Department of Health

Medicaid Program: Improper Managed Care Payments for Misclassified Patient Discharges

Report 2021-S-8 | August 2022

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability

Audit Highlights

Objective

To determine whether Medicaid managed care organizations (MCOs) made inappropriate payments to hospitals that failed to properly report correct patient discharge codes on inpatient claims. The audit covered the period from January 1, 2016 through December 31, 2021.

About the Program

The State's Medicaid program is administered by the Department of Health (Department). Many Medicaid recipients receive their medical services through managed care, whereby the Department pays MCOs a monthly premium for each enrolled recipient and, in turn, the MCOs arrange for the provision of services for recipients and reimburse providers.

MCOs use the All Patient Refined Diagnosis Related Groups methodology to reimburse hospitals for inpatient medical care. When a hospital bills an MCO for an inpatient stay, the hospital reports certain information on its claims, such as the patient's diagnoses and services received.

Hospitals must also use certain codes to indicate whether the patient was transferred or discharged at the end of their stay. These codes are important because payments may vary significantly depending on whether a patient is transferred or discharged. For example, a claim where a patient was transferred to another facility may result in a lower payment than if the patient was simply discharged home from the hospital.

Key Findings

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). These claims are at a high risk of overpayment if the first hospital inappropriately reported an actual transfer as a discharge. 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.

Key Recommendations

- Review the identified overpayments and make recoveries, as appropriate.
- Review the remaining high-risk claims totaling $29.8 million and recover overpayments, as appropriate. Ensure prompt attention is given to providers who received the highest payments.
- Ensure MCOs develop processes to identify and recover overpayments for inpatient claims that have a high risk of incorrect discharge codes.

Office of the New York State Comptroller
Division of State Government Accountability

August 19, 2022

Mary T. Bassett, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Bassett:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively. By doing so, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Improper Managed Care Payments for Misclassified Patient Discharges*. The audit was performed 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.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms

Term	Description	Identifier
ALOS	Average length of stay	*Key Term*
Department	Department of Health	*Auditee*
DRG	All Patient Refined Diagnosis Related Groups	*Key Term*
GME	Graduate medical education	*Key Term*
LOS	Length of stay	*Key Term*
MCO	Managed care organization	*Key Term*
MDW	Medicaid Data Warehouse	*System*
SIW	Service intensity weight	*Key Term*

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The Medicaid program is administered by the State's Department of Health (Department). For the State fiscal year ended March 31, 2021, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $68.1 billion (comprising $25.3 billion in fee-for-service health care payments and $42.8 billion in managed care premium payments). The federal government funded about 56.5% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.5%.

Many of the State's Medicaid recipients are eligible to 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 health care services for Medicaid recipients and reimburse providers.

MCOs use the All Patient Refined Diagnosis Related Groups (DRG) methodology to reimburse hospitals for inpatient medical care. The DRG methodology classifies patients according to their diagnosis and severity of illness, which provides the basis for calculating the reimbursement. To make DRG payment determinations, the MCOs use a third-party software (i.e., Grouper software).

When a hospital bills an MCO for an inpatient stay, the hospital reports certain information on its claims, such as the patient's diagnoses and services received, as well as the time and date of the admission and when the services ended. The Grouper software uses this information to assign the appropriate DRG and severity of illness for the inpatient stay, and, based on this information, a service intensity weight (SIW) is assigned to the claim. The SIW, established base payment amounts, and other factors are used to calculate the hospital's full payment. Generally, more acute or severe medical conditions receive a higher weight, which increases the hospital's payment.

Hospitals also report patient status codes to indicate whether the patient was transferred or discharged, because DRG reimbursement methodologies for transfers and discharges are different. For a transfer patient, the Medicaid payment is calculated by dividing the DRG payment by the average length of stay (ALOS) and then multiplying by the actual length of stay (LOS), not to exceed the full DRG payment for a discharge. This calculation results in a transfer payment that is lower than the discharge payment when the LOS is lower than the ALOS.

