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July 7, 2015

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

Re: Overpayments of Hospitals' Claims for
Lengthy Acute Care Admissions
Report 2015-F-12

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 have followed up on the actions taken by officials of the Department of Health (Department) to implement the recommendations contained in our audit report*, Overpayments of Hospitals' Claims for Lengthy Acute Care Admissions* (Report 2010-S-30).

Background, Scope and Objectives

The New York State Medicaid program provides health care services to those who are economically disadvantaged and/or have special health care needs. Medicaid recipients in need of inpatient hospital care are provided a full range of services, including (but not limited to) surgical, medical, nursing, radiological, laboratory, rehabilitative and psychiatric care.

To ensure accurate payment of inpatient services, the Department requires hospitals to indicate a patient's "level of care" on their claims to Medicaid. Certain levels of care are more intensive, and therefore more expensive than others. During long hospital stays, patients may transition to lower Alternate Level of Care (ALC) settings, which typically cost less. Hospitals should not bill Medicaid for more costly acute levels of care when Medicaid recipients are in ALC settings. To help ensure Medicaid services are appropriate, necessary, and billed correctly, the Department uses a contractor, the Island Peer Review Organization (IPRO), to review inpatient claims.

We issued our initial audit report on July 25, 2013. The audit objective was to determine whether Medicaid overpaid hospitals by reimbursing for higher levels of medical care than what

was actually provided to patients. The audit covered the period April 1, 2005 through March 31, 2010. Our initial audit found that Medicaid overpaid ten hospitals about $7.8 million for 94 of 297 sampled hospital stays (which totaled $72.3 million). The overpayments occurred primarily because the hospitals billed Medicaid for days for acute care when, in fact, patients received lower cost ALC. Further, given the relatively high incidence of overpayments from the sample that was reviewed (32 percent), we concluded there was high risk that Medicaid overpaid many other inpatient claims for acute care. We recommended that the Department recover the $7.8 million in inappropriate payments, formally notify hospitals of the proper way to bill inpatient claims for ALC, and review additional claims at high risk of overpayment due to incorrect charges for acute care.

The objective of our follow-up was to assess the extent of implementation, as of June 1, 2015, of the three recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials made significant progress in addressing the problems we identified in the initial audit, including recovering the $7.8 million in inappropriate payments. Additionally, since our initial audit, we identified and provided other claims to the Department that were at risk of overpayment due to incorrect charges for acute levels of care. As a result of these efforts, an additional $1.4 million in estimated recoveries are expected. The Department implemented the initial report's three recommendations.

Follow-Up Observations

Recommendation 1

Recover the $7.8 million in inappropriate payments identified in this audit.

Status - Implemented

Agency Action - The Department recovered the inappropriate payments identified in the original audit. The Department's contractor (IPRO) reviewed the claims representing the $7.8 million in overpayments, determined they were inappropriate, and voided the claims on the Department's behalf.

Recommendation 2

Formally notify the ten hospitals of the correct way to bill inpatient claims for ALC.

Status - Implemented

Agency Action - The Department directed their Medicaid fiscal agent, Computer Sciences Corporation (CSC), to contact the ten hospitals included in our review and provide training on the appropriate billing procedures for ALC. In May of 2013, CSC contacted each of the

ten hospitals as directed. In addition, the Department formally notified all hospitals of the requirements for the proper billing of inpatient claims for ALC in the May 2013 edition of Medicaid Update, the Department's official publication for Medicaid providers.

Recommendation 3

Modify IPRO's sampling plan to select and review claims at high risk of overpayment due to incorrect charges for high (acute) levels of care.

Status - Implemented

Agency Action - Subsequent to our initial audit, the Department instructed IPRO to conduct an analysis of 300 additional claims that we identified as being at high risk of overpayment due to incorrect charges for acute levels of care. The expected savings resulting from IPRO's additional review total an estimated $1.4 million. Because of this analysis, the Department determined similar Medicaid claims for long stays should be part of IPRO's ongoing claim review process. Therefore, the Department included in its current contract with IPRO a requirement to review similar high-risk long stay claims.

Major contributors to this report were Brian Krawiecki, Emily Proulx, and Anthony Calabrese.

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

Very truly yours,

Warren Fitzgerald
Audit Manager

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