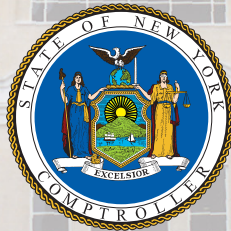




New York State Department of Health

Medicaid Overpayments for Hospital Readmissions

Report 2009-S-28



Thomas P. DiNapoli

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State of New York Office of the State Comptroller

Division of State Government Accountability

May 3, 2010

Richard F. Daines, M.D.
Commissioner
NYS Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Dr. Daines:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for 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 *Medicaid Overpayments for Hospital Readmissions*. This audit was performed pursuant to the State Comptroller's authority under 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,

*Office of the State Comptroller
Division of State Government Accountability*



State of New York Office of the State Comptroller

EXECUTIVE SUMMARY

Audit Objective

Our objective was to determine if New York State's Medicaid program overpaid hospitals when the hospitals readmitted the same patients that they had recently discharged.

Audit Results - Summary

The Department of Health administers New York State's Medicaid program which provides medical services to eligible low-income recipients. The Department uses its eMedNY computer system to process providers' medical claims and to reimburse them for medical services. During the period January 1, 2004 through June 30, 2009, New York's Medicaid program paid \$4.9 billion of claims for hospital readmissions for the same patient within 31 days of the patient's initial discharge. Studies have shown that claims for hospital readmissions often result from inadequate follow-up medical care after an initial discharge and, therefore, add substantially to health care costs.

To help control New York State's Medicaid costs, including hospital readmissions, eMedNY uses the Diagnosis Related Group (DRG) billing method. DRG uses standard payment amounts for specified hospital treatments and requires hospitals to combine admission and readmission claims for reimbursement under certain circumstances to avoid duplicate costs associated with separate DRG billing for an initial hospital admission as well as a subsequent readmission for the same or a related illness. Hospitals are required to properly prepare their claims in accordance with DRG billing policy and the Department uses a contractor to determine whether hospitals are complying with the policies and whether overpayments have taken place and recoveries are necessary.

We found that there is high risk that New York State's Medicaid program is overpaying millions of dollars when there is a DRG billing for an initial inpatient stay as well as for a subsequent readmission for the same patient. Our review of a limited sample of admission and related readmission claims totaling about \$514,000 at five hospitals identified total overpayments of nearly \$163,000 (32 percent) because claims were not combined into one DRG billing in accordance with Department policy. We found similar conditions at other hospitals and we directed the Department to follow up to verify overpayment conditions and to make recoveries as appropriate.

In addition, we concluded that there are substantial Medicaid cost savings opportunities if the Department could reform its DRG readmission billings to conform to policies of other states. For example, New Jersey denies all initial claims for a hospital readmission that takes place with

seven days of the discharge of the same patient from the same hospital for the same or a related illness. The hospital providers then have an opportunity to justify the claims for payment. As an illustration, if New York adopted the New Jersey policy, the Department may have reduced Medicaid spending about \$53 million during our audit period.

In Michigan, when a patient is discharged from one hospital and is readmitted to another hospital, the related DRG billing for the initial admission and the discharge must be combined to produce savings that are not attainable through separate admission and readmission billing. However, according to Department policy, combined DRG billing for an initial admission and related readmission is only required when the patient is readmitted to the same hospital. In this regard, the New York City Health and Hospital Corporation alone had 11 affiliated acute care hospitals that accounted for 8,900 admission and readmission claims for the same patient during our audit period. Under current Department policy, none of these were required to be combined.

Finally, we found the Department excluded certain categories of inpatient readmission claims from contractor review. However, the Department did not have a documented analysis demonstrating that the exclusions were cost effective. As an illustration, if the contractor had reviewed these claims and if the contractor had identified the same proportion of exceptions and recovery opportunities for these claims as it identified for claims that were examined, the Department would have realized additional savings of \$74.5 million during our audit period.

We made five recommendations to the Department concerning DRG billing for hospital readmissions. Department officials agreed with our recommendations.

This report, dated May 3, 2010, is available on our website at: <http://www.osc.state.ny.us>.

Add or update your mailing list address by contacting us at: (518) 474-3271 or

Office of the State Comptroller

Division of State Government Accountability

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Albany, NY 12236

Introduction

Background

In New York State, a hospital readmission takes place when a patient has been discharged from a particular hospital after treatment and then has to return to that particular hospital soon thereafter for treatment of the same or a related condition. Since hospital inpatient treatment is costly, it is important to make sure that such readmissions are not due to the lack of quality care during the initial hospital admission or the lack of appropriate follow-up care after discharge. In this regard, a recent study published in The New England Journal of Medicine reported that Medicare costs for unplanned readmissions totaled \$17.4 billion in 2004 with nearly 20 percent of discharged patients being readmitted within 30 days of discharge. The study identified lack of appropriate follow-up medical care as a major cause of Medicare readmissions and it cited New York State as having one of the highest rates of Medicare readmissions in the United States.