According to New York Codes, Rules and Regulations Title 10, Section 86-1.15, a DRG transfer occurs when a patient (1) is not discharged, not transferred among two or more divisions of merged or consolidated facilities, not assigned to a DRG specifically identified as a DRG for transferred patients only; and (2) meets one of the following conditions:

- Transferred from an acute care facility reimbursed under the DRG payment system to another acute care facility reimbursed under this system;
- Transferred to an out-of-state acute care facility; or
- A neonate (newborn) who is transferred to a DRG-exempt facility for neonatal services.

The regulation states that a DRG discharge occurs when a patient whose admission to the facility occurred on or after December 1, 2009 either:

- Is released from an acute care facility to a non-acute care setting (e.g., a nursing home, the patient's home);
- Is moved to a facility or unit that is exempt from the case-based payment system except when the patient is a newborn transferred to an exempt hospital for neonatal services and thus is classified as a transfer patient pursuant to this section;
- Is a newborn who is released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain; or
- Dies in the facility.

The Department's Encounter Intake System receives claim information from MCOs (called encounters). The Encounter Intake System processes the encounters and sends the resulting data to the Department's Medicaid Data Warehouse (MDW).

Audit Findings and Recommendations

For the period January 1, 2016 through December 31, 2021, the audit identified 2,808 managed care inpatient claims totaling $32.3 million where a Medicaid recipient was discharged from a hospital and admitted to a different hospital either the same day or one day after discharge. These claims are at a high risk of overpayment as the first hospital may have inappropriately reported an actual transfer as a discharge. To validate and confirm our methodology, we selected a judgmental sample of 166 claims from six hospitals totaling $2,474,162 and reviewed the associated patients' medical records. For the sampled 166 claims, we identified $323,531 in overpayments from 47 claims that were incorrectly coded as a discharge instead of a transfer. As a result, the Department should recover the overpayments related to these claims as appropriate and review the remaining 2,642 claims (totaling $29.8 million) that are at a high risk of overpayment due to the likelihood that the patient's status was miscoded as a discharge instead of a transfer.

Furthermore, from the sampled 166 inpatient claims, we also determined that five hospitals incorrectly billed 13 claims, totaling $101,447, because the hospitals provided outpatient services rather than inpatient services. We determined the 13 inpatient claims should have been billed as outpatient services instead. Further, for inpatient claims, Medicaid makes graduate medical education (GME) payments to teaching hospitals to help cover the expenses associated with training resident physicians, but GME payments are not made for outpatient claims. We found that Medicaid made $58,879 in GME payments to the hospitals for these 13 claims. One hospital refunded a GME payment of $3,645 to Medicaid. We believe the Department should take steps to correct the 13 claims and recover the remaining $55,234 of GME payments made to the hospitals for claims that were inappropriately billed as inpatient claims.

Inpatient Claims at Risk for Incorrect Discharge Coding

We identified 2,808 managed care inpatient claims totaling $32.3 million for Medicaid recipients who had more than one hospital admission between January 1, 2016 and December 31, 2021. These claims were selected because the second admission was the same day or the following day after the initial discharge from a different hospital. This time frame is based on the risk that miscoding exists when patients are reported as being discharged (rather than transferred) from a hospital but admitted to another hospital within a short period of time. We reviewed a sample of 166 claims totaling $2,474,162; the results are summarized in the table on page 8.

The sampled MCOs have not developed mechanisms to identify miscoded discharges. According to one MCO, a medical record review is necessary to make a determination whether a claim should be reported as a discharge or a transfer. However, claims data can be used to identify questionable claims. For example, an MCO paid $48,758 for a patient who was admitted to a hospital and stayed for two days; the hospital coded this claim as a discharge. However, the same patient was admitted to another hospital within an hour of being released from the first hospital.

We contacted officials from the first hospital, and they agreed the patient was not discharged but was transferred to the second hospital. If the first claim was coded appropriately as a transfer, the MCO would have paid $15,133. As a result, we calculated an overpayment of $33,625 for this miscoded claim.

