NEW YORK STATE | Department of Health

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Andrea Inman
Audit Director
Division of State Government Accountability
NYS Office of the State Comptroller
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Dear Andrea Inman:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2023-S-23 entitled, "Improper Medicaid Payments to Hospitals for Outpatient Services Billed as Inpatient Services for Recipients Enrolled in Managed Care."

Should you have any questions, please feel free to contact Nichole Katz, Acting Assistant Commissioner for Governmental Affairs, at (518) 473-1124.

Sincerely,

Johanne E Morne

Johanne E. Morne, M.S.
Executive Deputy Commissioner

Enclosure

cc: Nichole Katz

Department of Health Comments on the Office of the State Comptroller's Final Audit Report 2023-S-23 entitled, "Improper Medicaid Payments to Hospitals for Outpatient Services Billed as Inpatient Services for Recipients Enrolled in Managed Care"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2023-S-23 entitled, "Improper Medicaid Payments to Hospitals for Outpatient Services Billed as Inpatient Services for Recipients Enrolled in Managed Care". Included in the Department's response are the Office of the Medicaid Inspector General's (OMIG) replies to applicable recommendations. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with the laws and regulations.

Recommendation #1

Develop and provide guidance to hospitals and MCOs to assist them in determining if a service should be billed as an inpatient or outpatient claim, including when patients leave the hospital against medical advice.

Response #1

The Department has reviewed Medicare and Medicaid inpatient payment policies and associated regulations. We have drafted an article for an upcoming edition of the monthly Medicaid Update providing billing guidance to hospitals for short-stay inpatient encounters, including cases where patients leave against medical advice.

Managed Care Organizations generally follow fee-for-service guidance for coverage and billing. Managed Care Organizations must comply with guidance contained in the Medicaid Update per Section 37 in the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract. Once the Medicaid Update is published with fee-for-service guidance, the Department will distribute guidance to the Managed Care Organizations to share with their network providers.

Recommendation #2

Review the 13 reported admissions with payments totaling $151,508 that were inappropriately billed and recover overpayments, as appropriate.

Response #2

OMIG reviewed the OSC-identified claims and determined that $33,273 of the payments are not eligible to be reviewed for this project due to the claims having already been voided. OMIG continues to perform analysis on the remaining $118,235 OSC-identified claims, as well as the methodology OSC used to calculate the potentially inappropriate overpayments. OMIG will recover any overpayments identified. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to a provider's right to due process. It should be noted that the $151,508 identified by OSC is the maximum amount of payments to be reviewed, not the amount to be recovered, as a portion of these could be determined to be appropriately paid.

Recommendation #3

Develop a risk-based approach to review the remaining 61,138 reported admissions identified in this audit that have inpatient encounter and GME payments totaling $683.8 million, giving particular focus to shorter patient stays (e.g., patient stays of 10 or fewer hours), to identify improper payments and make recoveries, as appropriate.

Response #3

OMIG continues to perform analysis on the identified claims, as well as the methodology OSC used to calculate the potential overpayments. For clarification, for the data referenced in the above recommendation, the shorter recipient stays of ten or fewer hours account for 13,402 admissions, comprised of encounters and Graduate Medical Education totaling $143.9 million.

OMIG's analysis of the $683.8 million has isolated the following Diagnosis-Related Group codes. Based on the All Patient Refined Diagnosis Related Groups Weights, these encounters typically include an Average Length of Stay of at least three days. Hospital stays of this length are usually low risk of being inappropriately classified as inpatient.

Code	Diagnosis	Encounters	Total Paid
141x	Asthma	2380	$23,602,246
566x	Antepartum (Before Birth)	1894	$17,524,131
225x	Appendectomy	1365	$14,855,921
532x	Major Reproductive System Disorders	1304	$12,121,663
249x	Gastroenteritis	1218	$10,905,838
383x	Cellulitis or Skin Infection	1165	$10,844,292
420x	Diabetes	1119	$10,707,980
138x	Bronchiolitis	996	$9,844,347
560x	Childbirth Standard Delivery	956	$8,598,021
		12397	$119,004,439

OMIG's additional analysis has isolated the following Diagnosis-Related Group codes related to the OSC-identified shorter stay encounters of ten or fewer hours and considers them usually low risk of being inappropriately classified as inpatient.

Code	Diagnosis	Encounters	Total Paid
566x	Antepartum (Before Birth)	838	$7,815,529
225x	Appendectomy	303	$3,110,963
141x	Asthma	280	$2,671,977
383x	Cellulitis or Skin Infection	285	$2,624,050
560x	Childbirth Standard Delivery	234	$2,135,109
420x	Diabetes	185	$1,809,342
532x	Major Reproductive System Disorders	170	$1,522,520
249x	Gastroenteritis	152	$1,326,703
138x	Bronchiolitis	102	$926,736
		2579	$23,942,929

Additionally, OMIG identified 246 encounters totaling $2,863,550 which were also identified in the audit universe for OSC's audit 2021-S-8. For program integrity purposes related to OMIG activities, a Medicaid claim can only be recovered once.

OMIG will evaluate this approach in an effort to adequately identify overpayments for recovery. It should be noted that the $683.8 million identified by OSC represents the amount of payments to be reviewed, and does not necessarily equate to the amount that can or will be recovered, as a portion of these could be determined to have been appropriately paid.

Recommendation #4

Develop an ongoing process to identify and review the appropriateness of high-risk, short-stay inpatient claims, such as the ones identified in this audit.

Response #4

As a result of the recent analysis, OMIG has been meeting internally to discuss the development of a process to identify and review the appropriateness of high-risk, short-stay inpatient claims, including those OSC identified in this audit. It should be noted that the $683.8 million identified by OSC is the maximum amount of payments to be reviewed, and is not the amount to be recovered, as a portion of these could be determined to have been appropriately paid.