We believe that the risk associated with hospital readmissions identified in the study of Medicare patients also applies to New York State's Medicaid patients. Addressing the risk is particularly important since New York State Medicaid paid nearly \$4.9 billion for 390,000 claims for patient readmissions within 31 days of discharge for the period January 1, 2004 through June 30, 2009. This includes \$2.5 billion for Medicaid patient readmissions to the same hospital the patient was discharged from.

The Department of Health (Department) administers New York State's Medicaid program including payments to hospitals for their claims for reimbursement for Medicaid patient readmissions. The Department uses its eMedNY computer system to process the claims and to pay the provider hospitals. The eMedNY system pays many of the hospital claims using the Diagnosis Related Group (DRG) claims reimbursement method. Under DRG method, the hospital is reimbursed a fixed payment amount for providing patient care associated with the treatment of a specific condition. The amount of DRG reimbursement depends on the condition being treated and the patient factors including age and gender. The DRG payment is intended to cover the cost of all aspects of treatment (expected tests, medications, procedures, etc.) associated with the condition the patient is being treated for.

The DRG reimbursement is based on a minimum period and a maximum period of hospital stay specified for each condition being treated. The DRG method is intended to ensure hospitals keep patients long enough to provide necessary care with reduced likelihood of readmission while also providing hospitals with a financial incentive to not keep patients longer than medically

necessary. It is also intended to simplify Medicaid claims processing and reimbursement. If, however, a Medicaid patient is readmitted to the same hospital for a the same or a related condition within a short period of time after discharge, the DRG method requires the hospital to combine the new claim with the original one to avoid the cost associated with having two separate DRG claims and resulting duplicate reimbursements.

Audit Scope and Methodology

Our audit determined whether Medicaid overpayments were made for hospital readmissions that were billed using the DRG method. Our audit covered the period January 1, 2004 through June 30, 2009.

To accomplish our audit objective, we interviewed Department and contractor officials, reviewed applicable sections of Federal and State laws and regulations, and examined relevant Department policies and procedures. We reviewed other states' hospital readmission rules and we reviewed Medicare hospital readmission rules. We extracted from eMedNY all hospital DRG readmission claims paid during our audit period. As appropriate, we compared the results of our analysis of Department claims to the results of the contractor's claims review and analysis.

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 objectives. 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. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of whom have minority voting rights. 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.

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.

**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 it. Department officials advised us that they would refer the claims identified in our report to the Office of the Medicaid Inspector General (OMIG) for review and pursuit of recovery, as appropriate. In addition, officials noted that the Governor's Executive Budget for the 2010-11 fiscal year contained an initiative to adjust payments for potentially preventable admissions, including readmissions within a defined time period above a calculated standard. Officials further noted that at the time of their response (April 5, 2010), this initiative, which would require a change in State law, was under discussion with the State Legislature.

Within 90 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.

**Contributors to
the Report**

Major contributors to this report include Paul Alois, Wendy Matson, Claudia Christodoulou, Judy McEleney, Lisa Rooney, Tracy Samuel, Arnold Blanck, Sue Gold, and Brian Mason.

Audit Findings and Recommendations

As previously discussed, one of the key controls over readmission costs under the DRG method is the combining of admission and readmission claims into one DRG claim under appropriate circumstances. This avoids the cost of having duplicate DRG billings and duplicate reimbursement to provider hospitals. Hospitals are responsible for ensuring that they properly combine DRG admission and readmission claims and the Department and the contractor are responsible for ensuring that hospitals are compliant and, therefore, are not over reimbursed. However, we found that hospitals often are not properly combining the DRG claims and the Department and the contractor are not adequately fulfilling their roles to monitor and detect incorrect DRG claims that result in duplicate billings and payments. Consequently, there is increased risk that New York State Medicaid is overpaying millions of dollars to hospitals for readmission of patients.

Hospital Claiming Practices

The Department's policies require that when the same hospital discharges a patient and then readmits the patient for the same or a related condition, the claim for the original admission and the subsequent readmission must be combined into one DRG claim if: (1) the combined payment will be less than the amount paid if both stays were paid as a separate DRG claims; (2) the patient is readmitted with 31 days to the same facility for the same or a similar illness; and (3) the readmission resulted from a premature discharge, or was for care that that could have been provided during the first admission.