We recommend the Department review the 2,642 remaining high-risk claims to assess whether the discharge code is accurate, with priority given to:

- The top 10 hospitals that received 39% of the $29.8 million ($11.8 million), and
- Claims when the second admission was on the same day. Based on the results of our sampling below, 44 of the 47 overpaid claims involved a second admission on the day of discharge. Of the 2,642 claims, 1,379 claims totaling $17.2 million were for patients admitted to a different hospital on the same day of discharge from the first hospital.

Review of Medical Records to Validate Risk of Incorrect Discharge Coding

In order to validate and confirm our analysis, we selected a judgmental sample of 166 inpatient claims totaling $2,474,162 submitted by six hospitals. We reviewed patient medical records to assess the patients' status on leaving the hospitals and identified 47 claims that should have been billed as transfers (instead of discharges). Using the DRG formula, we recalculated the payment for the 47 claims as if they were correctly billed as transfers and identified $323,531 in overpayments, as detailed in the following table.

Summary of Sample Results

Hospital Name	Number of Sampled Claims	Sampled Payment Amount	Number of Miscoded Claims	Miscoded Payment Amount	Correct Payment Amount	Overpayment Amount
Bellevue Hospital Center	28	$332,490	10	$153,226	$77,330	$75,896
BronxCare Hospital Center	25	234,659	3	18,874	12,399	6,475
Lincoln Medical & Mental Health Center	30	499,330	17	289,739	124,805	164,934
Mount Sinai St. Luke's/ Morningside Hospital	20	308,359	4	101,376	63,766	37,610
New York Presbyterian Hospital	45	895,689	4	57,053	30,968	26,085
New York Presbyterian Hospital (Queens)	18	203,635	9	108,739	96,208	12,531
Totals	**166**	**$2,474,162**	**47**	**$729,007**	**$405,476**	**$323,531**

For one sampled claim, an MCO paid $6,372 for a patient who left the hospital against medical advice, and the hospital indicated the patient was discharged. However, the claim data showed the patient had a second admission to a different hospital within the same hour of the patient's release from the first hospital. We contacted officials from the first hospital, and they agreed the patient was not discharged but was transferred to the second hospital. We recalculated the claim as if the first hospital had correctly coded this patient as a transfer, and determined the MCO would have only paid $4,406. As a result of the incorrect discharge coding, the MCO overpaid $1,966 for this claim.

Incorrect reporting generally occurred because the hospitals made clerical errors coding the claims. When we provided the six hospitals with our findings, officials from all six confirmed the claims were inappropriately coded and indicated they would take actions to prevent future billing errors.

While the Department issued a Medicaid Update in September 2021 reminding hospitals to correctly identify and properly code whether patients are transferred or discharged, it should ensure MCOs develop processes to check for such compliance as well. In response to our preliminary findings, Department officials stated that it does not prescribe a specific method by which MCOs should identify and recover overpayments for inpatient claims or any other claims. However, 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.

Outpatient Claims Misclassified as Inpatient Claims

Of the 166 sampled inpatient claims, we determined that five hospitals billed 13 claims, totaling $101,447, as inpatient claims – yet the hospitals provided outpatient services, not inpatient services. We determined that these 13 inpatient claims should have been billed as outpatient claims instead. An adjustment of any of these claims to reflect the appropriate type of service could result in an overpayment. Three hospitals agreed that their claims should not have been billed as inpatient claims. The two remaining hospitals did not comment on our findings.

Additionally, while the MCO pays hospitals directly for inpatient care, the Department makes additional claim payments, known as GME payments, directly to certain hospitals to cover the expenses associated with training resident physicians. GME payments are not made for outpatient services. We determined Medicaid made $58,879 in GME payments to hospitals for these 13 claims. Of the three hospitals that agreed inpatient services were not provided, one hospital refunded a GME payment of $3,645 to Medicaid. We believe the Department should take steps to correct the 13 claims and recover the remaining $55,234 of GME payments made to the hospitals for claims that were inappropriately billed as inpatient claims.

