NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Acting Commissioner

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

March 2, 2023

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 Andrea Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Follow-Up Audit Report, 2022-F-21 entitled," Improper Medicaid Payments for Misclassified Patient Discharges (Report 2020-S-8)."

Thank you for the opportunity to comment.

Sincerely,

Megan E. Baldwin
Acting Executive Deputy Commissioner

Enclosure

cc: Diane Christensen
Amir Bassiri
Jacqueline McGovern
Andrea Martin
James Dematteo
James Cataldo
Amber Rohan
Brian Kiernan
Timothy Brown
Michael Atwood
Melissa Fiore
OHIP Audit
DOH Audit

Department of Health Comments to Follow-Up Audit Report 2022-F-21 entitled, "Improper Medicaid Payments for Misclassified Patient Discharges" (Report 2020-S-8) by the Office of the State Comptroller

The following are the responses from the New York State Department of Health (the Department) to Follow-Up Audit Report 2022-F-21 entitled, "Improper Medicaid Payments for Misclassified Patient Discharges" by the Office of the State Comptroller (OSC).

Recommendation #1:

Review the $252,107 in overpayments and recover as appropriate.

Status – Partially Implemented

Agency Action – In the initial audit, we identified 2,048 FFS inpatient claims totaling $28.5 million for Medicaid recipients who were reported as discharged from a hospital but then admitted to a different hospital within 24 hours of the discharge (which often meets the definition of a transfer). We selected a sample of 31 of these high-risk claims totaling $457,973 in Medicaid payments to three hospitals and reviewed the associated patients' medical records. We found 15 of the 31 claims were incorrectly coded as a discharge (instead of a transfer) and resulted in Medicaid overpayments of $252,107.

The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. As of November 1, 2022, OMIG was in the process of auditing two of the three hospitals and indicated the overpaid claims we identified were included in the reviews. However, these audits had not yet been completed and no recoveries had been made. Lastly, OMIG's request to audit the claims of the third hospitals was denied as part of an attempt to coordinate efforts with another oversight agency.

Response #1:

OMIG is currently performing FFS audits in this area. As part of these audits, OMIG is reviewing both the discharge and subsequent admission medical records of both facilities. After reviewing the medical records received from the providers, the results of these audits determined that the majority of the identified payments were paid appropriately due to medical reasonings for discharges and admissions. OSC's identified overpayments were the result of data analysis and only reviewing the medical records of the discharging facility.

OMIG will perform its own extraction of data from the Medicaid Data Warehouse (MDW) which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

State Comptroller's Comment – OMIG's statement that its audits are not identifying overpayments has no bearing on the recommendation. OMIG also doesn't need to perform its own extraction of data from the MDW to implement this recommendation because the recommendation references 15 specific claims totaling $252,107 that the three hospitals agreed were incorrectly billed as a discharge instead of a transfer based on medical documentation confirming the findings. Since hospital officials already confirmed these claims were billed incorrectly, it is unclear why OMIG has not recovered the $252,107 in overpayments.

As OMIG takes action on the remaining recommendations, we encourage OMIG to review every aspect of our claim selection methodology (provided during our initial audit), including those claims we discarded from our audit due to the issues cited.

Recommendation #2:

Review the remaining 2,017 high-risk claims totaling $28 million identified in this audit and recover overpayments as appropriate. Ensure prompt attention is paid to those providers that received the largest dollar amounts of payments.

Status – Partially Implemented

Agency Action – As of November 1, 2022**,** OMIG was in the process of auditing 12 providers we identified in the initial audit, including six of the top 10 providers identified by total high-risk Medicaid payments received. The 12 providers under review accounted for almost $8 million of the $28 million (28%) in payments identified in the initial audit. Although the audits had not yet been completed, and no recoveries had been made, OMIG officials stated they plan to pursue recovery of any payments determined to be inappropriate.

Response #2:

OMIG is currently performing FFS audits in this area. As part of these audits, OMIG is reviewing both the discharge and subsequent admission medical records of both facilities. After review of the medical records received from the providers, the results of these audits determined that the majority of the identified payments were paid appropriately due to medical reasonings for discharges and admissions. OSC's identified overpayments were the result of data analysis and only reviewing the medical records of the discharging facility. Pending the outcome of OMIG's audit activities, OMIG will determine appropriate next steps in this category.

OMIG will perform its own extraction of data from the MDW which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process. For clarification, the $28 million identified is to be reviewed, and is not the amount to be recovered. The amount to be recovered is the net difference between the discharge rate and transfer rate for the claims submitted by these facilities.

Recommendation #3:

Formally remind hospitals to use correct billing codes based on information documented in the medical records.

Status – Implemented

Agency Action – In the September 2021 edition of the *Medicaid Update* (the Department's official publication for Medicaid providers), hospitals were reminded to accurately report the correct patient discharge status code on Medicaid claims.

Response #3:

The Department confirms agreement with this recommendation status.

Recommendation #4:

Develop a process to identify and recover Medicaid overpayments for FFS inpatient claims that have a high risk of miscoded patient status codes such as those identified by this audit.

Status – Not Implemented

Agency Action – According to OMIG officials, there are no current plans to perform additional audits beyond those of the 12 providers referenced in Recommendation 2, Agency Action. However, officials plan to decide if there is a need for additional reviews once the results of the 12 audits are known. We encourage officials to develop a process to continue to identify and recover Medicaid overpayments for FFS inpatient claims that have a high risk of miscoded patient status codes like the ones identified in our initial audit.

Response #4:

OMIG disagrees with OSC's determination that this recommendation has not been implemented. OMIG is currently performing FFS audits in this area. As part of these audits, OMIG is reviewing both the discharge and subsequent admission medical records of both facilities. After review of the medical records received from the providers, the results of these audits determined that the majority of the identified payments were paid appropriately due to medical reasonings for discharges and admissions. OSC's identified overpayments were the result of data analysis and only reviewing the medical records of the discharging facility. Pending the outcome of OMIG's audit activities, OMIG will determine appropriate next steps in this category.

OMIG will perform its own extraction of data from the MDW which may include those OSC-identified overpayments not already adjusted or recovered, to ensure the data used by OSC is complete and to confirm the accuracy of the claims detail for use in OMIG audit activities. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.