To assess whether these policies were complied with, we worked with officials at nine hospitals to review a judgmental sample of 44 DRG claims totaling about \$387,000 for admissions and the related 44 DRG claims totaling about \$480,000 for the readmissions of the same patients on the same days. Officials at five of the hospitals which accounted for 24 sets of the admission and readmission claims (totaling about \$514,000) acknowledged that 15 of the sets (totaling about \$347,000) should have been combined into single DRG claims according to Department policy. When combined, payments for these 15 sets of claims would have totaled only about \$184,000. Therefore, the hospitals overbilled and the Department overpaid the claims by about \$163,000 (\$347,000 - \$184,000). Further, as a result of our review, the five hospitals refunded the \$163,000 to Medicaid.

To illustrate what we found, a Medicaid recipient was admitted to a hospital on May 27, 2007 for treatment of kidney and urinary tract infections and was discharged. About five hours after discharge, the recipient was readmitted to the same hospital again to treat kidney and urinary infections. Although both the admission and the readmission were clearly related, the hospital did

not combine them into a single claim. Consequently, the hospital received two DRG payments (of \$11,076 each) totaling \$22,152. Had the two claims been combined as required, the hospital only would have been reimbursed for \$11,076. Thus, the hospital was overpaid \$11,076 in this instance.

The remaining four hospitals did not agree that any of their separate claims totaling about \$354,000 for readmissions for the same patients on the same day as discharge should have been combined. For these hospitals, we recommend that the Department examine our analysis of the claims and follow up with the hospitals to verify whether overpayments have been made and recoveries are in order.

Based on our review we identified factors that may be causing hospitals to not follow Department policies for combining DRG admission and readmission claims when it is appropriate to do so. For example, regulations that are the basis for Department policy state that the “*same or a related condition*” is necessary for a stay to be considered a DRG readmission requiring combined billing and that it is inappropriate to reimburse separately for readmission if “*the readmission resulted from a premature discharge, or was for care which could have been provided during the first admission.*” However, these criteria are not further defined or otherwise clarified and illustrated with specific examples and the Department’s policy has not been updated since 1988. Therefore, some provider hospitals take wide latitude in making determinations about what constitutes “*same or related condition,*” “*premature discharge,*” and “*care which could have been provided during the first admission.*”

In addition, officials at certain hospitals informed us that they routinely submit separate admission and readmission claims for hospital stays within 31 days of each other for the same patient because they assume the Department’s contractor will advise them if there is a problem that they need to respond to. This is contrary to the Department’s stated policy and greatly increases the risk for overpayments.

In response to our findings Department officials indicated that they will consider evaluating the impact of DRG readmissions during 2010, and they will update policies as appropriate. We believe the Department should act expeditiously to address the lack of clarity about separate and combined admission and readmission claims because there is presently considerable risk for substantial Medicaid overpayments to take place.

Reimbursement Policy

Considering the fiscal constraints confronting New York State and the significant contributing impacts from the State’s Medicaid program, we urge the Department to evaluate potential cost saving reform initiatives for DRG reimbursement for readmissions as explained in the following paragraphs.

The New Jersey Medicaid payment policy requires automatically denying a hospital readmission that takes place within seven days of discharge for the same patient for a similar illness. New Jersey then permits hospitals to submit a formal justification for billing the readmissions that have been denied. In this regard, New Jersey officials told us that, based on the review of the justifications, they continue to deny about 75 percent of the claims that were initially denied. They further advised that readmission claims are often denied because the patients were not stable at the time of discharge for the original admission. We concluded that, if New York followed the same policy as New Jersey and had the same experience as New Jersey, the State would have saved about \$53 million in hospital Medicaid payments in addition to the amounts that are already identified and saved through contractor efforts.

Presently, New York only requires the combining of admission and readmission claims for the same patient under specified conditions for a particular hospital. The rules for combining hospital claims do not apply when a patient is discharged from one hospital (hospital A) and then is readmitted to another hospital (hospital B) even when hospital A and hospital B are affiliated within the same overall organizational structure. In contrast, Michigan extends limitations requiring the combining of admission and readmission claims to other hospitals, including those that are affiliated. If New York extended the limitations to affiliated hospitals, the State would have the potential to generate significant Medicaid savings. For example, the New York City Health and Hospital Corporation is a very large municipal hospital system that includes 11 affiliated acute care facilities. If New York treated the affiliated hospital as one hospital provider instead of separate hospitals (as would be the case in Michigan), nearly 8,900 DRG admission and readmission claims paid by eMedNY during our audit period would have been subject to potential combining as one DRG claim with resultant cost savings.

