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State Comptroller

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STATE OF NEW YORK
**OFFICE OF THE STATE COMPTROLLER**

December 6, 2023

James V. McDonald, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Improper Managed Care Payments for Misclassified Patient Discharges
Report 2023-F-26

Dear Dr. McDonald:

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 have followed up on the actions taken by officials of the Department of Health (Department) to implement the recommendations contained in our audit report, *Improper Managed Care Payments for Misclassified Patient Discharges* (Report 2021-S-8).

## Background, Scope, and Objective

The Department administers New York's Medicaid Program. Many Medicaid recipients receive their medical services through managed care, whereby the Department pays managed care organizations (MCOs) a monthly premium for each enrolled recipient and, in turn, the MCOs arrange for the provision of services for recipients and reimburse providers. When a hospital bills an MCO for an inpatient stay, the hospital reports certain information on its claims, including patient status codes to indicate whether the patient was transferred or discharged at the end of their stay. These codes are important because reimbursement methodologies for transfers and discharges are different, and may result in lower payments for transfers.

The objective of our initial audit report, issued on August 19, 2022, was to determine whether MCOs made inappropriate payments to hospitals that failed to properly report correct patient discharge codes on inpatient claims. The audit covered the period January 1, 2016 through December 31, 2021. The audit identified 2,808 managed care inpatient claims, totaling $32.3 million, for Medicaid recipients who were reported as discharged from a hospital but then admitted to a different hospital within the same day or the following day (which often meets the definition of a transfer). We selected a judgmental sample of 166 claims, totaling $2,474,162, from six hospitals and reviewed the associated patients' medical records. Our review found:

- 47 claims were overpaid $323,531 because they were incorrectly coded as discharges when the patients were actually transferred to another facility.

- 13 claims, totaling $101,447, were incorrectly billed as inpatient claims when outpatient services were actually provided. Medicaid also improperly paid $58,879 as graduate medical education (GME) payments for these claims because GME payments are not allowed for outpatient services.

The objective of our follow-up was to assess the extent of implementation, as of October 27, 2023, of the five recommendations included in the initial audit report.

**Summary Conclusions and Status of Audit Recommendations**

Department officials have made minimal progress in addressing the problems identified in the initial audit report, and significant actions are still needed. In particular, none of the overpaid or high-risk claims that we had identified have been reviewed. In addition, the Department has not taken steps to ensure MCOs develop processes to identify and recover Medicaid managed care overpayments like those we identified, nor has the Department made enhancements to the Medicaid Data Warehouse (MDW) to allow for a more thorough review of claims submitted by MCOs. Of the initial report's five audit recommendations, none have been implemented.

**Follow-Up Observations**

**Recommendation 1**

*Review the $323,531 in overpayments associated with the 47 inpatient claims improperly coded as discharges and recover as appropriate.*

Status – Not Implemented

Agency Action – The six hospitals we sampled in our initial audit agreed that 47 inpatient claims in our review were overpaid $323,531 because they were incorrectly coded as discharges. Subsequent to the audit, hospitals voided six of the claims, totaling $8,984 in overpayments. The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. We shared details of our findings with OMIG at the conclusion of our initial audit. Despite the providers agreeing the claims were inappropriately coded, OMIG has not yet started to review the remaining 41 claims, totaling $314,547 in overpayments, that had not yet been voided by the hospitals. OMIG stated that it is currently reviewing fee-for-service (FFS) payments related to a similar issue identified in another Office of the New York State Comptroller (OSC) audit, *Improper Medicaid Payments for Misclassified Patient Discharges* (Report 2020-S-8). According to OMIG officials, they are adjusting their methodology based on their FFS review before starting a review of the encounter claims referenced in this recommendation.

**Recommendation 2**

*Review the remaining 2,642 high-risk claims totaling $29.8 million and recover overpayments as appropriate. Ensure prompt attention is given to those providers that received the highest amounts of payments and claims when the second admission was on the same day.*

Status – Not Implemented

Agency Action – According to OMIG officials, a review of the FFS payments identified in OSC audit *Improper Medicaid Payments for Misclassified Patient Discharges* (Report 2020-S-8) is ongoing, and OMIG will be adjusting its methodology before starting a review of the encounter claims referenced in this recommendation. We note that providers have voided 103 of the claims, totaling $1,434,589, since our initial audit, and for another 81 claims, the related claim for the hospital the patient appeared to have been transferred to has been voided. However, OMIG may have already lost the opportunity to recover overpayments related to claims totaling $6.4 million due to federal look-back provisions. We encourage OMIG to expedite its review of the remaining claims (including the 81 claims for the origin hospital where a subsequent hospital's claim was voided) and recover overpayments as appropriate.

**Recommendation 3**

*Review the 13 inpatient claims totaling $101,447 where outpatient services were provided. Recover any overpayments as well as the remaining $55,234 in GME payments associated with the outpatient claims.*

Status – Not Implemented

Agency Action – Our initial audit found hospitals incorrectly billed 13 inpatient claims, totaling $101,447, because the hospitals actually provided outpatient services rather than inpatient services. The audit also identified $55,234 in improper GME payments related to the 13 claims. Since Medicaid does not make GME payments for outpatient services, the GME payments should not have been made. At the time of our follow-up, OMIG had not yet reviewed any of the 13 claims or related GME payments, stating that it is still reviewing the FFS payments identified in OSC audit *Improper Medicaid Payments for Misclassified Patient Discharges* (Report 2020-S-8).

**Recommendation 4**

*Ensure MCOs develop processes to identify and recover Medicaid managed care overpayments for inpatient claims that have a high risk of miscoded patient status codes like those identified by this audit.*

Status – Not Implemented

Agency Action – Department officials stated the Department does not prescribe a specific method by which MCOs should identify and recover overpayments for inpatient claims or any other claims. However, we note the New York State Medicaid Plan states that the Department is responsible for administering or supervising the administration of the Medicaid program under the Social Security Act, which requires post-payment claims review to ensure the proper and efficient payment of claims. While the Department does not need to "prescribe a specific method," it should ensure MCOs develop processes to identify and recover Medicaid managed care overpayments for inpatient claims that have a high risk of miscoded patient status codes.

**Recommendation 5**

*Enhance the MDW's ability to obtain more complete data for encounter inpatient claims, including admission hour and discharge hour, to allow for a more thorough review of the claims submitted by the MCOs and correct the derived LOS [length of stay] field.*

Status – Not Implemented

Agency Action – Our initial audit found the Department's encounter data on the MDW was either missing certain data fields or contained incomplete fields that would otherwise be useful, including admission hour, discharge hour, and LOS. According to Department officials, even though such information is deemed critical to the intended analytics anticipated to be part of quality measures by the Department, it is not required information to be reported by MCOs. As a result, we found there continues to be empty admission hour and discharge hour fields in the MDW. In addition, our initial audit found that the LOS field in the MDW, which is derived by the Department, included an extra day (except where a patient's admission date and discharge date were the same). Although Department officials stated the derived LOS field had been fixed, they were unable to provide support for the fix, and we identified incorrect LOS fields on encounters in the MDW with service dates after the date officials stated the fix had been made.

Major contributors to this report were Thomas Sunkel, Yanfei Chen, and Benjamin Babendreier.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this follow-up.

Sincerely,

Christopher Morris
Audit Manager

cc: Melissa Fiore, Department of Health
Frank T. Walsh, Jr., Office of the Medicaid Inspector General