DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

MAR - 1 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: Review of Ohio's Medicaid Hospital Outlier Payments for State Fiscal Years 2000 Through 2003 (A-05-04-00064)

Attached is an advance copy of our final report on Ohio's Medicaid hospital outlier payments for State fiscal years 2000 through 2003. We will issue this report to the Ohio Medicaid agency within 5 business days. We conducted the audit as part of a multistate review of State Medicaid outlier payments.

Ohio pays hospitals for Medicaid inpatient admissions under a prospective payment system that includes preestablished, fixed amounts for each admission based on diagnosis-related group (DRG) codes. The State makes outlier payments to hospitals to help cover significantly higher costs for certain inpatient admissions. The outlier payment policy is intended to promote access to care for extremely costly patients.

In Ohio, a hospital inpatient admission qualifies as an outlier if it exceeds certain cost or charge thresholds. The State pays each cost outlier under one of three methods. Two methods use cost-to-charge ratios from recent cost reports to convert the billed outlier charges to outlier payments. The third method uses fixed cost-to-charge ratios of 0.60 or 0.80, depending on the DRG, to convert the billed charges. The fixed ratios were enacted through State legislation prior to our audit period and have not been updated.

Our objective was to determine whether Ohio's methods of computing inpatient cost outlier payments were reasonable.

Ohio's "fixed ratio" method of computing inpatient cost outlier payments was not reasonable. Instead of using recent cost-to-charge ratios, Ohio used outdated fixed ratios to convert allowable billed charges to outlier payments. During State fiscal years 2000 through 2003, cost outlier payments to hospitals under this method exceeded estimated costs calculated using recent hospital-specific cost-to-charge ratios by about $24.7 million ($14.5 million Federal share). Because these payments did not reflect an efficient and economical application of payment methodology, as section 1902(a)(30)(A) of the Social Security Act requires, they were not reasonable. Ohio's two other methods of computing cost outlier payments were reasonable.

We recommend that the Ohio Department of Job and Family Services work with the State legislature to revise the State's "fixed ratio" cost outlier payment method to ensure that payments to hospitals do not exceed the costs calculated through the application of current cost-to-charge ratios.

In its comments on our draft report, Ohio stated that action has already been taken to incorporate the use of hospital-specific cost-to-charge ratios into Ohio's Medicaid hospital outlier reimbursement policy effective January 1, 2006. Ohio also stated that a related State plan amendment is currently pending before the Centers for Medicare & Medicaid Services.

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 Paul Swanson, Regional Inspector General for Audit Services, Region V, at (312) 353-2618.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

Report Number: A-05-04-00064

MAR - 3 2006

Mr. Robert Ferguson
Deputy Director
Office of Chief Inspector
30 East Broad Street, 32nd Floor
Columbus, Ohio 43215-3414

Dear Mr. Ferguson:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Ohio's Medicaid Hospital Outlier Payments for State Fiscal Years 2000 through 2003." A copy of this report will be forwarded to the action official noted below 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. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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Please refer to report number A-05-04-00064 in all correspondence.

Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Ms. Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare & Medicaid Services
Department of Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OHIO'S MEDICAID HOSPITAL OUTLIER PAYMENTS FOR STATE FISCAL YEARS 2000 THROUGH 2003

Daniel R. Levinson
Inspector General

MARCH 2006
A-05-04-00064

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

Medicaid Outlier Payments and the Prospective Payment System

Ohio pays hospitals for Medicaid inpatient admissions under a prospective payment system that includes preestablished, fixed amounts for each admission based on diagnosis-related group (DRG) codes. The State makes outlier payments to hospitals to help cover significantly higher costs for certain inpatient admissions. The outlier payment policy is intended to promote access to care for extremely costly patients.

In Ohio, a hospital inpatient admission qualifies as a cost outlier if it exceeds certain cost or charge thresholds. The State pays each cost outlier under one of three methods. Two methods use cost-to-charge ratios from recent hospital cost reports to convert the billed outlier charges to outlier payments. The third method uses fixed cost-to-charge ratios of 0.60 or 0.80, depending on the DRG, to convert the billed charges. The fixed ratios were enacted through State legislation prior to our audit period and have not been updated.