Contractor Claims Review

The contractor's review of DRG admission and readmission claims is reportedly effective at identifying where claims should have been combined and at achieving resultant cost savings. For example, the contractor reports savings of about \$1,800 per claim examined for DRG readmissions that are within one day of discharge from the original admission. Further, the contractor reports savings of about \$1,025 per claim examined for DRG readmissions within 2 to 31 days of discharge from the original admission.

To maximize return on investment, the Department instructed the contractor to exclude about \$725 million in certain DRG readmission claims that the Department believed had little or no likelihood of payment error. For example, the Department excluded from contractor review those claims pertaining to the categories of AIDS/HIV, Admission Day (to claim interim

payment prior to discharge), Patient Transfers, and Medicaid as a secondary payer. However, we found that the Department prepared no formal analysis to ensure the cost effectiveness of excluding these categories of claims from contractor review. To illustrate the importance of such an analysis, if the contractor review of these claims identified errors and savings at the same proportion as results for claims that are reviewed, then additional savings of about \$74.5 million would have been generated during our audit period. This includes savings of \$11.8 million for 6,842 readmissions within one day of discharge and \$62.7 million for 66,089 readmissions within 2 to 31 days of discharge. (Estimated savings are after considering any additional contractor costs associated with reviewing the claims.)

- Recommendations**
1. Follow-up with the four hospitals identified in this report that did not agree they were overpaid for any DRG readmission claims and determine whether any such claims were, in fact, overpaid. Make recovery of any overpayment.
 2. Remind all hospitals that the role of the Department's contractor does not relieve them of their responsibility to adhere to Department policies for combining admission and readmission claims as appropriate for DRG billing.
 3. Update Department policies for DRG readmission claims to provide useful clarifications and illustrations that will foster compliance.
 4. Formally evaluate policy changes for DRG readmissions including (a) denying all readmissions within one day of discharge for the same patient until appropriate justification is provided for paying the readmission claim and (b) treating affiliated hospitals as one hospital entity.
 5. Perform an analysis to determine if it is cost effective for the Department to exclude from contractor review the categories of claims cited in this report.

Agency Comments



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

April 5, 2010

Steven E. Sossei, CPA
Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236

Dear Mr. Sossei:

Enclosed are the New York State Department of Health's comments on the Office of the State Comptroller's draft audit report 2009-S-28 on "Medicaid Payments for Hospital Readmissions."

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in cursive script, appearing to read 'James W. Clyne, Jr.'.

James W. Clyne, Jr.
Executive Deputy Commissioner

Enclosure

cc: James Sheehan
Robert W. Reed
Donna Frescatore
Diane Christensen
Nicholas Meister
Stephen Abbott
Ron Farrell
Mary Elwell
Irene Myron
Lynn Oliver

**Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2009-S-28 on
"Medicaid Payments for Hospital Readmissions"**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2009-S-28 on "Medicaid Payments for Hospital Readmissions."

Recommendation #1:

Follow-up with the four hospitals identified in this report that did not agree they were overpaid for any DRG readmission claims and determine whether any such claims were, in fact, overpaid. Make recovery of any overpayment.

Response #1:

The Office of the Medicaid Inspector General (OMIG) will review the overpayments identified and pursue appropriate recoveries.

Recommendation #2:

Remind all hospitals that the role of the Department's contractor does not relieve them of their responsibility to adhere to Department policies for combining admission and readmission claims as appropriate for DRG billing.

Recommendation #3:

Update Department policies for DRG readmission claims to provide useful clarifications and illustrations that will foster compliance.

Recommendation #4:

Formally evaluate policy changes for DRG readmissions including (a) denying all readmissions within one day of discharge for the same patient until appropriate justification is provided for paying the readmission claim and (b) treating affiliated hospitals as one hospital entity.

Responses #2, #3 and #4:

The Governor's Executive Budget contains an initiative that implements a payment adjustment for potentially preventable admissions. This payment adjustment will reduce payment rates for those hospitals that have rates of potentially preventable readmissions within a defined time period above a calculated standard. At the time of this response, this proposal, which would require a change in state law, is under discussion with the New York State Legislature.

Recommendation #5:

Perform an analysis to determine if it is cost effective for the Department to exclude from contractor review the categories of claims cited in this report.

Response #5:

A new method, if enacted, would reassess the types of claims that are identified for review.