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

Division of State Government Accountability

Overpayments of Hospitals' Claims for Lengthy Acute Care Admissions

Medicaid Program
Department of Health

Report 2010-S-30 July 2013

Executive Summary

Purpose

To determine whether Medicaid overpaid hospitals by reimbursing for higher levels of medical care than those actually provided to patients. The audit covers the period April 1, 2005 through March 31, 2010.

Background

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, rehabilitative and psychiatric care. When billing Medicaid for inpatient services, hospitals must indicate a patient's level of care on a claim to ensure accurate processing and payment. Certain levels of care are more intensive, and therefore more expensive than others. When a patient is designated to a lower (and therefore less costly) Alternate Level of Care (ALC) setting, hospitals should not bill Medicaid for more intensive acute levels of care.

To help ensure Medicaid payments are correct, the Department uses a contractor, the Island Peer Review Organization (IPRO), to review claims. We coordinated with the Department and IPRO to review a judgmental sample of 297 hospital stays that were billed by ten hospitals for patients admitted for 50 or more days for high levels of care and without any ALC.

Key Findings

- For the five years ended March 31, 2010, Medicaid overpaid 94 (of the 297) selected inpatient stays by about $7.8 million, primarily because hospitals billed Medicaid for days in acute care settings when, in fact, patients received lower cost ALC.
- In one case, Medicaid paid $130,432 for 249 days of acute care for a patient hospitalized in 2008. Although the hospital provided acute care on the first day of the admission, the patient actually received less costly ALC for the remaining 248 days. If the hospital billed this admission correctly (with 248 days at the ALC rate), Medicaid would have paid only $67,748. Thus, Medicaid overpaid the hospital $62,684 ($130,432 - $67,748).
- During our audit period, Medicaid paid claims for nearly 10,600 inpatient stays per year (on average) of 50 or more days of acute care without any ALC. These inpatient stays cost Medicaid about $750 million per year. Given the relatively high incidence (32 percent) of overpayments from the sample that was reviewed, there is high risk that Medicaid overpaid many other inpatient claims for acute care by tens of millions of dollars a year.

Key Recommendations

- Recover the $7.8 million in inappropriate payments identified in this audit.
- Formally notify hospitals of the correct way to bill inpatient claims for ALC.
- Review additional claims at high risk of overpayment due to incorrect charges for acute care.

Other Related Audits/Reports of Interest

Department of Health: Medicaid Claims Processing Activity April 1, 2011 through September 30, 2011 (Report 2011-S-9)

Department of Health: Medicaid Claims Processing Activity October 1, 2010 through March 31, 2011 (Report 2010-S-65)

State of New York
Office of the State Comptroller

Division of State Government Accountability

July 25, 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 *Overpayments of Hospitals' Claims for Lengthy Acute Care 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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Background

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 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. At that time, the federal government funded about 49 percent of New York's Medicaid costs, the State about 34.5 percent, and the localities (the City of New York and counties) 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, rehabilitative and psychiatric care. From April 1, 2005 through March 31, 2010, Medicaid paid hospitals $26.3 billion for inpatient medical services.

In general, Medicaid reimburses hospitals for inpatient medical care through the use of two payment methods - Diagnosis Related Groups (DRGs) and per diem rates. Hospitals receiving a DRG payment are paid an amount that covers a span of inpatient days. The DRG payment is dependent on several factors such as a patient's medical diagnosis, procedures performed, age and/or birth weight. In addition to the DRG payment, supplemental payments can also be made for care involving unusually high costs. Conversely, hospitals receiving per diem payments are paid a predetermined daily amount for each day a patient is hospitalized. Hospital rehabilitation claims, for example, are paid using the per diem method.

When billing Medicaid for inpatient care, hospitals must indicate a patient's level of care to ensure accurate processing and payment. Certain levels of care (such as acute care) are more intensive, and therefore more expensive than others. When a patient is placed in a lower Alternate Level of Care (ALC) setting, hospitals should not bill Medicaid for more intensive acute levels of care (such as DRG rates). Rather, hospitals should bill a less expensive ALC per diem rate.

