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**New York State Office of the State Comptroller**  
Thomas P. DiNapoli

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Division of State Government Accountability

# **Payments for Death-Related One-Day Inpatient Admissions**

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## **Medicaid Program Department of Health**

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# Executive Summary

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## Purpose

To determine whether the Department of Health (Department) appropriately and effectively implemented and applied the new APR DRG-based hospital inpatient payment system for Medicaid services when patient deaths occur within one day of admission. The audit covers the period December 1, 2009 through September 30, 2012.

## Background

Effective December 1, 2009, responding to statutory changes enacted by the Legislature, the Department implemented a change to the Medicaid reimbursement methodology used to compensate hospitals for inpatient medical care. The new methodology, based on All Patient Refined Diagnosis Related Groups (APR DRG), was implemented to provide a more equitable payment method for hospital inpatient services and to better reflect the variable costs associated with individual patient treatment.

## Key Findings

- Since the implementation of the APR DRG-based methodology, Medicaid has paid significantly more for certain claims when patient deaths occur within the first day of admission. For instance, Medicaid paid \$153,329 on a claim with hospital charges totaling \$9,685 for a patient who died within the first day of admission. The APR DRG-based methodology assigns additional importance to the reason for admission and severity of illness in calculating reimbursements. Usually, the more severe the illness, the higher the reimbursement factor. Because patient deaths can result from more severe medical conditions, Medicaid payments for death-related one-day admissions can be substantially higher than the hospital's charges for treating the patient.
- For the 1,833 claims we reviewed, Medicaid payments averaged 225 percent of the hospitals' submitted charges (more than 5 times the rate for other inpatient claims). Under the APR DRG-based methodology, there is no adjustment for a 'short stay' except for certain patient transfers and specialty hospitals. By modifying the APR DRG-based reimbursement methodology to reflect the lower charges associated with one-day death-related inpatient admissions, we estimate that Medicaid could have saved as much as \$31.1 million.

## Key Recommendations

- Formally assess the Department's implementation and application of the APR DRG-based system, including the inpatient reimbursement methodology, that compensates hospitals for the cost of care when death occurs within one day of admission.
- Use the results of the formal assessment to revise the APR DRG-based reimbursement methodology, as warranted.

## Other Related Audits/Reports of Interest

[Department of Health: Medicaid Claims Processing Activity April 1, 2011 Through September 30, 2011 \(2011-S-9\)](#)

[Department of Health: Improper Medicaid Payments For Misclassified Patient Discharges \(2009-S-26\)](#)

**State of New York**  
**Office of the State Comptroller**

**Division of State Government Accountability**

August 15, 2013

Nirav R. Shah, M.D., M.P.H.  
Commissioner  
Department of Health  
Corning Tower  
Empire State Plaza  
Albany, NY 12237

Dear Dr. Shah:

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 the Medicaid Program entitled *Payments for Death-Related One-Day Inpatient Admissions*. 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*

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This report is also available on our website at: [www.osc.state.ny.us](http://www.osc.state.ny.us)

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## Background

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Medicaid is a federal, state and local government program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the fiscal year ended March 31, 2012, New York's Medicaid program had more than 5.5 million enrollees and Medicaid claims costs totaled about \$50 billion. The federal government funds about 49 percent of New York's Medicaid costs; the State funds about 34.5 percent; and the localities (the City of New York and counties) fund the remaining 16.5 percent.

The Department of Health (Department) administers the Medicaid program in New York State. Medicaid recipients in need of inpatient hospital care are provided a full range of necessary diagnostic, palliative and therapeutic care, including but not limited to surgical, medical, nursing, radiological, laboratory and rehabilitative services. For the fiscal year ended March 31, 2012, Medicaid paid hospitals approximately \$5.5 billion for inpatient services. The Department uses its automated eMedNY system to process Medicaid claims and make payments.

