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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

December 8, 2015

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Medicaid Overpayments for Inpatient
Transfer Claims Among Merged or
Consolidated Facilities
Report 2014-S-18

Dear Dr. Zucker:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we conducted an audit of the Department of Health (Department) to determine whether the Department established adequate controls over inpatient claims for recipients who were transferred between merged or consolidated hospitals and whether corresponding overpayments occurred.

For the period December 1, 2009 through June 30, 2014, we identified 353 cases of improperly paid Medicaid claims that resulted in actual overpayments of \$1.6 million and potential overpayments that ranged from \$2.1 million to \$5.3 million. According to State regulations, hospitals cannot bill for transfer claims when patients are transferred among their merged or consolidated facilities. Rather, only one claim should be submitted for the entire episode of care. We determined that the hospitals identified in our audit inappropriately billed Medicaid for patient transfers that occurred among their merged or consolidated facilities.

Background

Medicaid is a federal, state, and local government program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the fiscal year ended March 31, 2014, New York's Medicaid program had approximately 6.5 million enrollees and Medicaid claim costs totaled about \$50.5 billion. The federal government funded about 49.25 percent of New York's Medicaid claim costs; the State funded about 33.25 percent; and the localities (the City of New York and counties) funded the remaining 17.5 percent.

In December 2009, the Department implemented APR-DRGs (All Patient Refined Diagnosis Related Groups) as the new method used to reimburse hospitals for inpatient medical care. APR-DRGs were implemented, in part, to better reflect the costs associated with individual patient treatment. To make APR-DRG reimbursement determinations, the Department uses a third-party software (Grouper) that factors in various information from a hospital's claim, including diagnosis code, procedure code, age, gender, and patient discharge status – such as transferred to another hospital or discharged to home.

New York Codes, Rules and Regulations (NYCRR) establish how the Department will reimburse Medicaid claims for individual patient care provided at more than one hospital. According to the regulations, “a transfer patient ... is not transferred among two or more divisions of merged or consolidated facilities.”¹ Hence, patient care provided by two or more merged or consolidated facilities is considered one episode of care and cannot be billed as a patient transfer.

The regulations also establish Medicaid reimbursement rules. Generally, when a patient is transferred among different hospitals, two separate payments are made: a payment for the first hospital's claim and a payment for the second hospital's claim. However, the regulations specify that patient transfers among “hospitals or divisions that are part of a merged or consolidated facility shall be reimbursed as if the hospital that first admitted the patient had also discharged the patient.”² In other words, when a patient is transferred from the first hospital to a merged or consolidated division or hospital, only the first hospital should bill Medicaid one claim for the entire episode of care.

Finally, the regulations establish the rates of payment for merged, acquired, or consolidated facilities. Specifically, the regulations state that “payments for hospitals subject to a merger, acquisition, or consolidation for inpatient acute care services ... will be effective on the date the transaction is effected.”³

In addition, the regulations allow the Commissioner of the Department of Health to grant temporary rate adjustments for facilities subject to or impacted by mergers, acquisitions, consolidations, or restructurings for up to three years. Thus, a temporary rate adjustment allows the merged facility a higher rate amount for up to three years after the merger. When the temporary rate adjustment expires, the Department computes a new blended rate amount for the merged facilities.

For the period December 1, 2009 through June 30, 2014, Medicaid paid about \$229 million for 23,422 inpatient patient transfer claims.

Results of Audit

We identified 353 cases of improperly paid Medicaid claims, resulting in actual overpayments of \$1.6 million and potential overpayments ranging from \$2.1 million to \$5.3 million because the transfers occurred among two or more divisions of merged or consolidated hospitals.

¹ 10 NYCRR 86-1.15 (m).

² 10 NYCRR 86-1.21 (b) (3).

³ 10 NYCRR 86-1.31 (a).

Our findings are presented into two categories: transfers between merged facilities and transfers between divisions of consolidated or otherwise affiliated facilities. Cases were classified as merged when the first and second hospitals on the claims shared the same Medicaid Entity Identification Number and the same APR-DRG base rate reimbursement amount at the time the claims were adjudicated. Cases classified as consolidated and affiliated also had the same Medicaid Entity Identification Number, but had different APR-DRG base rate reimbursement amounts at the time the claims were adjudicated.

We made several recommendations to the Department to address the problems we identified. In particular, we recommend the Department: develop and implement policies and controls over inpatient transfer payments among divisions of merged or consolidated facilities; inform providers how to properly bill such claims; and review the 353 cases in question and recover the related overpayments.

Transfers Between Merged Hospitals

We identified 196 cases of improper Medicaid payments on inpatient claims that involved transfers of patient care between two or more divisions of merged hospitals. The cases accounted for a total of 392 claims: 196 from the first hospital which indicated a patient transfer and 196 from the second hospital which indicated a patient admission within one day of the discharge date of the first hospital claim. In total, Medicaid reimbursed \$6.5 million for the 392 claims: \$2.3 million for the first claims and \$4.2 million for the second claims. Because the patient was transferred between merged facilities, only one claim payment should have been made to the first hospital for the entire episode of care. Separate payments should not be made to both facilities because that often results in overpayments.