The Ohio Department of Job and Family Services administers the State's Medicaid program.

Medicare Outlier Payments

Ohio's Medicaid outlier policy was designed to be similar to the Medicare outlier policy. However, Medicare adopted new regulations in 2003 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 Ohio's methods of computing inpatient cost outlier payments were reasonable.

SUMMARY OF FINDINGS

Ohio's "fixed ratio" method of computing inpatient cost outlier payments was not reasonable. Instead of using recent cost-to-charge ratios, Ohio used outdated fixed ratios to convert allowable billed charges to outlier payments. During State fiscal years 2000 through 2003, cost outlier payments to hospitals under this method exceeded estimated costs calculated using recent hospital-specific cost-to-charge ratios by about $24.7 million ($14.5 million Federal share). Because these payments did not reflect an efficient and economical application of payment methodology, as section 1902(a)(30)(A) of the Social Security Act requires, they were not reasonable.

The two other methods of computing cost outlier payments were reasonable.

RECOMMENDATION

We recommend that the Ohio Department of Job and Family Services work with the State legislature to revise the State's "fixed ratio" cost outlier payment method to ensure that payments to hospitals do not exceed the costs calculated through the application of current cost-to-charge ratios.

STATE'S COMMENTS

Ohio agreed, stating that action has already been taken to incorporate the use of hospital-specific cost-to-charge ratios into Ohio's Medicaid hospital outlier reimbursement policy effective January 1, 2006. Ohio also stated that a related State plan amendment is currently pending before CMS. We have attached the State's comments in their entirety as an appendix.

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INTRODUCTION

BACKGROUND

Medicaid Program

Title XIX of the Social Security Act (the 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, 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 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 determines eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. The Ohio Department of Job and Family Services administers the State's Medicaid program.

Outlier Payments and the Prospective Payment System

Ohio pays hospitals for Medicaid inpatient admissions using a prospective payment system that includes a preestablished amount for each admission 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. To compensate hospitals that incur significantly higher costs for Medicaid patients, the State established outlier payments similar to those enacted for Medicare. Congress established Medicare outlier payments for situations in which the costs of treating a Medicare patient are extraordinarily high in relation to the average costs of treating comparable conditions or illnesses. These outlier policies are intended to promote access to care for patients with extremely costly illnesses.

Ohio Medicaid Cost Outlier Payments

Ohio's Administrative Code, section 5101:3-2-07.9, and the approved State plan, Attachment 4.19-A, authorize Medicaid cost outlier payments to supplement base DRG payments to hospitals that provide extraordinarily high-cost services. These criteria define the cost outlier qualification requirements and describe the reimbursement methodology.

Historically, Ohio has relied on a Medicaid outlier payment formula similar to the Medicare outlier payment formula. A hospital inpatient stay qualifies as a cost outlier when it exceeds certain cost or charge thresholds.[1] The State establishes and updates these threshold amounts and calculates and pays all cost outliers. Hospitals do not need to take any action beyond routine billing for services.

Ohio pays for each cost outlier hospital admission using one of three methods. Two methods use cost-to-charge ratios from recent cost reporting periods (tentatively settled cost reports) to calculate the outlier payment amounts. Ohio derives the ratios by dividing a hospital's total costs

[1]Ohio also pays day outliers when the length of certain hospital stays exceeds a threshold. We did not include day outliers in our audit.

by its total billed charges. Because a hospital cannot calculate the exact cost for each admission, the State must use the cost-to-charge ratio to convert billed charges to estimated costs. The third method applies fixed ratios of either 0.60 or 0.80, depending on the DRG, to convert a portion of the charges to the outlier payment.

For State fiscal years (FYs) 2000 through 2003, Ohio made about $477 million in inpatient hospital cost outlier payments under these three methods. A hospital could have received cost outlier payments under one or two (but not all three) of the methods.

- **"Exceptional Cost" Cost Outliers.** Ohio paid about $84 million (17.6 percent) of the $477 million under this method. Any hospital admission could qualify for payment if the costs calculated through the application of the hospital's cost-to-charge ratio exceeded the "exceptional cost" threshold that the State established. If the claim did not exceed the threshold, Ohio assessed outlier payment eligibility under one of the two other methods. The threshold was subject to periodic revision.