Pursuant to Chapter 58 of the Laws of 2009, Public Health Law Section 2807-C (35) was added which required the utilization of All Patient Refined Diagnosis Related Groups (APR DRG) for Medicaid payments of hospital inpatient services. Accordingly, effective December 1, 2009, New York's Medicaid program implemented the 3M™ APR DRG-based inpatient reimbursement methodology. While the previous reimbursement methodology was based, in part, on the patient's length of stay in the hospital, the new methodology is based in part on patient severity of illness and risk of mortality. According to the Department, the new methodology addresses the inadequacies of the previous method by using an updated system that is intended to reflect the variable costs associated with individual patient treatment. Further, the Public Health Law's requirement to use an updated and more precise cost base was expected to reduce the total amount of Medicaid reimbursement paid to hospitals for inpatient services, which the Department had found to be significantly overpaid.<sup>1</sup>

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<sup>1</sup> [http://www.health.ny.gov/regulations/recently\\_adopted/docs/2011-03-16\\_hospital\\_inpatient\\_reimbursement.pdf](http://www.health.ny.gov/regulations/recently_adopted/docs/2011-03-16_hospital_inpatient_reimbursement.pdf)

# Audit Findings and Recommendations

## Questionable Payments for One-Day Admissions

According to the New York Codes, Rules and Regulations (NYCRR) Title 10 Section 86, the new inpatient reimbursement methodology was developed to provide a more equitable and fair payment method for inpatient hospital services. However, based on our review of 1,833 inpatient claims in which patients died within the first day of admission, we concluded that implementation and application of the new methodology may have resulted in excessive payments of up to \$31.1 million for these services.

Since the implementation of the APR DRG-based methodology, Medicaid has paid significantly more for claims when patient deaths occur within the first day of admission. For instance, on a claim with hospital charges totaling \$9,685, Medicaid paid \$153,329 for care provided to a patient who died within the first day of admission.

The new reimbursement methodology bases payments on the reason for admission and the severity of illness, as well as other factors. More specifically, the new methodology classifies a hospital stay into one of approximately 300 APR DRGs (diagnosis related groups) based on information submitted on a hospital claim, including patient diagnoses and the medical procedures performed, as well as patient age, gender and other information. In addition to the DRG grouping, the severity of illness is used to determine provider reimbursement. Severity of illness ranges from minor to moderate, major and extreme.

Patient deaths can result from severe medical conditions, such as sepsis or extremely low birth weight. Usually, the more severe an illness is, the higher the reimbursement factor or “weight.” Medicaid payments for death-related one-day admissions can be substantially higher than the hospital’s charges for treating the patient. Conversely, if a hospital incurs costs that greatly exceed the regular payment from the APR DRG-based system, hospitals can request supplemental payments.

A provider’s “charges” represent the amounts billed for a patient’s care. Our review of the 1,833 questionable claims showed that payments often exceeded the amounts providers actually charged Medicaid. In some instances, the payments significantly exceeded the charges. In contrast, the amounts insurers (including Medicaid) pay on claims is usually less (and often considerably less) than providers’ actual charges. In fact, during our audit period, Medicaid payments for inpatient APR DRG services generally averaged about 40 percent of providers’ submitted charges.

However, for the 1,833 claims we reviewed, Medicaid paid the hospitals \$50.8 million, although the hospitals’ charges totaled only \$22.6 million. Thus, Medicaid paid the hospitals \$28.2 million (\$50.8 million - \$22.6 million) more than the hospitals charged on their claims. The payments in question averaged 225 percent of providers’ submitted charges (more than 5 times the overall rate for inpatient claims). For example, the hospital charged Medicaid \$9,685 for the services related to the aforementioned payment of \$153,329. Thus, Medicaid paid the hospital \$143,644

(\$153,329 - \$9,685) more than the hospital charged. On yet another claim, a hospital charged Medicaid \$36,618. Nevertheless, Medicaid paid the hospital \$273,555 (or \$236,937 [\$273,555 - \$36,618] more than the hospital charged). In these instances, we question why Medicaid paid the hospitals so much more than the amounts the hospitals actually charged on their claims.

