THOMAS P. DINAPOLI
STATE COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

August 28, 2024

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

Re: Improper Medicaid Payments to Hospitals for Outpatient Services Billed as Inpatient Services for Recipients Enrolled in Managed Care
Report 2023-S-23

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 conducted an audit of the Department of Health to determine whether Medicaid made improper payments to hospitals for outpatient services that were erroneously billed as inpatient services for recipients enrolled in managed care. The audit covered the period from July 2019 through June 2023.

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The Medicaid program is administered by the State's Department of Health (DOH).

Most of the State's Medicaid recipients receive their medical services through Medicaid managed care organizations (MCOs). When managed care enrollees receive inpatient care or outpatient care from hospitals, MCOs reimburse the hospitals. DOH also pays hospitals Graduate Medical Education (GME) payments related to inpatient care to help cover the expenses associated with training resident physicians. If a hospital later re-bills an inpatient claim as an outpatient claim, however, the GME payment is not allowed. DOH requires MCOs to submit post-adjudicated claims (called encounters) to DOH to report the care and corresponding costs for all recipients.

Varying rules, regulations, and guidance exist relating to when a patient's medical care is considered a hospital inpatient admission. New York Codes, Rules and Regulations define an inpatient admission as the formal acceptance by a health facility of a patient who is to be provided with room, board, and continuous nursing service in an area of the health facility where patients generally stay at least overnight. Regulations from the Centers for Medicare & Medicaid

Services (CMS) require that an order for inpatient admission must be present in the medical record.

Outpatient care provided in a hospital is defined by CMS as care that a patient receives (typically in the emergency department or observation room) without being admitted to the hospital as an inpatient, even if the care takes place overnight. CMS guidance also states that inpatient admissions are generally appropriate when the admitting practitioner expects the patient to stay through at least two midnights.

Our audit focused on inpatient claims with patient stays less than 24 hours ("short-stay") to identify high-risk claims that could have been incorrectly classified as inpatient instead of outpatient.

Results of Audit

For the period from July 2019 through June 2023, we identified a risk population of 61,171 short-stay admissions where providers reported both an inpatient encounter and GME claim and were reimbursed $684.5 million. We reviewed the medical records for a sample of 33 admissions with payments totaling $773,492 and obtained feedback from hospitals and MCOs. Seven of the 33 (21%), totaling $83,568, were incorrectly classified as inpatient instead of outpatient, all with patient stays of 10 or fewer hours. In one case, a patient arrived at the emergency department in stable condition. The patient was discharged about 5 hours later despite the admission order stating that the patient was expected to stay through at least two midnights. Hospital officials confirmed that this case should have been billed as an emergency department (outpatient) claim even though an admission order was present. We also identified six additional inappropriate payments, totaling $67,940, that were due to other issues. In total, the 13 inappropriately billed admissions resulted in improper payments of $151,508 ($83,568 + $67,940).

The remaining risk population of 61,138 (61,171 – 33) reported short-stay admissions identified in this audit, with inpatient encounter and GME payments totaling $683.8 million, was provided to DOH for their review. Based on our sample review, patient stays of 10 or fewer hours were higher risk. Following is a table of the $683.8 million broken out by hours of patient stay.

Breakdown of Payments

Hours of Patient Stay	Reported Admissions	Payments	Percent of Payments
Less than 5	4,181	$43,286,081	6%
5–10	9,221	100,699,988	15%
11–15	11,105	121,425,674	18%
16–20	19,499	218,140,804	32%
21–23	17,132	200,252,952	29%
Totals	**61,138**	**$683,805,499**	

DOH did not conduct reviews of short-stay inpatient encounters or provide guidance to MCOs and hospitals to assist them with determining whether a short-stay claim should be billed as inpatient or outpatient, which could have contributed to the billing misclassifications. In

addition, hospital officials told us that some of the inappropriate payments were due to clerical errors.

