OFFICE OF THE NEW YORK STATE COMPTROLLER

DIVISION OF STATE GOVERNMENT ACCOUNTABILITY

New York State Department of Health

Medicaid Overpayments for Non-Emergency Out-of-State Inpatient Services

Report 2009-S-35

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 the Department of Health entitled *Medicaid Overpayments for Non-Emergency Out-of-State Inpatient Services*. 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

EXECUTIVE SUMMARY

Audit Objective

The objective of our audit was to determine if the Department of Health was appropriately paying out-of-state hospitals for non-emergency services provided to New York State Medicaid recipients.

Audit Results - Summary

The New York State Medicaid Program has not been appropriately paying out-of-state hospitals for their non-emergency inpatient services to New York State Medicaid recipients. In fact, the Department has been making millions of dollars of Medicaid overpayments to out-of-state providers of such services for some time. In total, our audit concludes that as much as $9.2 million of potential New York State Medicaid overpayments have taken place during our audit period of May 1, 2002 through April 30, 2009.

The overpayments happened because Department management failed to follow regulations requiring the Department to use the payment methodology that would result in the lowest Medicaid cost. Instead, the Department had adopted non-compliant practices of paying out-of-state hospital claims based on outdated understandings of how the home state of the out-of-state provider hospital processed its Medicaid billings. We also found that costly out-of-state non-emergency hospital inpatient services were taking place without the prior approval of the Department that is required when services are performed outside the usual medical marketing area of New York State Medicaid recipients.

One of the claims we examined was for a Plattsburgh Medicaid recipient who received inpatient non-emergency services at a hospital 800 miles away in Cincinnati, Ohio. The Department did not provide the required prior approval for the service which was billed to New York State for over $1.5 million. Moreover, the claim was not re-priced to ensure it did not exceed the amount it would have been limited to under New York's Regulations. Had there been a re-pricing of the claim to limit payment to what New York Medicaid would pay, the Department would have been able to determine that it was overpaying up to $1.4 million to the out-of-state hospital.

We recommend that that the Department further review the potential overpayments and pursue recovery where appropriate. We also recommend that the Department complies with established requirements for ensuring that out-of-state provider claims be paid using the calculation method that would result in the lowest Medicaid cost. In addition, we recommend that prior approvals

be obtained for claims not within the usual medical marketing area of New York State Medicaid recipients.

Our audit includes four recommendations to the Department to improve its oversight of claim payments for out-of-state non-emergency inpatient services and to recover any overpayments made to the providers of such services. Department officials generally concurred with our recommendations and indicated that steps have been and are being taken to implement them.

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
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Introduction

Background

The Department of Health (Department) administers the New York State Medicaid program, which generally requires Medicaid recipients to obtain non-emergency hospital-based treatment within the State. However, in some cases recipients may also obtain services from hospital providers located outside the State. According to NYCRR Title 18, Section 527.1, payment for out-of-state hospital-based treatment should be limited to the lesser of: the hospital's customary charge for similar services to public beneficiaries; the amount payable under the federal Medicare program; the amount payable under the Medicaid program in the hospital's home state; or the maximum amount payable for similar in-State care under New York's Medicaid program. New York and many other states generally use the Diagnostic Related Group (DRG) methodology to classify services and establish reimbursement rates for hospitals treating Medicaid recipients.

Approval requirements differ depending upon whether the out-of-state hospital is located in an area where it is customary for the inhabitants of a region to receive care or utilize medical resources and facilities. Department guidelines refer to this area of customary use as the recipient's medical marketing area. If the out-of-state hospital is within the recipient's medical marketing area, the Department does not require prior approval for the patient to receive services. However, if the out-of-state hospital is not within this area, the recipient's New York-based physician must formally request prior approval to obtain the services. This request must include a list of in-State hospitals that have been contacted and an explanation why each is unable to provide the necessary services.