We calculated the reimbursement amount for each of the 196 cases as a single episode of inpatient care (instead of reimbursement as two separate inpatient claims) and concluded that the Department overpaid a total of \$1.6 million. For example, on July 1, 2012 a hospital transferred a patient to another hospital that it was merged with. The second hospital, receiving the transferred patient, admitted the patient on July 1, 2012. The first hospital billed Medicaid for a transfer claim and was paid \$140,092. The second hospital also billed Medicaid and was paid \$69,560 for its inpatient claim. In total, Medicaid paid \$209,652 (\$140,092 + \$69,560) for the two claims. We determined that the payment as a single episode of care for this case would have been \$137,469, resulting in an overpayment of \$72,183 (\$209,652 - \$137,469).

The overpayments occurred because the Department does not adequately monitor or control such payments to merged hospitals. In particular, the Department lacks an automated mechanism to identify merged hospitals and, as a result, it cannot readily detect or prevent inappropriate payments for inpatient transfers among merged facilities.

According to the Department, facilities are considered merged only after the Department calculates a merged base rate amount for the affected facilities, as indicated by both hospitals having the same base rate amount. We noted that, at the time the claims were adjudicated and paid by Medicaid, the base rate amounts for each facility in a case were equal. However, Department officials stated that “having identical rates doesn’t necessarily mean that the rates

were merged.” Furthermore, they explained that when the Department grants merged hospitals a temporary rate adjustment, they allow transfers to occur between the merged facilities:

While these two facilities were actually merged, their rates were not. We would have allowed the transfers between these two merged facilities to continue because we hadn’t officially “merged/combined” their rates. The temporary rate adjustment allows the hospitals to bill transfer claims.

However, we determined the Department’s practice conflicts with the applicable regulations, which do not permit merged facilities to bill Medicaid transfer claims when patients are transferred among their facilities – regardless of when the Department processes merged base rate amounts. Although the applicable regulation provides for temporary rate adjustments (including increases) for up to three years, it does not provide for duplicative claims and related overpayments. Only one claim should be submitted because transfer claims are not permitted for the occurrences in question. In response to our findings, Department officials reviewed some of our exception cases and said that a clinical review would be required to determine the appropriateness of the transfers.

Transfers Between Consolidated Hospitals

Regulations for Medicaid reimbursement do not permit consolidated facilities to bill Medicaid transfer claims when patients are transferred among their facilities – only one claim should be submitted for the entire episode of care because transfer claims are not permitted.

Federal Employer Identification Numbers (FEINs) are issued by the Internal Revenue Service to identify a business entity for tax purposes. Each Medicaid provider must register its FEIN with the Department. The Department also assigns other identifiers to further identify facilities in the Medicaid program. For example, Medicaid Provider Identification (ID) numbers and facility license numbers further establish the identity of a provider in the Medicaid program. When key identifiers are the same for two facilities, we considered them to be consolidated or affiliated facilities for the purpose of applying inpatient transfer regulations.

We identified 157 cases (314 claims) where the recipients’ inpatient care for both the first and second claims was provided by hospitals that were assigned the same identifiers (Medicaid Entity ID, FEIN, and facility license number), but did not have the same base rate payment amount at the time of adjudication. In total, Medicaid reimbursed \$7.4 million for the 157 cases: \$2.1 million for the initial transfer claims and \$5.3 million for the subsequent claims.

Because the patient was transferred between consolidated facilities, only one claim payment should have been made – to the first hospital – for the entire episode of care. Separate payments should not be made to both facilities because that can result in overpayments. Moreover, in 48 of the 157 cases, we found that the Medicaid Provider IDs on both claims were identical – meaning care was provided by the exact same facility in those 48 cases. For example, two claims that contained the same facility identifiers (including the Medicaid Provider ID) were billed separately for an episode of care provided to the same Medicaid patient. At the time the claims were adjudicated, they had different base rate amounts. The initial claim for a patient transfer

on February 11, 2010 paid \$22,165. The subsequent claim with an admission date of February 11, 2010 paid \$33,612. We did not compute a single, net overpayment amount for consolidated facilities because the services may require a clinical review to determine if a readmission (vs. a transfer) occurred, in which case the overpayment calculation would be different. Thus, in this example, we determined the overpayment ranged from \$22,165 to \$33,612. Moreover, for the 48 cases involving one (the same) facility, the total Medicaid overpayments ranged from \$477,108 paid for the transfer claims to \$1,346,436 paid for the subsequent inpatient claims.

Since the hospitals' base rate amounts were different between the first and second hospitals, we estimated that the overpayments for the 157 cases ranged from \$2.1 million (total payments for the first claim) to \$5.3 million (total payments for the second claim). The overpayments occurred because the Department has not taken adequate steps to develop and implement effective Medicaid payment control policies for consolidated facilities. As a result, the Department cannot readily detect or prevent inappropriate payments for inpatient transfers between consolidated or affiliated hospitals. Consequently, the Department does not properly enforce the applicable payment regulations for consolidated facilities.