The APR DRG-based methodology is continually reassessed and updated. For example, in 2011, 3M™ modified the reimbursement structure of a particular DRG for newborns with low birth weights. The modification, in part, lowered the reimbursements of claims for babies with a birth weight of about one pound and the highest level of illness severity. Although newborns of this weight and illness severity can survive, there is a greater chance for an admission of short duration due to mortality. Prior to the 2011 modification, the high severity of illness resulted in the highest reimbursement “weight” for these claims. However, pursuant to the 2011 change, claims for such admissions were assigned the lowest reimbursement “weight.” Thus, reimbursements can be reduced in recognition of the potentially shorter durations of care.

To estimate the broader potential impact of excessive payments for claims related to deaths within one day of inpatient admission, we used an approach similar to the aforementioned 2011 modification. Thus, we re-priced the 1,833 questionable claims by applying the lowest reimbursement “weight” to each claim. Under this method, we estimated that Medicaid would have paid about \$19.7 million for the claims - saving as much as \$31.1 million (\$50.8 million - \$19.7 million). For example, a hospital charged Medicaid \$65,428 to treat a patient who died within the first day of admission. Nevertheless, Medicaid paid the hospital \$128,764. In comparison, if the lowest reimbursement “weight” was applied in the payment calculation, Medicaid might have paid the hospital only \$56,619 (or \$72,145 less than the actual payment).

The \$19.7 million in estimated payments would have been about 87 percent of the providers’ actual charges (which totaled \$22.6 million). As noted previously, Medicaid generally paid about 40 percent of charges for inpatient claims. Thus, our estimated payments (amounting to 87 percent of charges) would have been much higher than payments corresponding with the general percentage (40 percent) associated with Medicaid inpatient claims. Moreover, our approach is merely an example of several the Department could use to modify the APR DRG-based methodology and better align reimbursements with the extent of inpatient services actually provided.

In responding to our preliminary observations, Department officials told us that an evaluation of the new APR DRG-based methodology requires an assessment of the entire APR DRG-based system and not just a specific claim segment (i.e., one-day inpatient admissions ending in death). Officials also acknowledged that they had not reviewed the new methodology to ensure it met its objectives with regard to one-day inpatient stays.

To comply with Section 2807-c-(35)(c) of the Public Health Law, Department officials state they will evaluate all aspects of the APR DRG-based methodology, including reimbursements for inpatient admissions of one day, by December 1, 2013. Given the State’s current financial challenges and the magnitude of the potentially excessive payments we identified, Department officials should formally review this matter and take the necessary corrective actions promptly.



## Recommendations

1. Formally assess the Department's implementation and application of the APR DRG-based system, including the inpatient reimbursement methodology, that compensates hospitals for the cost of care when death occurs within one day of admission.
2. Use the results of the formal assessment and work with 3M™, as necessary, to revise the APR DRG-based reimbursement methodology, as warranted.

## Audit Scope and Methodology

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Our objective was to determine whether the Department appropriately and effectively implemented and applied the new APR DRG-based hospital inpatient payment system for Medicaid services when patient deaths occur within one day of admission. Our audit period was from December 1, 2009 through September 30, 2012.

To meet our objective we met with Department officials and reviewed applicable laws, rules and regulations. We analyzed inpatient APR DRG claims that did not involve third party insurance. We also reviewed and re-priced 1,833 inpatient APR DRG claims totaling \$50.8 million in Medicaid payments, wherein patients died within the first day of hospital admission.

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 the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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 (some of whom have minority voting rights) to certain boards, commissions and public authorities. 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

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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

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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. In their response, officials indicated that the Department will perform an overall analysis of the APG DRG system to assess payment accuracy and equity and to propose any necessary refinements. Our rejoinder to certain Department comments is included in the report's State Comptroller's Comments.