Out-of-state hospitals must be enrolled as providers in New York State's eMedNY System to bill and receive payment for services to New York State Medicaid recipients. From May 2002 through April 2009, hospitals in 42 states outside New York were authorized to submit claims through eMedNY for non-emergency inpatient services to Medicaid recipients. During this period, the Department paid out-of-state hospitals over $116 million for these services based on 16,998 claims as illustrated below.

State	No. of Claims	Amount Paid
Pennsylvania	6,705	$34,383,486
Vermont	5,104	28,578,091
New Jersey	2,339	20,836,586
Virginia	310	5,718,099
Ohio	137	5,694,810
All Other States	2,403	21,374,580
Total	**16,998**	**$116,585,652**

Audit Scope and Methodology

We audited to determine whether the Department was appropriately paying out-of-state hospitals for non-emergency inpatient services to New York State Medicaid recipients for the period May 1, 2002 through April 30, 2009.

To accomplish our objectives, we interviewed Department officials, reviewed applicable sections of federal and State laws and regulations, and examined the Department's relevant policies and procedures. We also identified 24 states where hospitals had been reimbursed $13.2 million based on a percentage of their actual charges submitted as part of 256 claims. We considered these payments to be high risk since this methodology often results in higher payments to providers. We contacted officials at each of these 24 states' Medicaid programs to determine the customary method used to calculate their own in-state reimbursements. We also determined that 183 of these claims resulted in individual payments in excess of $10,000 each. For each of these claims, we worked with Department staff to determine the appropriate DRG classification for the services provided and used this information to determine the maximum amount that should have been paid for similar in-State care. Finally, we reviewed all claims filed on behalf of the 50 recipients who accounted for the largest payments for this type of out-of-state care to determine if they had received prior approval when required. In total, our tests included 461 Medicaid claims totaling $15.9 million.

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 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

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 generally concurred with our recommendations and indicated that steps have been and are being taken to implement 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 the Report

Major contributors to this report include Bob Wolf, Rebecca Vaughn, Christopher Morris, Judith McEleney, Mark Breunig, Anthony Calabrese and Brian Mason.

Audit Findings and Recommendations

Overpayments to Out-of-State Providers

As previously discussed, restrictions contained in the Medicaid regulations limit reimbursement for non-emergency inpatient services provided to Medicaid recipients by out-of-state hospitals. In general, these payments should be no more than the amount an in-State provider would receive for similar services under New York's DRG System. We identified $9.2 million of potential Medicaid overpayments made between May 2002 and April 2009 which occurred because the Department calculated reimbursements to some providers using a cost-based methodology that was almost always more expensive. Department officials told us that, irrespective of the regulations, they did not have resources available to routinely re-price these out-of-state claims using New York's methodology and, as a result, simply paid the hospitals based upon what they believed was the customary method used in the provider's home state. However, we found the Department's information was outdated or inaccurate for most states.

We focused part of our examination on $13.2 million in Medicaid reimbursements paid to hospitals in 24 other states based on 256 Medicaid claims that were calculated based on a percentage of the hospital's actual charges. We found 183 of these claims each resulted in payments of more than $10,000. Seven of these claims lacked all the information we needed, but we were able to re-price the remaining 176 claims using New York State's DRG methodology. We found only 12 of these claims were correctly paid. The other 164 claims, which totaled $11 million, were overpaid by $9.2 million.

In one case, a hospital in Cincinnati, Ohio submitted a claim for non-emergency services provided to a Medicaid recipient from Plattsburgh which totaled over $1,567,000. We re-priced the claim using the DRG method and determined that the hospital should have been paid only about $117,000; a savings of $1,450,000 for this case alone. In another case, a hospital in Boston submitted a claim totaling $422,000 for inpatient services and was subsequently paid $316,500, calculated based upon 75 percent of the billed charges - the method reportedly used by Massachusetts. We re-priced the claim and determined the hospital should have been paid only $4,400; an overpayment of more than $312,000. Department officials also recalculated this claim and agreed that it was significantly overpaid. They noted that the hospital may have qualified for a higher payment if it provided sufficient documentation justifying additional reimbursable costs, but no such documentation was provided during our audit.

