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
Division of State Government Accountability
NYS Office of the State Comptroller
110 State Street, 11th Floor
Albany, New York 12236
ainman@osc.ny.gov

Dear Ms. Inman:

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 2021-S-8 entitled, "Medicaid Program: Improper Managed Care Payments for Misclassified Patient Discharges."

Should you have additional questions or concerns, please contact Mischa Sogut, Assistant Commissioner for Governmental Affairs at 518-473-1124 or mischa.sogut@health.ny.gov.

Sincerely,

Megan Baldwin

Megan E. Baldwin
Acting Executive Deputy Commissioner

Enclosure

cc: Mischa Sogut

Department of Health Comments to Final Audit Report 2021-S-8 entitled, "Medicaid Program: Improper Managed Care Payments for Misclassified Patient Discharges" by the Office of the State Comptroller

The following are the responses from the New York State Department of Health (the Department) to Final Audit Report 2021-S-8 entitled, "Medicaid Program: Improper Managed Care Payments for Misclassified Patient Discharges" by the Office of the State Comptroller (OSC).

Recommendation #1:

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

Response #1:

The Office of the Medicaid Inspector General (OMIG) is currently performing fee-for-service (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 anticipates similar results for the Managed Care (MC) encounters to the findings of the FFS audits being conducted.

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 comment that its audits are not identifying overpayments has no bearing on the recommendation. For the sample of managed care claims referenced in this recommendation, we reviewed medical documentation that indicated whether a patient was discharged or transferred to confirm our findings. Furthermore, hospitals agreed with our findings. It is unclear why OMIG would not ensure these 47 specific managed care inpatient claims were reviewed and recovered.

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.

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 anticipates similar results for the MC encounters to the findings of the FFS audits being conducted.

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 $29.8 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:

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

Response #3:

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 anticipates similar results for the MC encounters to the findings of the FFS audits being conducted.

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.

State Comptroller's Comment – OMIG's response addressed the wrong audit findings. This recommendation pertains to outpatient services that were incorrectly billed as inpatient claims. We encourage OMIG to review these 13 inpatient claims and recover all overpayments (the hospitals that responded to our findings agreed the claims should not have been billed as inpatient claims).

Recommendation #4:

Ensure managed care organizations (MCO) 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.

Response #4:

The Department does not prescribe a specific method by which MCOs should identify and recover potential overpayments for inpatient claims or any other claims. However, the Department publishes the Service Utilization and Cost Reporting guide that provides standards for reporting encounter data that align with medical expenses and utilization reported on the various Managed Care Operating Reports. In addition, the Medicaid Model Contract Section 22.7 Recovery of Overpayments speaks to MCO obligations to audit provider claims for a six-year period from the date the care, services or supplies were provided or billed, whichever is later, and to recoup any overpayments discovered as a result of the audit.

Recommendation #5:

Enhance the Medicaid Data Warehouse's (MDW) 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 length of stay (LOS) field.

Response #5:

The Department has a project underway to expand the number of data elements loaded into the MDW from the encounters submitted by MCOs. The completion date is tentatively scheduled for the 2nd quarter of 2023. The completed project strives to provide more information sent to the MDW in order to enhance data analysis. Upon implementation of the project the LOS information on the encounter will match the value stored in the MDW.

The following are responses to the State Comptroller's Comments in the final report.

State Comptroller's Comment (page 16):

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.

Response to the State Comptroller's Comment 1:

Part 98-1.21 of Title 10NYCRR (Fraud and Abuse Prevention Plans and Special Investigation Units), and more specifically Section 98-1.21 (b)(5) requires plans to develop procedures for

detecting and preventing possible fraud and abuse, as well as procedures for case investigations and detection of patterns of repetitive fraud and abuse involving one or more MCOs, including (vi), the submission of claims for services not provided. Additionally, Section 98-1.21 (b)(14) requires the development of a fraud and abuse detection procedures manual for use by officers, directors, managers, and claims, underwriting, member services, utilization management, complaint, and investigative personnel. These requirements ensure that MCOs develop the necessary policies and procedures required to conduct post-payment claims reviews. Furthermore, these policies and procedures are reviewed during the course of ongoing full operational surveys. It should be noted that the OMIG performs post-payment claim reviews on behalf of the Department and they are consistent with Social Security Act requirements.