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October 26, 2012

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

Re: Report 2012-F-11

Dear Dr. Shah:

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 have followed up on the actions taken by officials of the Department of Health (Department) to implement the recommendations contained in our audit report, *Medicaid Overpayments for Hospital Readmissions* (Report 2009-S-28).

Background, Scope and Objectives

The Department of Health (Department) administers New York State's Medicaid program which provides medical coverage to people who are economically disadvantaged and/or have special health needs. The Department uses its eMedNY system to process providers' medical claims and to reimburse them for medical services provided. To help control New York State's Medicaid costs (including hospital readmissions), eMedNY uses the Diagnosis Related Group (DRG) billing method which uses standard payment amounts for specified hospital treatments. The DRG method also requires hospitals to combine admission and readmission claims for reimbursement to avoid duplicate costs associated with separate DRG billing for an initial hospital admission as well as a subsequent readmission for the same or a related illness. Hospitals are required to prepare claims in accordance with DRG billing policies. The Department uses a contractor to determine whether hospitals are complying with these policies. The contractor determines whether overpayments were made and if recoveries are necessary.

Our initial report was issued on December 23, 2009. Our objective was to determine if New York State's Medicaid program overpaid hospitals when the hospitals readmitted the same patients they had recently discharged and did not combine the claims. During the audit period, (January 1, 2004 through June 30, 2009), New York's Medicaid program paid $4.9 billion of

claims for hospital readmissions for the same patient within 31 days of the patient's initial discharge. We found hospitals were often not properly combining DRG claims. We also found the Department and its contractor was not adequately monitoring claims to detect incorrect DRG readmission claims resulting in inappropriate payments. The objective of our follow-up was to assess the extent of the implementation, as of August 22, 2012, of the five recommendations included in our initial report.

Summary Conclusions and Status of Audit Recommendations

Department officials made progress in addressing the problems we identified in the initial report. Of the initial report's five audit recommendations, three have been implemented, one has been partially implemented, and one is no longer applicable.

Follow-up Observations

Recommendation 1

Follow-up with the four hospitals identified in this report that did not agree they were overpaid for any DRG readmission claims and determine whether any such claims were, in fact, overpaid. Make recovery of any overpayment.

Status - Partially Implemented

Agency Action - In July 2010, the Department implemented a new Medicaid hospital readmission payment policy. Pursuant to the new policy, the Department has reduced payments to hospitals with readmission rates that exceed a Department-established limit. Further, because the Department used paid claims data from 2007 and thereafter to calculate reductions in reimbursement rates, officials determined that it would be inappropriate to recover payments from any hospitals dating back to 2007. Also, the Department did not review payments prior to 2007. At the time of our follow-up, most of these payments were beyond the statute of limitation, and therefore, they are no longer recoverable.

Recommendation 2

Remind all hospitals that the role of the Department's contractor does not relieve them of their responsibility to adhere to Department policies for combining admission and readmission claims as appropriate for DRG billing.

Status - Not Applicable

Agency Action - Pursuant to the aforementioned policy change, the Department no longer requires hospitals to combine admission and readmission claims.

Recommendation 3

Update Department policies for DRG readmission claims to provide useful clarifications and illustrations that will foster compliance.

Status - Implemented

Agency Action - Pursuant to the aforementioned policy change, the Department no longer requires hospitals to combine admission and readmission claims. Further, the new policy clarified and simplified the process for preparing admission and related readmission claims.

Recommendation 4

Formally evaluate policy changes for DRG readmissions including (a) denying all readmissions within one day of discharge for the same patient until appropriate justification is provided for paying the readmission claims and (b) treating affiliated hospitals as one hospital entity.

Status - Implemented

Agency Action - As noted previously, the Department established a new policy which reduces reimbursements for hospitals with excessive readmission rates (rather than deny all readmissions within one day of discharge). In addition, under the new policy, the Department treats affiliated hospitals as one hospital entity. Further, the Department also factors readmissions into the payment adjustment process, whether or not patients are readmitted to the same hospital.

Recommendation 5

Perform an analysis to determine if it is cost effective for the Department to exclude from contractor review the categories of claims cited in this report.

Status - Implemented

Agency Action - The Department's new readmission payment policy ensures all appropriate categories of claims are considered when the contractor identifies claims for excessive (preventable) readmissions and adjusts providers' reimbursement rates for such claims.

Major contributors to this report were Paul Alois, Amanda Strait and Rebecca Tuczynski.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issue discussed in this report. We also thank the management and staff of the Department of Health for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Dennis Buckley
Audit Manager

cc: Mr. James Cox, Medicaid Inspector General
Mr. Stephen Abbott, Department of Health
Mr. Stephen LaCasse, Department of Health
Mr. Thomas Lukacs, Division of the Budget