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 This Report

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## Division of State Government Accountability

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### Vision

A team of accountability experts respected for providing information that decision makers value.

### Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

# Agency Comments

Nirav R. Shah, M.D., M.P.H.  
Commissioner

**NEW YORK**  
*state department of*  
**HEALTH**

Sue Kelly  
Executive Deputy Commissioner

July 5, 2013

Mr. Brian Mason, Audit Director  
Office of the State Comptroller  
Division of State Government Accountability  
110 State Street – 11<sup>th</sup> Floor  
Albany, NY 12236-0001

Dear Mr. Mason:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2012-S-5 entitled, "Medicaid Payments for Death Related One-Day Inpatient Admissions."

Thank you for the opportunity to comment.

Sincerely,



Sue Kelly  
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko  
Jason A. Helgeson  
James C. Cox  
Robert W. LoCicero, Esq.  
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**Department of Health  
Comments on the  
Office of the State Comptroller's  
Draft Audit Report 2012-S-5 entitled,  
Payments for Death-Related One-Day  
Inpatient Admissions**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2012-S-5 on "Payments for Death-Related One-Day Inpatient Admissions."

**Recommendation #1**

Formally assess the Department's implementation and application of the APR DRG-based system, including the inpatient reimbursement methodology, that compensates hospitals for the cost of care when death occurs within one day of admission.

**Recommendation #2**

Use the results of the formal assessment and work with 3M™, as necessary, to revise the APR DRG-based reimbursement methodology, as warranted.

**Response #1 and 2**

Section 2807-c-(35)(c) of the Public Health Law requires the Department of Health (the Department) to update the base period utilized for costs and statistics for rate-setting no less frequently than every four years. This requires the Department to implement an update effective no later than December 1, 2013. Part of this required update will include an overall analysis of the APR DRG system to assess payment accuracy and equity and to propose any necessary refinements that ensure hospitals do not avoid treating expensive cases or are advantaged by treating less costly conditions. A goal of a severity-adjusted DRG system is to reduce the amount of cost variation within DRGs and to more fully capture differences in severity of illness between patients.

Caution must be exercised when drawing conclusions and formulating recommendations for systemic changes based on a review of a very small and targeted sample of cases or comparing payments to a methodology no longer being utilized. To do so may result in unintended consequences to other aspects of the methodology. While acknowledging that there will be cost and payment variation in cases within a DRG and the applicable severity levels, the current payment system has been designed to provide equitable payments for patients expected to have similar resource use and clinical patterns of care.

The Department does not agree that a methodology change is needed but, as stated above, will evaluate all aspects of the current methodology in preparation of the upcoming base year update.

\*  
Comment  
1

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Comment  
2

\* See State Comptroller's Comments, page 12.

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## State Comptroller's Comments

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1. Our report does not recommend systemic changes to the APR DRG-based reimbursement methodology. Rather, the report recommends assessment of the APR DRG-based methodology that compensates hospitals for care when death occurs within one day of an inpatient admission. During our audit period, this pertained to only about 650 high-dollar claims per year. In addition, contrary to the Department's assertion, we applied an approach similar to one in current use to estimate the potential Medicaid cost savings for the 1,833 claims we examined. As noted in our report, 3M™ used such an approach to modify certain facets of the APR DRG-based methodology in 2011. As our report also notes, Medicaid could have paid \$31.1 million more than necessary for the 1,833 claims in question.
2. We are pleased that the Department will evaluate all aspects of the APR DRG methodology in efforts to comply with the pertinent provisions of the Public Health Law. However, we also note that unnecessary payments for death-related one-day inpatient admissions could have approached \$1 million per month during our audit period. As such, material cost savings could be realized through adjustments to the claims payment process for such admissions. Thus, we encourage the Department to evaluate this aspect of the APR DRG methodology in the most timely manner.