We have addressed claim payments for acute care (versus ALC) in previous audit reports. In those audits, we determined that Medicaid sometimes paid for acute care when, in fact, lower cost ALC was provided to a patient. Furthermore, when overpayments were made for ALC days, they were often material. Consequently, we made several recommendations to the Department to help prevent overpayments for ALC days.

Audit Findings and Recommendations

Hospital Acute Care Claims

Medicaid overpaid certain inpatient claims because hospitals billed for higher (and more costly) levels of care than what were actually provided to patients. For the five years ended March 31, 2010, Medicaid overpaid 94 (of 297) selected inpatient stays by about $7.8 million, primarily because hospitals billed Medicaid for days in acute care settings when, in fact, patients received lower cost ALC. Since the average claim overpayment was nearly $83,000, the Department should take prompt actions to recover the overpayments identified and ensure that similar overpayments do not occur in the future.

When a patient is hospitalized for an extended inpatient stay (for instance, 50 or more days), it would not be unusual for a portion of that admission to be spent in acute care and another portion in lower cost ALC. In such cases, hospitals should bill Medicaid accurately for the different levels of care actually provided to patients. During the five years ended March 31, 2010, Medicaid paid almost $3.8 billion for 52,944 hospital stays of 50 or more days of high levels of care and without any ALC. In certain instances, patients were hospitalized for five years exclusively at high levels of care.

To help ensure Medicaid services are appropriate, necessary and billed correctly, the Department uses a contractor, the Island Peer Review Organization (IPRO), to review inpatient claims. In coordination with the Department, we requested IPRO to review a judgmental sample of 297 hospital stays (costing Medicaid $72.3 million) that were billed by ten hospitals for patients admitted for 50 days or more for high levels of care and without any ALC. Based on its review, IPRO concluded the hospitals incorrectly billed 94 (32 percent) of the 297 selected hospital stays. In 90 cases, the hospitals billed days for higher levels of care that should have been billed at less expensive ALC rates. In the remaining 4 cases, hospitals lacked sufficient medical records to support their claims.

Medicaid paid $10.6 million for the 94 hospital stays that were billed in error. Based on its review, IPRO concluded that Medicaid should have paid only $2.8 million for those stays. Thus, Medicaid overpaid the hospitals by $7.8 million ($10.6 million - $2.8 million). The overpayments ranged from approximately $100,000 to $1.4 million by hospital. In one case, Medicaid paid $130,432 for a patient who was hospitalized for 249 days, from April 19, 2008 through December 24, 2008. However, IPRO concluded only the first day of the stay was acute care, and the remaining 248 days should have been billed at a lower ALC rate. Had this stay been billed accurately (with 248 days billed at the ALC rate), Medicaid would have paid the hospital only $67,748. Thus, Medicaid overpaid the hospital $62,684 ($130,432 - $67,748) for this admission.

In another case, Medicaid paid a hospital $1,207,766 for 1,835 days of care (over five years) at an acute psychiatric rate. However, IPRO determined that the patient did not need any acute psychiatric care. Moreover, had the hospital billed Medicaid at an ALC rate, it would have been paid only $568,815. Because the hospital billed improperly (for acute care), Medicaid overpaid

the hospital by $638,951 ($1,207,766 - $568,815).

During our audit period, Medicaid paid claims for nearly 10,600 inpatient stays per year (on average) of 50 or more days of acute care without any ALC. On average, these inpatient stays cost Medicaid about $750 million per year. Given the relatively high rate (32 percent) of overpayments from our audit sample, we conclude there is high risk that Medicaid overpaid many other claims for acute care as well. Moreover, given the annual volumes and amounts of these questionable claims, the related overpayments could amount to several tens of millions of dollars a year. Consequently, additional Department attention to these high risk claims is warranted.

As noted previously, we have addressed this matter with Department officials in previous audits. Nevertheless, Medicaid continued to make material overpayments for claims for acute care when ALC was actually provided. Prior to our audit, IPRO's reviews of these types of "long stays" were limited. After we advised the Department of our audit results, officials agreed to take corrective actions and instruct IPRO to include other similar long stay claim payments in their reviews. In addition, at the time we concluded our fieldwork, Department officials were taking steps to recover the $7.8 million in overpayments our audit identified.