- **"Specifically Identified Hospital" Cost Outliers.** Ohio paid about $247 million (51.8 percent) of the $477 million under this method. About a dozen hospitals qualified by having either high outlier experience with high Medicaid volume or exceptionally high volumes of HIV cases. These hospitals could also have been paid for "exceptional cost" outliers under the first method but were not paid under the "fixed ratio" method. For each of these hospitals, when costs did not meet "exceptional cost" outlier conditions, the State compared total allowable charges that the hospital claimed with a DRG outlier charge threshold, also subject to periodic revision. If the claim exceeded the threshold, Ohio calculated the total payment by multiplying the total allowable charges by 85 percent of the hospital's cost-to-charge ratio.

- **"Fixed Ratio" Cost Outliers.** Ohio paid about $146 million (30.6 percent) of the $477 million under this method. The State used this method to pay outlier claims that did not qualify under the two other methods. Under this method, the State compared the hospital's allowable charges for the admission with the DRG outlier charge threshold used under the "specifically identified hospital" method. If the charges exceeded the threshold, Ohio multiplied the charges above the threshold by the applicable fixed ratio to determine the cost outlier portion of the payment. For DRG codes 385, 388 through 390, and 892 through 898, the fixed ratio was 0.80; for all other codes, the ratio was 0.60. State legislation set the ratios. The total payment was the sum of the outlier payment, the DRG base payment, and any add-on payments.

For a perspective on the number of hospitals associated with the payments under each method, during State FY 2003, Ohio made total outlier payments of about $153 million. The State paid about $13 million to 15 hospitals under the "exceptional cost" method, about $83 million to 10 hospitals under the "specifically identified hospital" method, and about $57 million to 235 hospitals under the "fixed ratio" method.

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. However, if the State does not routinely update the cost-to-charge ratios, the estimated costs may not be reliable or reflective of current conditions. This would be particularly evident when a hospital's costs and charges do not change at approximately the same rate. On a national basis, hospitals have steadily increased charges in relationship to costs since the mid-1980s. This increase has caused the national average cost-to-charge ratio to decrease.[2]

Excessive Medicare Outlier Payments

In 2003, CMS modified the Medicare inpatient prospective payment system policy to correct a vulnerability that resulted in excessive outlier payments. From Federal FY 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 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 ensures that the outlier payment appropriately reflects the hospital's costs of providing care.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Ohio's methods of computing inpatient cost outlier payments were reasonable.

Scope

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

Our audit covered the 4-year period of State FYs 2000 through 2003 and included about $477 million in inpatient cost outlier payments to hospitals. We used Medicaid cost reports for State FYs 1998 through 2001 and other statistical and financial information that the State provided to identify trends in hospital charges and costs.[3]

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

[3]Our audit included outlier claims submitted as of May 12, 2004. Not all claims for State FY 2003 were submitted as of this date.

We also identified all hospitals that received DRG base and outlier payments for State FYs 2000 through 2003 and selected four hospitals for onsite review based on an analysis of payment trends. We selected the hospitals to obtain a blend of facilities that received high cost outlier payments and experienced significant growth in cost outlier payments, as well as to ensure coverage of each of Ohio's three cost outlier payment methods. We reviewed a total of 120 hospital claims to determine why these hospitals received higher or increasing levels of outlier payments.

We did not perform a detailed review of State or hospital internal controls because the audit objective did not require us to do so. The scope of the audit did not include a review of day outliers.

We performed the audit at the Ohio Department of Job and Family Services office in Columbus, OH, and at four hospitals.

Methodology

We obtained a general understanding of Ohio's methods for making outlier payments and evaluated compliance with Federal requirements and the State plan. We also identified all hospitals that received DRG base and outlier payments for State FYs 2000 through 2003 and analyzed payment trends to select four hospitals for onsite review. We selected two hospitals that were paid under both the "exceptional cost" and the "specifically identified hospital" methods and two hospitals that were paid under both the "exceptional cost" and the "fixed ratio" methods. We tested the State's Medicaid payment data during our visits to the hospitals.

