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Department
of Health

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Executive Deputy Commissioner

March 2, 2016

Brian Mason
Assistant Comptroller
Division of State Government Accountability
NYS Office of the State Comptroller
110 State Street, 10th Floor
Albany, New York 12236

Dear Mr. Mason:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2014-S-18 entitled, "Medicaid Overpayments for Inpatient Transfer Claims Among Merged or Consolidated Facilities."

Please feel free to contact Amy Nickson, Assistant Commissioner, Office of Governmental and External Affairs at (518) 473-1124 with any questions.

Sincerely,

Howard Zucker M.D.

Howard A. Zucker, M.D., J.D.
Commissioner of Health

Enclosure

cc: Ms. Nickson

Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2014-S-18 entitled,
Medicaid Overpayments for Inpatient Transfer Claims
Among Merged or Consolidated Facilities

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2014-S-18 entitled, "Medicaid Overpayments for Inpatient Transfer Claims Among Merged or Consolidated Facilities."

Background:

New York State is a national leader in its oversight of the Medicaid Program. With the transition to care management, the Office of the Medicaid Inspector General (OMIG) continues to improve upon our processes and direct our resources to match this changing direction in the Medicaid program. In conjunction with the Department, NYS will continue its focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse wherever it exists.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,405,500 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to $7,868 in 2014, consistent with levels from a decade ago.

Recommendation #1:

Review the 353 cases of improper payments for inpatient transfers identified in this report and recover inappropriate payments.

Response # 1:

We have reviewed the 353 cases and 326 were paid correctly, or the claims were outside of the audit period. OMIG is pursuing recoupment and has sent draft audit reports on the remaining 27 cases identified by OSC.

Recommendation #2:

Establish and implement Medicaid policies to enforce regulations for inpatient transfers among divisions of merged or consolidated facilities.

Response #2:

The Department will be reviewing its documentation and regulations regarding transfers among merged facilities in order to clarify the policy. It is anticipated that this review and clarification will be completed during the first quarter of 2016.

Recommendation #3:

Develop and implement mechanisms to identify merged and consolidated hospitals and to prevent payments for inpatient transfers between them.

Response #3:

The Department currently has a process for matching Medicaid provider numbers and location codes with the appropriate rate codes and rates in order for merged entities to be reimbursed properly. This process is only used for proper rate assignment to the eMedNY payment system, and is not an official list of merged entities. In the development of the new NYMMIS system, edits will be implemented to automatically identify merged facilities and prevent transfer payments.

Recommendation #4:

Inform providers how to properly bill for patient transfers among divisions of merged or consolidated facilities.

Response #4:

The Department will prepare a Medicaid Update, to be issued by March 31, 2016, instructing providers not to submit separate claims for transfer payments when the transfer is between divisions of a hospital receiving the same rate of payment due to a merged cost rate.

Office of the State Comptroller's Comment:

OSC Comment #1:

We are puzzled and disappointed by the Department's response, which blatantly contradicts the applicable Medicaid regulations pertaining to merged and consolidated hospitals. According to the regulations, the purpose of such mergers and consolidations was to create new, more economical health care entities by reducing operating costs and/ or improving service delivery. Further, the regulations specifically state that inpatient care provided to a Medicaid recipient by two or more merged or consolidated facilities is considered one episode of care and cannot be billed as a patient transfer (and the basis for another payment).

Nevertheless, the Department allowed certain hospitals to receive duplicative payments for the admissions in question because merged/consolidated facilities were not recognized as such (for Medicaid payment purposes) until the Department developed so-called "merged rates." For instance, we note that 111 of the 353 total cases identified by our report pertained to two hospitals that were merged prior to the audit period (December 1, 2009 through June 30, 2014). Thus, because the Department did not establish the "merged rates" until July 1, 2014 – the day after our audit period ended – material amounts of duplicative payments persisted over four and a half years. Further, merged rates have yet to be developed for other hospitals, and as such, the risk of additional improper payments remains.

In addition, the Department's assertion that certain claims we reviewed were outside the audit period is incorrect. In fact, all of the claims in question were for services that took place during our audit period.

Based on our audit results, we urge Department officials to ensure full and timely compliance with the applicable Medicaid regulations and to reexamine practices pertaining to the payment of transfer claims among merged and consolidated facilities. This examination should include an assessment of the Medicaid costs resulting from the failure to implement regulations until years after mergers take effect. This would be consistent with one of the Medicaid Redesign Team's main objectives, to lower health care costs, as referenced in the Department's response.

Response to OSC Comment #1:

The following detail to this final report has been updated to provide further clarification of the consistent treatment of merged/consolidated facilities.

The purpose of transferring a patient is to ensure the most appropriate care. In order to reimburse hospitals appropriately, a transfer payment methodology was developed by the Department. This method reimburses the transferring hospital for the services they provided to a patient while under their care, while the receiving hospital is also reimbursed for the services they performed while the patient is under their care.

The transfer payment is a pro-rated amount of the Diagnosis Related Group (DRG) for an acute inpatient stay based on days at the hospital, with a maximum allowable payment of the total DRG payment. Payment received by the transferring hospital may be a portion of the full acute inpatient stay DRG amount.

Based on regulations, transfers between merged or consolidated facilities are reimbursed as if the hospital that first admitted the patient also discharged the patient. Due to this transfer requirement, only one claim can be submitted for the merged entity which includes the diagnosis and procedure codes for the services performed at both hospitals; both hospitals cannot submit a claim.