In December 2009, the Department implemented a new inpatient reimbursement methodology known as All Patient Refined Diagnosis Related Groups (APR DRG). According to Department officials, the amount of incorrect payments should decrease significantly with the Department's shift to the APR DRG method because it does not rely as heavily on the length of hospitalization as the prior payment methodology did. However, we note that payments made using the per diem approach still remain at risk of overpayment. During the 2012 calendar year alone, Medicaid paid about $1.2 billion for per diem acute care claims.

Recommendations

1. Recover the $7.8 million in inappropriate payments identified in this audit.

2. Formally notify the ten hospitals of the correct way to bill inpatient claims for ALC.

3. Modify IPRO's sampling plan to select and review claims at high risk of overpayment due to incorrect charges for high (acute) levels of care.

Audit Scope and Methodology

Our objective was to determine whether New York State's Medicaid program overpaid hospitals that incorrectly reported the patients' levels of medical care. The audit covers the period April 1, 2005 through March 31, 2010.

To meet our objective, we met with Department officials and reviewed applicable laws, rules and regulations. We analyzed DRG and per diem psychiatric and rehabilitation claims for recipients having hospital stays of 50 or more days. From this analysis, we selected a judgmental sample of

297 hospital stays for such admissions from 10 New York City hospitals for review. We provided the sample to IPRO for detailed evaluation of the billing and medical records pertaining to the related claims.

We conducted our performance audit in accordance with generally accepted government auditing standards. These 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 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 (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

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. In their response, Department officials concurred with our recommendations and indicated that certain actions have been and will be taken to address them.

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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Vision

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

Agency Comments

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

May 24, 2013

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

Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments regarding Office of the State Comptroller's Draft Audit Report 2010-S-30 entitled, "Overpayments of Hospitals' Claims for Lengthy Acute Care Admissions."

Thank you for the opportunity to comment.

Sincerely,

Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: Michael Nazarko
Robert W. Locicero, Esq.
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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2010-S-30 Entitled
Overpayments of Hospitals' Claims
For Lengthy Acute Care 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 2010-S-30 entitled, "Overpayments of Hospitals' Claims for Lengthy Acute Care Admissions."

Recommendation #1:

Recover the $7.8 million in inappropriate payments identified in this audit.

Response #1:

This recommendation is in regards to the OSC observation of hospitals billing Medicaid at the inpatient acute care rate instead of the lower cost alternate level of care (ALC) rate. The utilization review contractor, Island Peer Review Organization (IPRO), under direction of the Department's Division of Certification and Surveillance (DCS), reviewed the approximately 300 claims referenced in the OSC audit findings. Based on their analysis, IPRO contacted providers and obtained the hospital inpatient documents necessary to implement Recommendation #1. IPRO is now in the process of submitting void and adjustment transactions to correct claims history and recover overpayments.

Recommendation #2:

Formally notify the ten hospitals of the correct way to bill inpatient claims for ALC.

Response #2:

The Department has directed the Computer Science Corporation (CSC) Provider Relations Unit to contact the providers and provide billing guidance as to the correct way to bill inpatient claims for ALC. In addition, the Department is preparing an article for the May 2013, Medicaid Update which will also explain the proper methodology for billing claims of this nature, referencing the appropriate section of the Provider Manual billing guidelines.

Recommendation #3:

Modify IPRO's sampling plan to select and review claims at high risk of overpayment due to incorrect charges for high (acute) levels of care.

Response #3:

Pursuant to an agreement reached at the exit conference for this audit, the OSC has transmitted a second review sample of 300 claims consisting primarily of long stay cases. The Department has instructed IPRO to evaluate this sample and develop a plan to incorporate the review of these additional claims as part of its ongoing claim review. These additional reviews will be initiated during the current contract year.

In addition to the above sample, IPRO has been instructed to conduct an analysis of long stay per diem claims. Based on their findings, a determination will be made by the Department as to whether additional long stay claims will be added to the sampling plan as part of IPRO's ongoing claim review process for the current contract year.