As illustrated in the following table, the largest amount ($4.4 million) of the overpayments we identified went to providers in Ohio. Hospitals in several other states including Rhode Island, Pennsylvania and North Carolina also received significant overpayments.

State	No. of Claims	Amount Paid	Overpayment
OH	46	$ 4,930,538	$ 4,412,839
RI	58	2,359,424	2,133,354
PA	17	929,675	700,467
NC	3	763,626	618,893
NE	5	629,025	445,668
MD	12	380,505	211,442
MA	1	339,405	234,620
NJ	4	237,745	132,146
SC	7	166,124	105,650
All Others	11	323,082	230,119
Totals	**164**	**$ 11,059,149**	**$ 9,225,198**

These overpayments could have been prevented if Department management had properly programmed the eMedNY System to apply the correct criteria to non-emergency inpatient service claims submitted by out-of-state providers. In addition, these overpayments may also have been prevented if the Department performed manual reviews of such claims as an alternative to, or in concert with, the automated controls. Department officials told us they did not have resources to allocate to reviewing and re-pricing these claims and, as a result, had decided to simply pay the claims using the method reportedly used by the provider's home state. However, we found this information was inaccurate and outdated, often resulting in even greater overpayments.

We contacted officials in each of the 24 states (including Ohio) where the Department had paid provider claims based on a percentage of billed charges during our audit period. We found 18 (75 percent) of them actually use a DRG methodology similar to New York's to calculate and pay claims for non-emergency hospital services. Most of these states had changed their reimbursement methods at some time as a result of their own Medicaid policy revisions. However, Department officials did not stay abreast of these revisions and, as a result, compounded the overpayment problem by continuing to use outdated information.

As a result of our audit, the Department has recently changed the way it reimburses out-of-state hospitals for inpatient services. For any claims that have discharge dates after November 2009, out-of-state providers will now

be paid based on DRG methodology and rates applicable to New York State providers. This change will significantly reduce the extent of overpayments. At the same time, this single-method approach still falls short of the lowest cost requirement contained in the Medicaid regulations. As our sample showed, paying a hospital based on the methodology in place in its home state was less expensive than the DRG method for 12 of the 176 claims we examined. Department managers need to devise other supplemental methods to identify these situations, such as manual review of claims from certain states or for certain procedures that are likely to result in lower cost.

Lack of Prior Approvals

The Department's State Medicaid Handbook states that necessary medical care and services can be obtained in a "usual medical marketing area location" where "…it is customary for the inhabitants of the district generally to use medical care resources and facilities outside New York State." The Handbook further states prior approval for claims will be required for medical care and services outside the usual medical marketing area. Notwithstanding these requirements, Department management has chosen to apply a much more liberal interpretation of this usual medical marketing area, opting instead to allow all recipients to seek care in any state bordering New York without prior approval regardless of where they actually reside within the State. As a result, we found that during our audit period the Department did not look for appropriate physician requests, or require prior approval, for 11,915 claims for totaling $86.2 million because the inpatient services were provided by a hospital in a neighboring state.

We examined all claims filed on behalf of the 50 Medicaid recipients who incurred the most cost for non-emergency inpatient services at out-of-state hospitals during our audit period. These 461 claims totaled $15.9 million. We found required prior approval had not been granted for 269 of these claims totaling $10.8 million and covering 33 of the 50 Medicaid recipients, even though the services were provided at locations which could not reasonably be considered within the patient's usual area of service.

For example, we found one recipient traveled over 270 miles from their home in Caledonia in northern Livingston County to Pittsburgh, Pennsylvania for non-emergency treatment. Similarly, another recipient who resided in an Ulster County nursing home traveled nearly 200 miles to Boston, Massachusetts for care. Since these services were provided in a bordering state, the Department did not look for prior approval. Even after applying the Department's more liberal criteria, we still found 59 of these claims totaling $4.9 million lacked appropriate approval because the 13 recipients had received care in states that do not border New York. For example, one recipient from Plattsburgh in Clinton County obtained non-emergency services more than 800 miles away in Cincinnati, Ohio without prior approval.

