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January 18, 2023

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

Re: Improper Medicaid Payments for Misclassified Patient Discharges
Report 2022-F-21

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 to implement the recommendations contained in our audit report, *Improper Medicaid Payments for Misclassified Patient Discharges* (Report 2020-S-8).

Background, Scope, and Objective

The Department of Health (Department) uses 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 Department uses a third-party software (called Grouper).

When a hospital bills Medicaid 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. 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, often resulting in lower payments for transfers.

We issued our initial audit report on August 17, 2021. The audit objective was to determine whether the Medicaid program made inappropriate fee-for-service (FFS) payments to hospitals that failed to properly report correct patient discharge codes on inpatient claims. The audit covered the period January 1, 2015 through December 31, 2019. We found the Department did not have a process to identify and recover improper Medicaid payments for inpatient claims with incorrect patient status codes. As a result, we identified over $28 million in improper and questionable Medicaid payments for recipients who were reported as discharged from a hospital but then admitted to a different hospital within 24 hours of the reported discharge (which often meets the definition of a transfer).

The objective of our follow-up was to assess the extent of implementation, as of November 17, 2022, of the four recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Officials have made some progress in addressing the problems we identified in the initial audit report, but additional action is still required. Of the initial report's four audit recommendations, one has been implemented, two have been partially implemented, and one has not yet been implemented.

Follow-Up Observations

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 hospital was denied as part of an attempt to coordinate efforts with another oversight agency.

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.

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.

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.

Major contributors to this report were Vicki Wilkins, Caitlin Colacino, and Michael Gouvakis.

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.

Very truly yours,

Christopher Morris
Audit Manager

cc: Mellisa Fiore, Department of Health
Frank T. Walsh, Jr., Acting Medicaid Inspector General