DOH officials stated they could not provide information on inpatient admission rules for MCOs because the billing rules are determined by what is in the MCOs' contracts with hospitals. Also, many admissions are determined on a case-by-case basis. Nonetheless, statements from officials at two hospitals and five MCOs were not always consistent on inpatient admission rules. Both hospitals stated that an inpatient admission order was required to bill a claim as inpatient, but four of the MCOs stated their policies don't require an inpatient admission order. In addition, the hospitals and MCOs we spoke with provided differing policies for handling inpatient admissions relating to patients leaving against medical advice. Without clear guidelines to follow, the likelihood of errors increases, especially when patient stays are just a few hours in duration as highlighted by the seven sampled misclassified cases we identified. DOH officials stated they are developing guidance to send to hospitals and MCOs regarding inpatient admission rules.

Recommendations

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.

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

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.

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.

Audit Scope, Objective, and Methodology

The objective of this audit was to determine whether Medicaid made improper payments to hospitals for outpatient services that were erroneously billed as inpatient services for recipients enrolled in managed care. The audit covered the period from July 2019 through June 2023. Our audit evaluated inpatient encounter claims where the recipients stayed in the hospital less than 24 hours (time from admission to discharge).

To accomplish our audit objective and assess relevant internal controls, we interviewed DOH, hospital, and MCO officials, and examined hospital and MCO policies and procedures as well as applicable federal and State regulations. We also analyzed claims from the Medicaid Data Warehouse (MDW) and eMedNY (DOH's Medicaid claims processing and payment system) and reviewed medical records provided by hospitals. We relied on data from the MDW and eMedNY that, based on work performed by OSC, is sufficiently reliable for the purposes of this audit without requiring additional testing.

We used a non-statistical sampling approach to provide conclusions on our audit objective. We selected a judgmental sample for this work. Because we used a non-statistical sampling approach, we cannot project the results to the population. We initially selected 30 admissions each from two different hospitals (based on location and high count of patient stays less than or equal to 24 hours). The 60 admissions were selected based on various risk factors, such as duration of stay and GME claims with no corresponding inpatient encounter payments. We later identified a final population at risk of misclassification with reported admissions of less than 24 hours where both the encounter and GME claims were paid. Based on the results of this work, 33 of the 60 admissions were in the final risk population. We obtained information from five MCOs billed for the 33 admissions.

We shared our methodology and findings with DOH and the Office of the Medicaid Inspector General during the audit for their review. We took their comments into consideration and adjusted our analyses as appropriate.

Statutory Requirements

Authority

This 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.

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 objective. 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. These duties could be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of DOH's oversight and administration of Medicaid payments to hospitals for outpatient services inappropriately billed as inpatient services for recipients enrolled in managed care.

Reporting Requirements

We provided a draft copy of this report to DOH officials for their review and formal comment. We considered DOH's comments in preparing this report and have included them in their entirety at the end of the report. In their response, DOH officials generally concurred with the audit recommendations and indicated that certain actions have been and will be taken to address them. Our response to certain DOH remarks are included in the report's State Comptroller's Comments, which are embedded in DOH's response.

Within 180 days after 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 the recommendations were not implemented, the reasons why.

Major contributors to this report were Paul J. Alois, Samuel Carnicelli, Mostafa Kamal, Jamala M. Benjamin-Hurdle, Suzanne Loudis, and Kelly Traynor.

We would like to thank the management and staff of DOH for the courtesies and cooperation extended to our auditors during this audit.

Very truly yours,

Andrea Inman
Audit Director

cc: Melissa Fiore, Department of Health
Amir Bassiri, Department of Health
Frank T. Walsh, Jr., Office of the Medicaid Inspector General

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

July 26, 2024

Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Andrea Inman:

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

Thank you for the opportunity to comment.

Sincerely,

Johanne E Morne

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

Enclosure

cc: Melissa Fiore
Amir Bassiri
Jacqueline McGovern
Jennifer Danz
James Dematteo
James Cataldo
Brian Kiernan
Timothy Brown
Amber Rohan
Michael Atwood
OHIP Audit
DOH Audit

Department of Health
Comments on the Office of the State Comptroller's Draft 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) Draft 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.

General Comments:

The following comments address specific statements made in the draft audit report.

Audit, Scope, Objective, and Methodology (page 3, last paragraph)

"We used a non-statistical sampling approach to provide conclusions on our audit. We selected a judgmental sample for this work. Because we used a non-statistical sampling approach, we cannot project the results to the population."