Review and Comparison of Encounter Data Obtained From MDW With MCO Data

The Department's encounter data on the MDW either is missing certain data fields or contains incomplete fields that would otherwise be useful and, in some cases, necessary to identify these claims and reprice them. These issues did not affect our audit findings and claim recalculations since we used alternate sources of information, such as data provided by MCOs and published hospital reimbursement rates. The missing/incomplete fields include admission hour, discharge hour, and LOS. Information such as admission hour and discharge hour is useful in analyzing and reviewing inpatient claims data more efficiently. Based on our judgmental sample, same-day admissions were more likely to have been miscoded than next-day admissions. However, if admission hour and discharge hour are used, the risk population may be more narrowly defined (e.g., a discharge at 11:30 p.m. on one day with a second admission at 1 a.m. the following day may be more likely to be inappropriately coded).

The LOS field in the MDW encounter data was not always listed correctly or consistently during the period of our audit. Of the 2,808 claims in our audit population, the LOS field was empty on 1,761 claims. LOS was also incorrectly reported for 870 claims in our audit population. LOS is defined as the number of elapsed days between admission date and discharge date, excluding the discharge date. However, the LOS field in the MDW, which is derived by the Department, included an extra day (except where the admission date and discharge date of a patient are the same). The Department could not explain why these calculations for encounter transactions differ from the LOS calculation on fee-for-service claims. However, this did not impact our recalculation of miscoded claims since we derived the LOS independently from what was reported on the MDW.

In addition, the Department would face difficulty in recalculating the type of overpayments identified. The DRG payment formula requires certain information such as the DRG base amount, SIW, and ALOS. However, these fields are not required to be submitted on encounter claims. As a result, the Department would have to reference existing public rate tables and identify MCO-specific contract information to accurately reprice any overpayments that could result from improper discharge coding. The Department should enhance the MDW's ability to obtain more complete encounter data.

Recommendations

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

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.

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.

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.

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 field.

Audit Scope, Objective, and Methodology

The objective of the audit was to determine whether MCOs made inappropriate payments to hospitals that failed to properly report correct patient discharge codes on inpatient claims. The audit examined inpatient Medicaid managed care claims from January 1, 2016 through December 31, 2021 for patients who were discharged from a hospital and had a second admission to a different hospital the same day or the following day.

To accomplish our audit objective and assess related internal controls, we used the MDW to identify DRG inpatient claims. We interviewed officials from MCOs and the Department, and examined the Department's relevant Medicaid policies and procedure as well as applicable federal and State laws, rules, and regulations. To identify the audit population, we performed data analysis using inpatient encounter data available on the MDW for claims with dates of service between January 1, 2016 and December 31, 2021.

Our judgmental sample of 166 claims totaling $2,474,162 was selected from a risk population of 2,168 inpatient claims totaling $23.5 million with dates of service between January 1, 2016 and December 31, 2020. Claims were selected from the largest hospitals and their associated MCOs by claim volume in the risk population. We reviewed patient medical records related to these claims to assess whether the individual was transferred or discharged. We shared our findings with the hospitals and MCOs and considered their feedback in finalizing the review of the claims. The results of our sample cannot be projected to the population as a whole.

We shared our methodology and our findings, including the calculation of overpayments, with officials from the Department and the Office of the Medicaid Inspector General for their review.

Statutory Requirements

Authority

The audit was performed 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 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. 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 the report. In their response, Department officials agreed with many of the audit recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinder to one Department comment is included in the report's State Comptroller's Comment, which is embedded within the Department's response.

Within 180 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.

Agency Comments and State Comptroller's Comment

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

June 9, 2022

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

Thank you for the opportunity to comment.

Sincerely,

Kristin M. Proud

Kristin M. Proud
Acting Executive Deputy Commissioner

Enclosure

cc: Diane Christensen
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Department of Health Comments to Draft 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 Draft 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 analysis on the OSC data and methodology provided. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

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 analysis on the OSC data and methodology provided. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

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 analysis on the OSC data and methodology provided. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

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 (MMCORs). In addition, the Medicaid Model Contract Section 22.7 Recovery of Overpayments speaks to MCO obligations to audit provider claims for a six (6) 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.

State Comptroller's Comment – 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 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 4th quarter of 2022. The completed project strives to provide more information sent to the MDW in order to enhance data analysis. The Department is evaluating the LOS field issue and will take appropriate action so the LOS field matches what is submitted on the encounter claim, as necessary.

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