In their response to our draft report, Department officials stated that claim payments to all out-of-state providers are now made in accordance with the DRG methodology used for New York State providers, pursuant to changes in Department regulations effective December 2009. Further, the Department will require prior approval of an out-of-state service only when it is necessary to negotiate a special rate payment because the service is not available in New York and the out-of-state provider will not accept the DRG payment. In this case, the Department will confirm that the service is not available in New York and negotiate the payment amount prior to approving the service. Thus, the Department will not question the need to obtain a service out-of-state (and require prior approval of such service) if the provider is willing to accept the DRG payment for it.

We believe this action would be a fiscally imprudent use of New York State taxpayer funds. Prior to the recent changes in the regulations, the Department required physicians to demonstrate why the needed services could not be obtained at hospitals within New York State. In light of the current fiscal issues facing the State, we believe New York State Medicaid funds should first be used in support of in-state healthcare systems rather than be directed to other states without consideration of medical necessity.

Recommendations

1. Review the 164 claims we identified as overpayments (approaching $9.2 million) and recover funds, as appropriate.
2. Management should formally assess the level of risk of the out-of-state inpatient claim payments we did not review. For claims at higher risk, identify overpayments and make recoveries.
3. Management should adhere to Department regulations by reimbursing out-of-state hospitals using the calculation method that will result in the lowest reimbursement amount.
4. Management should require prior approvals be obtained for services rendered to New York State Medicaid recipients by out-of-state healthcare providers.

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

March 11, 2010

Brian E. Mason, Audit Manager
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236

Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments on the Office of the State Comptroller's draft audit report 2009-S-35 on "Medicaid Overpayments for Non-Emergency Out-of-State Inpatient Services."

Thank you for the opportunity to comment.

Sincerely,

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-35 on
"Medicaid Overpayments for Non-Emergency
Out-of-State Inpatient Services"

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-35 on "Medicaid Overpayments for Non-Emergency Out-of-State Inpatient Services."

Recommendation #1:

Review the 164 claims we identified as overpayments (approaching $9.2 million) and recover funds, as appropriate.

Recommendation #2:

Management should formally assess the level of risk of out-of-state inpatient claim payments we did not review. For claims at higher risk, identify overpayments and make recoveries.

Responses #1 and #2:

Prior to the start of the OSC audit, the Office of the Medicaid Inspector General (OMIG) had already initiated reviews of payments for non-emergency out-of-state inpatient hospital services. OMIG identified $21 million in potential overpayments (encompassing the $9.2 million identified by OSC) and referred a sample totaling $3.5 million to the Department's utilization review contractor, Island Peer Review Organization (IPRO), for review. Depending on the results of IPRO's review, the OMIG will make a decision on whether further review activities and/or recoveries of overpayments are warranted.

Recommendation #3:

Management should adhere to Department regulations by reimbursing out-of-state hospitals using the calculation method that will result in the lowest reimbursement amount.

Response #3:

As of December 2009, Department regulations specify that out-of-state providers are to be reimbursed utilizing the Diagnostic Related Group (DRG) methodology at New York State rates. The DRG methodology is commonly utilized by State Medicaid programs, Medicare and commercial insurers, thus helping to insure accurate and understandable billing through the use of a standard methodology.

Recommendation #4:

Management should follow guidelines requiring prior approvals be obtained for claims not within the usual medical marketing area of New York State Medicaid recipients.

*
Comment

Response #4:

Per revised Department regulations, the usual medical marketing area no longer applies. Payments to all out-of-state providers are now in accordance with New York State rates using the DRG methodology. Requiring a prior approval program, therefore, would serve only to add unnecessary expenses to the Medicaid program. Prior approval will only be required in the event that it is necessary to negotiate a special rate because the service is not available in New York State and the out-of-state provider of the service refuses to accept New York State DRG reimbursement. In these special cases, the Department will confirm the services are not available in New York State and negotiate reimbursement prior to issuance of the prior approval.

*** State Comptroller's Comment:**

We amended Recommendation no. 4 by deleting the reference to the *usual medical marketing area* and instead referencing *out-of-state providers*.