Recommendations (page 3, 3rd recommendation)

"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."

Department Comments

Even though OSC said they cannot project their results to the population of 61,171 short-stay admissions totaling $684.5 million and their judgmental sample of 33 short admissions totaling $773,492 (less than 1% of the at-risk population) found only 7 payments that may have been charged as inpatient instead of outpatient, OSC still recommends the Department and OMIG review the remaining 61,138 short-stay admissions totaling $683.8 million. The Department and OMIG have concerns that such a large and burdensome review may not be justified by the very small potential for improper payments and recoveries. In an effort to utilize resources to maximize the health of the Medicaid program, the Department and OMIG agree to such reviews to the

extent that resources are available, giving priority to other reviews with a higher likelihood of substantial impact as is appropriate.

State Comptroller's Comment – We acknowledge that reviewing a population of claims can be a large undertaking. Accordingly, audit Recommendation 3 states OMIG should develop a "risk-based" approach for the remaining 61,138 reported admissions, giving particular focus to shorter patient stays (e.g., patient stays of 10 or fewer hours). If DOH uses this approach, the claims with the highest risk can be identified and prioritized for review and recovery.

Audit Recommendation Responses:

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 is reviewing both Medicare and Medicaid inpatient payment policy and associated regulations. Once completed, the Department will publish a Medicaid Update article that will provide billing guidance to hospitals on short stay inpatient encounters. MCOs generally follow fee-for-service (FFS) guidance for coverage and billing. MCOs 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 FFS guidance, the Department will distribute guidance to the MCOs 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 has verified voids totaling $33,273. OMIG continues to perform analysis on the OSC-identified claims, as well as the methodology OSC used to calculate the potential overpayments, and will monitor for adjustment and recovery, as appropriate. It should be noted that the $151,508 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 paid appropriately.

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, of the 61,138 reported admissions with inpatient encounter and GME payments totaling $638.8 million, the shorter patient stays of 10 or fewer hours account for 13,402 of the admissions with inpatient encounter and GME payment totaling $144 million.

OMIG's analysis has isolated the following top 10 Diagnostic Related Groups codes. Based on the All Patients Refined Diagnosis Related Group Weights, these encounters typically include an Average Length of Stay (ALOS) of at least three days. Hospital stays of this length are usually low risk of being inappropriately classified as inpatient.

State Comptroller's Comment – We question OMIG's approach to create the list of the top 10 Diagnostic Related Groups codes. For example, OMIG's list includes code "137x – Major Respiratory Infections"; however, three of the seven reported admissions that our audit found were incorrectly billed as inpatient instead of outpatient had the code "137x," and all three cases had patients who were discharged within 10 hours of the start of the stay. We encourage OMIG to reconsider its approach by applying information based on the findings from this audit.

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
137x	Major Respiratory Infections	1116	$15,969,954
138x	Bronchiolitis	996	$9,844,347
560x	Childbirth Standard Delivery	956	$8,598,021
		13513	$134,974,397

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

State Comptroller's Comment – We agree it would not be appropriate to recover a claim payment more than once. However, a claim can be reviewed against multiple different criteria to confirm appropriateness of payment. OSC audit 2021-S-8 identified a population of inpatient claims for Medicaid recipients who were reported as discharged from a hospital but then admitted

to a different hospital within the same day or following day (which often meets the definition of a transfer). The OSC audit found those claims were at a high risk of overpayment if the first hospital incorrectly reported an actual transfer as a discharge. As such, OMIG should review the appropriateness of the high-risk claims identified in both OSC audits by determining: (1) if the service provided was inpatient or outpatient and (2) if the recipient was discharged or transferred to another hospital.

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 paid appropriately.

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:

OMIG continues to perform analysis on the identified claims, as well as the methodology OSC used to calculate the potential overpayments. For clarification, of the 61,138 reported admissions with inpatient encounter and GME payments totaling $638.8 million, the shorter patient stays of 10 or fewer hours account for 13,402 of the admissions with inpatient encounter and GME payment totaling $144 million. 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 paid appropriately.