At each hospital, we reviewed 30 cost outlier claims to determine whether the outlier payments were reasonable. Through interviews with hospital officials and reviews of supporting documentation, we obtained an understanding of how hospital charges were established, billed, and adjusted. In addition, we evaluated trends in charge increases for high-priced procedures that were often included within the more costly outlier admissions. We identified and evaluated the reasons for the charge increases for those procedures with the greatest overall increases. We confirmed that charges that the hospitals billed to Medicaid for specific DRGs were consistent with similar charges for other payers.

To quantify the impact of using fixed ratios of 0.60 and 0.80 instead of recent cost-to-charge ratios, we requested and received a recalculation of outlier payments from the State. The recalculation used hospital-specific ratios from recent cost reporting periods, i.e., the most recently available tentatively settled cost reports. We reviewed Ohio's overall recalculation methodology and tested some of the data used in the recalculation at the two hospitals that received payments under the "fixed ratio" method.

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

FINDINGS AND RECOMMENDATION

Ohio's "fixed ratio" method of computing inpatient cost outlier payments was not reasonable. Instead of using ratios based on recent cost reporting data, Ohio used outdated fixed ratios to convert allowable billed charges to outlier payments. During the audit period, cost outlier payments to all hospitals under this method exceeded estimated costs calculated using recent hospital-specific cost-to-charge ratios by about $24.7 million ($14.5 million Federal share). Because these payments did not reflect an efficient and economical application of payment methodology, as section 1902(a)(30)(A) of the Act requires, they were not reasonable.

The "exceptional cost" and "specifically identified hospital" payment computation methods were reasonable. Both of these methods used, on an ongoing basis, recent (tentatively settled) cost-to-charge ratios that were about 18 months old in relation to the payment calculation year. In addition, we concluded that the specific hospital charge increases that we reviewed at the four hospitals were reasonable, and that the hospitals' Medicaid charges were consistent with the charges billed to other payers.

COST OUTLIER PAYMENTS

Ohio's Use of Fixed Ratios

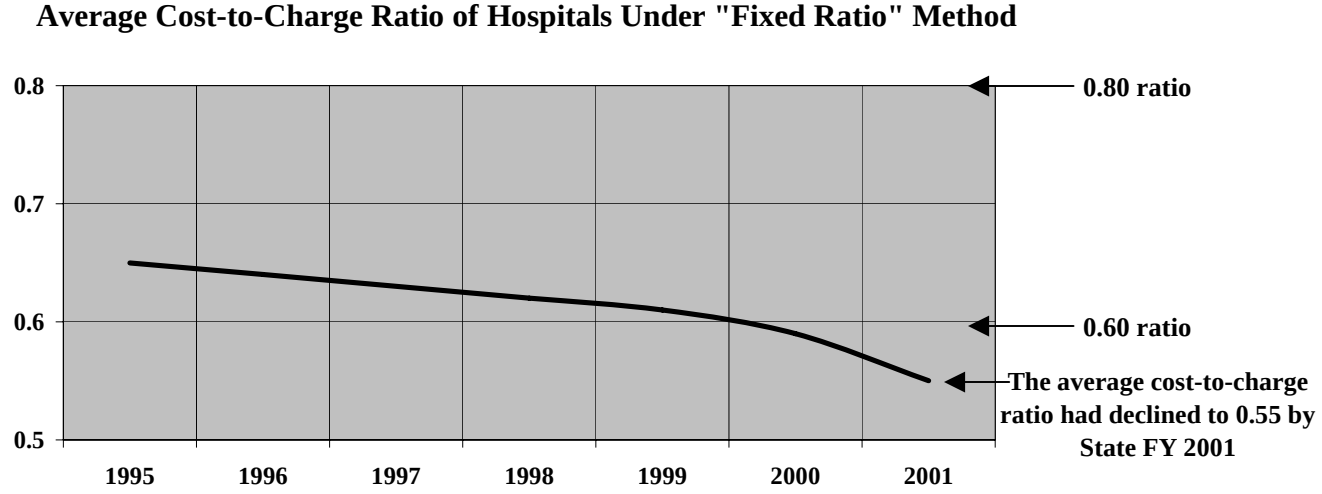
Section 1902(a)(30)(A) of the Act requires a State, with respect to its Medicaid program under the State plan, to "provide such methods and procedures relating to . . . the payment for, care and services available under the plan . . . to assure that payments are consistent with efficiency, economy, and quality of care . . . ."