The Department's consistent interpretation of the payment regulation considers an entity to be merged for payment purposes after the Department calculates a merged rate for the entire entity. Since the payment rate calculation method utilizes the hospital's costs from their Institutional Cost Report (ICR), the merged rate combines all the costs and utilization for all the divisions (hospitals) of the entire entity and develops one payment rate that is utilized by all divisions. Until the time this merged rate is developed, which may be a different effective date than the Certificate of Need merger approval date due to rate scheduling, the separate divisions are receiving distinct separate rates based on specific costs from each facility's ICR. Payment rates do not reflect the entire entity's total costs until the costs and utilization of all divisions are combined and used to develop one payment rate. Until the time a merged rate is developed, both divisions are allowed to submit a claim for payment. For example, if the transferring hospital has a Direct Medical Education (DME) payment and the receiving hospital does not, if only the receiving hospital is allowed to submit a claim prior to the merged cost rate, the entity will not be reimbursed for the DME costs. By both facilities submitting a claim prior to the merged cost rate, the entity is appropriately reimbursed. Therefore, until the reimbursement rate for the entire entity is a merged cost rate that is utilized by all divisions, there is not a duplicate payment. For this example, at the time the rate is a merged cost rate, the receiving hospital will now receive a DME payment that was developed by combining the DME costs and utilization of all the divisions to determine an average DME payment for the entity. It is at that time that both hospitals can no longer submit transfer claims as it would then result in a duplicate payment.

Merged facilities were flagged by the Office of the State Comptroller (OSC) based on Medicaid Provider Numbers, Entity Identification Numbers, Federal Employee Identification Numbers and facility license numbers. Since the payment rate methodology utilizes a hospital's ICR costs; a "merged entity" cannot be flagged based solely on these identifiers. The costs reflected in the payment rate must also be considered in order to appropriately reimburse an entity for total costs versus the costs of only one division.

The Department received two (2) files from OSC to review with a total of 353 cases. Each case consisted of 2 claims: a transfer claim and a receiving (admit) claim. The first file consisted of 196 cases and the second, 157. The claims under review are for the transfer of patients between merged or consolidated hospitals. In order to determine the ability or appropriateness for these hospitals to submit claims for transfer, the Department reviewed the claims file based on its transfer policy that has been consistently applied for transfer payments for merged entities.

Based on the policy above, 326 cases of the 353 cases would be acceptable as transfer claims based on the facilities involved and the scope of the audit. The remaining 27 cases (2 in the 157 case file and 25 in the 196 case file) were inconclusive and require a review of the medical record to determine their appropriateness.

As stated above, for a provider to be considered a merged entity for transfer purposes, the rate data needs to be combined calculating one rate for the entire entity as a merged rate. The Department is noting that all of the 157 cases submitted by OSC for review to the Department state in the file by OSC, "Not the Same Rate." Therefore, since the claims in question do not have the same rate for both providers, they cannot be a merged rate. The 196 case file did not provide the same information.

Based on the Department's review:

<u>157 Case File</u>:

- 63 cases are transfers between Mount Sinai Hospital and Mount Sinai Hospital of Queens. Merged rates for these facilities were not implemented until July 1, 2014, after the time period of this audit.
- 14 cases are transfers between the University of Brooklyn Hospital (UBH) and Long Island College Hospital (LICH). The merger between UBH and LICH did not take place due to action by State Supreme Court.
- In 6 cases, the facilities involved are not part of a merged or consolidated entity.
- 54 cases are transfers between Beth Israel Medical Center and Beth Israel Kings Highway. These two facilities do not have merged payment rates.
- 4 cases are transfers between NY Presbyterian Hospital and NY Downtown Hospital. Merged rates were not implemented until July 1, 2014, after the time period of this audit.
- In 3 cases, the discharge date of the first facility is not the same as the admit date of the second facility. Without a clinical review of these cases, the cause of the second admission cannot be determined. However, with different discharge and admission dates, these would not be considered transfer cases and are outside of the scope of the audit.
- In 11 cases, one of the two claims cannot be found in eMedNY. Therefore, the claim may have been voided by the facility.
- The remaining 2 cases are inconclusive and require a review of the medical record. Using the payment of the claim as supplied in the original file by OSC, this results in an

overpayment of $15,000 to $19,000 if the 2 claims are found to be inappropriate. However, if the claims are not to have been submitted separately, all diagnosis and procedure codes should be combined to one claim which may cause an increase in the one claim payment as the new grouping of the claim may result in an All Patient Refined Diagnosis Related Group (APR-DRG) with a higher weight or in a higher severity level. Therefore, the overpayment noted above from the original claim file could be reduced.

196 Case File:

- 162 cases are not claims for merged entities. Mount Sinai Hospital and Mount Sinai Hospital of Queens accounts for 54 of the cases. Actual merged rates for these facilities were not implemented until July 1, 2014, after the time period of this audit. These claims also include 19 cases of transfers between University of Brooklyn Hospital and Long Island College Hospital and, based on an action by the State Supreme Court, this merger did not take place.
- For 9 cases, the discharge date of the first facility is not the same as the admit date of the second facility. Without a clinical review of these cases, the cause of the second admission cannot be determined. However, with different discharge and admission dates, these would not be considered transfer cases and are outside of the scope of the audit.
- The remaining 25 cases are inconclusive. Using the payment of the claim as supplied in the original file by OSC, this results in an overpayment of $209,845 if the claims are found to be inappropriate. As with the 157 case file, if the claims are not to have been submitted separately, all diagnosis and procedure codes should be combined to one claim which may cause an increase in the one claim payment as the new grouping of the claim may result in an APR-DRG with a higher weight or in a higher severity level. Therefore, the overpayment noted above from the original claims file could be reduced.