0.22%	Urban
90	13,565,862	25,636	13,591,498	0.19%	Rural
91	106,750,542	184,338	106,934,880	0.17%	Urban
92	33,978,313	53,587	34,031,900	0.16%	Rural
93	41,689,947	41,978	41,731,925	0.10%	Urban
Total	**$4,813,396,884**	**$245,856,545**	**$5,059,253,429**	**5.11%**	

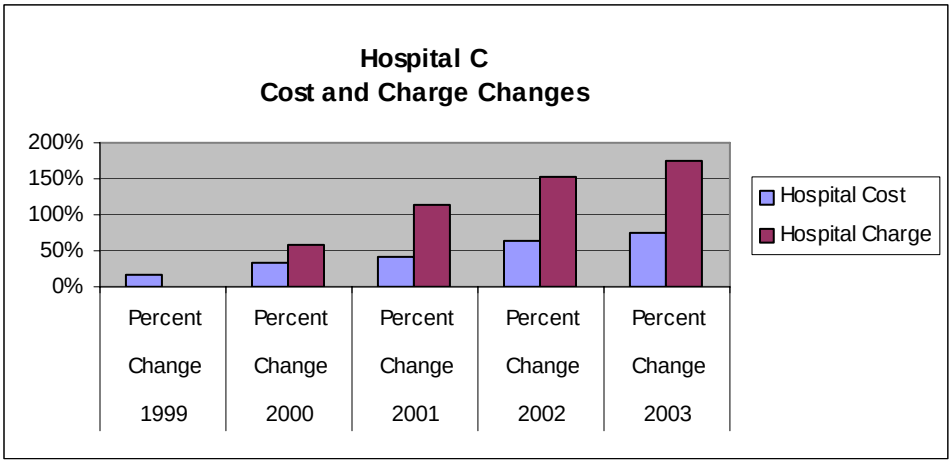
COST AND CHARGE CHANGES AT THE SAMPLED HOSPITALS

We used the hospitals' fiscal year 1998 cost report data as a constant base year in this analysis. The percent of change each year is in relation to the 1998 data.





COST AND CHARGE CHANGES AT THE SAMPLED HOSPITALS



APPENDIX C

GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Rhonda M. Medows, MD, Commissioner

Sonny Perdue, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

April 21, 2006

Ms. Lori S. Pilcher
Regional Inspector General for Audit Services, Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Re: Report Number A-04-04-00009

Dear Ms. Pilcher:

We have reviewed your letter, dated March 29, 2006, and accompanying draft report entitled "Review of Georgia's Medicaid Cost Outlier Payments".

As requested, we would like to comment on our actions related to your recommendation. In line with your recommendation, the Department of Community Health is rebasing its Medicaid Diagnosis Related Groupings (DRGs) with an implementation date of October 1, 2006. As part of this rebasing, the FY 04 cost report data will be utilized for calculating cost-to-charge ratios which will be based on submitted cost reports. The Medicaid State plan will be amended to reflect this change.

We appreciate the opportunity to respond to this draft report. If you need further information, please contact Alan Sacks, Audit Coordinator, at (404) 657-7113.

Sincerely,

Carie Summers

Carie Summers
Chief Financial Officer

C: Rhonda M. Medows, MD
Jim Connolly
Alan Sacks