Ohio's "fixed ratio" cost outlier payment method did not reasonably relate payments to the corresponding hospital-specific costs. This method used fixed ratios of either 0.60 or 0.80, depending on the DRG codes that were involved. The method applied these ratios to the outlier portion of the billed charges to convert the charges to outlier payments. The fixed ratios were enacted through legislation prior to our audit period and have not been updated. Because the outlier payments calculated using this method did not consider the cost-to-charge ratios of the specific hospitals receiving the payments, the payments did not reasonably reflect outlier costs.

Declining Cost-to-Charge Ratios

The average cost-to-charge ratio of all hospitals that received payments under the "fixed ratio" method declined from about 0.65 in State FY 1995 to about 0.55 in State FY 2001.[4] The figure on the next page illustrates this decline compared with the fixed-rate reimbursement (0.60 and 0.80) of billed charges.

[4]The statewide average was based on cost-to-charge ratios taken from tentatively settled Medicaid cost reports. We did not obtain statewide data for periods subsequent to State FY 2001.



With regard to hospital-specific cost-to-charge ratios, two of the four hospitals that we reviewed received some outlier payments under the "fixed ratio" method. The two hospitals jointly received about $20 million in outlier payments under this method for claims with service dates falling within the audit period.[5]

Consistent with the statewide declining trend in the average ratios, the tentatively settled cost-to-charge ratios for these two hospitals also generally declined from State FYs 1995 through 2003. (See Table 1.)

Table 1: Hospital-Specific Cost-to-Charge Ratios for Two Reviewed Hospitals

	1995	1996	1997	1998	1999	2000	2001	2002	2003
Hospital A	0.64	0.59	0.55	0.55	0.55	0.48	0.44	0.46	0.41
Hospital B	0.60	0.58	0.52	0.67	0.52	0.48	0.47	0.42	0.39

Because of the declining trend in overall cost-to-charge ratios for hospitals that were paid under the "fixed ratio" method, Ohio's use of outdated ratios resulted in payments that did not reasonably reflect outlier costs.

Program Savings Potential

If Ohio had used recent cost-to-charge ratios rather than fixed ratios to calculate outlier payments, it could have realized program savings of about $24.7 million ($14.5 million Federal share) for all hospitals paid under this method during the audit period. Table 2 shows the potential savings for State FYs 2000 through 2003 for all hospitals receiving outlier payments based on the outdated ratios.

[5]The two other hospitals that we reviewed were not paid under the "fixed ratio" method.

Table 2: Calculation of Potential Program Savings[6]

State FY	Actual Outlier Payments Based on Fixed Ratios of 0.60 and 0.80	Outlier Payments Based on Hospital-Specific Cost-to-Charge Ratios	Total Savings (Difference)	Federal Share of Savings
2000	$20,918,973	$17,424,055	$3,494,918	$2,050,468
2001	28,863,715	24,948,740	3,914,975	2,311,009
2002	39,333,166	34,241,756	5,091,410	2,992,730
2003	57,332,067	45,145,225	12,186,842	7,169,519
Total	**$146,447,921**	**$121,759,776**	**$24,688,145**	**$14,523,726**

The yearly potential savings rose substantially from about $3.5 million for State FY 2000 to about $12.2 million for State FY 2003. If cost-to-charge ratios continue to decline, the gap between what Ohio pays for outlier admissions using fixed ratios and the estimated costs that the hospitals incur will continue to widen.

RECOMMENDATION

We recommend that the Ohio Department of Job and Family Services work with the State legislature to revise the State's "fixed ratio" cost outlier payment method to ensure that payments to hospitals do not exceed the costs calculated through the application of current cost-to-charge ratios.