Department officials agreed, stating "Our regulation, on its face, prohibits transfer payments between consolidated facilities." They also acknowledged their practice conflicts with the regulation and explained that "the Department has had difficulty in applying this regulation to consolidated facilities" because "the term 'consolidation' conveys a broad range of business arrangements." Accordingly, Department officials said they did not apply the transfer regulations to the 157 consolidated cases we identified because they were not "merged" facilities. According to Department officials, facilities are not merged in cases where there are "two facilities that have the same provider identification but receive two distinct rates."

Overall, Department officials disagreed with our application of the regulations to determine the inappropriate transfer claims. Department officials contend that the cases were not governed by Department regulations for hospital transfer payments among merged facilities because the facilities in question did not have the same merged base rate amount. However, as stated previously, the regulations do not allow merged or consolidated facilities to bill Medicaid transfer claims, regardless of base rate amounts. Subsequently, the Department agreed that the cases require clinical reviews to determine the propriety of the claims.

Lastly, Department officials noted that certain cases indicate there was no transfer among divisions of the hospital, but rather a transfer within the same building, and these cases would require a clinical review to determine if they were readmissions rather than transfers. If these transfer cases are determined to be readmissions, it would result in the recovery of overpayments for inappropriate inpatient transfers and potentially lower future inpatient reimbursement rates for these providers due to preventable or avoidable readmissions.

Recommendations

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

2. Establish and implement Medicaid policies to enforce regulations for inpatient transfers among divisions of merged or consolidated facilities.
3. Develop and implement mechanisms to identify merged and consolidated hospitals and to prevent payments for inpatient transfers between them.
4. Inform providers how to properly bill for patient transfers among divisions of merged or consolidated facilities.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether Medicaid overpaid inpatient claims for recipients who were transferred between merged or consolidated hospitals. Our audit tests and analyses were based on inpatient claims with the following set of attributes: “transfer” discharge status on the first hospital claim; both hospitals involved had the same Medicaid Entity ID; and the second hospital claim had an admission date within one day of the discharge date of the first hospital claim. The inpatient services were performed from December 1, 2009 through June 30, 2014.

To accomplish our audit objective and assess internal controls related to our objective, we interviewed officials from the Department. We reviewed applicable federal and State regulations and examined the Department’s relevant Medicaid policies and procedures.

We identified merged facilities as hospitals having the same Medicaid Entity ID and same base rate amount. We identified consolidated facilities as hospitals having the same Medicaid Entity ID, FEIN, and facility license number but different base rate amounts. We designed and executed computer programs to evaluate Medicaid payments for transfers between merged and consolidated hospitals. We identified and evaluated 353 inpatient transfer cases that were at high risk of overpayment.

For merged hospitals, we selected 10 of the 196 cases to determine pricing logic for the overpayment calculation. Using Grouper software, we determined that the higher paying APR-DRG code assigned to each of the two claims could be used to determine the combined APR-DRG payment. To determine an overpayment amount, we calculated a new combined payment and then subtracted this amount from the total case payment to compute the net overpayment.

For consolidated hospitals, we estimated the overpayment range from the total paid for the first claims to the total paid for the second claims. We did not compute a single, net overpayment amount for these cases because some may first require a clinical review to determine if a readmission (vs. a transfer) occurred.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members (some of whom have minority voting rights) to certain boards, commissions, and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials generally concurred with most of our recommendations and indicated that certain actions will be taken to address them. However, officials contend that most of the problematic claims identified in the report were paid correctly. Our rejoinder to particular Department comments is included in the report's State Comptroller's Comment.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Major contributors to this report were Warren Fitzgerald, Gail Gorski, Earl Vincent, and Lisa Rooney.

We would like to thank Department of Health management and staff for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Andrea Inman
Audit Director

cc: Ms. Diane Christensen, Department of Health
Mr. Dennis Rosen, Medicaid Inspector General

Agency Comments



Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

October 13, 2015

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2014-S-18 entitled, "Medicaid Overpayments for Inpatient Transfer Claims Among Merged or Consolidated Facilities."

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in cursive script, appearing to read "Sally Dreslin".

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko
Robert W. LoCicero, Esq.
Jason A. Helgersen
Dennis Rosen
Robert Loftus
James Cataldo
Ronald Farrell
Brian Kiernan
Elizabeth Misa
Ralph Bielefeldt
Diane Christensen
Lori Conway
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**Department of Health
Comments on the
Office of the State Comptroller's
Draft 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) Draft 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. Through the efforts of the Department and the Office of the Medicaid Inspector General (OMIG), for 2009 through 2013, New York State alone accounted for 54.9 percent of the national total of fraud, waste, and abuse recoveries. These results reflect a trend of increased productivity and enforcement. For 2011 through 2013, the administration's Medicaid enforcement efforts recovered over \$1.73 billion, a 34 percent increase over the prior three-year period.

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 1,330,000 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to \$7,929 in 2013, 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. The remaining 27 cases are inconclusive and will be reviewed by OMIG. The Department will recover any inappropriate payments.

* Comment 1

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 additional guidance will be completed by year end 2015.

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 eMedNY 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 year end 2015, 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.

State Comptroller's 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.