STATE'S COMMENTS

In written comments to a draft of this report, Ohio agreed with the findings and recommendation, stating that action has already been taken to incorporate the use of hospital-specific cost-to-charge ratios into Ohio's Medicaid hospital outlier reimbursement policy effective January 1, 2006. Ohio also stated that a related State plan amendment is currently pending before CMS. Aside from addressing the findings and recommendation, Ohio expressed concern with its belief that we concluded that hospital charge increases were justified. Ohio stated that its own analysis has shown that the growth in hospital charges has been over twice the rate of growth in costs. We have attached the State's comments in their entirety as an appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

Regarding Ohio's comments concerning hospital charge increases, we were not making a generalization on all hospitals. We have revised our final report to clarify that our conclusion on hospital charge increases applied only to the specific charges that we tested at four selected hospitals.

[6]The Ohio Department of Job and Family Services performed the calculation.

APPENDIX

Bob Taft
Governor

Barbara E. Riley
Director

30 East Broad Street • Columbus, Ohio 43215-3414
www.jfs.ohio.gov

December 6, 2005,

Mr. Paul Swanson, Regional Inspector General
for Audit Services
Department of Health and Human Services
Office of Audit Services
233 North Michigan Avenue
Chicago, Illinois 60601

Report Number: A-05-04-00064

Re: Audit of Medicaid Outlier Payments in Ohio for the Period of State Fiscal Years 2000 through 2003.

Dear Mr. Swanson:

This letter is being sent in response to your letter dated October 19, 2005, and the draft report entitled, "Medicaid Outlier Payments in Ohio for the Period of State Fiscal Years 2000 through 2003," audit report number A-05-04-00064. Thank you for the opportunity to respond.

ODJFS was pleased to learn that the result of the OIG review as well as the department's own internal review, came to the same conclusion with respect to the use of the "fixed ratios" instead of more current hospital cost to charge ratios in the calculation of certain cost outliers. As a result of this internal department review and communications with the OIG audit staff, ODJFS proposed Ohio Administrative Code (OAC) rule 5101:3-2-07.9 for amendment on January 14, 2005, to incorporate the use of hospital specific cost to charge ratios into Ohio Medicaid's hospital outlier reimbursement policy as part of our program maintenance efforts. This policy change takes effect on January 1, 2006, and the related State Plan Amendment is currently pending before CMS. Payments made during the period of review, were made in accordance with the approved state plan.

In the Findings and Recommendation section however, the report concluded "that hospital charge increases were justified based on our review of outlier claims at four hospitals." We understand the auditor was making this statement from a technical perspective that hospital board recommendations supported the charges reported and that further analysis of overall hospital charge growth was beyond the scope of the audit. ODJFS contends that, while it may have been appropriate for the OIG auditors to reach this conclusion based on the scope of the audit, we have significant reservations about this conclusion for all hospitals in the state,

in light of the Medicare experience cited in the report. The Medicare experience indicated that "Medicare adopted new regulations in 2003 to address program vulnerabilities that resulted in excessive payment to certain hospitals that were aggressively increasing charges."

From ODJFS's own analysis, we have shown that the growth in hospital charges has been over twice the rate of growth in costs causing allowable costs, as calculated off the cost report, to be overstated. For example, we found that from SFY 2002 to SFY 2003, hospitals reported charges per case increased 12.1% while their costs went up 4.1%. This causes us to question the validity of these charge increases. In addition, the growth in hospital charges are up to three times the rate of inflation that Medicaid or Medicare would use to inflate inpatient hospital payment rates. These reported cost and charge increases also exceed other published measures of both cost and price increases in the hospital industry. These charge increases ODJFS believes are not reasonable when compared to hospital's reported cost growth, and are, in our opinion not driven by hospital input price increases as suggested by the report.

Again, thank you for the opportunity to respond to the draft report. Please note that the department reserves the right to make these, and other arguments not set forth herein, if this final report is significantly different from the draft report provided to the department.

Please contact Bryan Chauvin, Office of the Chief Inspector, at 614-466-3015 if you have any questions or comments.

Sincerely,

Robert Ferguson

Robert Ferguson, Chief Inspector
Office of the Chief Inspector
Ohio Department of Job & Family Services

cc Director Riley
Office of Ohio Health Plans
Office of Legal Services