NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

April 24, 2013

Dennis Buckley, Audit Manager
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, New York 12236

Dear Mr. Buckley:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Follow-up Report 2012-F-11 on Department actions relative to the recommendations contained in earlier OSC Report 2009-S-28 on "Medicaid Overpayments for Hospital Readmissions."

Thank you for the opportunity to comment.

Sincerely,

Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: Nirav R. Shah, M.D., M.P.H.
Jason Helgerson
James C. Cox
Michael Nazarko
Stephen Abbott
Diane Christensen
Stephen LaCasse
Ron Farrell
Michelle Contreras
John Brooks

Department of Health
Comments on the
Office of the State Comptroller's
Follow-Up Report 2012-F-11 on
Medicaid Overpayments for
Hospital Readmissions

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Follow-Up Report 2012-F-11 on "Medicaid Overpayments for Hospital Readmissions" (Report 2009-S-28).

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.

Response #1:

After this audit was completed, the Legislature, at the Department's request, passed legislation effective July 1, 2010 that penalized providers who have high rates of readmission. The penalty was based upon 2007 data and is adjusted periodically. These readmission claims are known as potentially preventable readmissions, or PPR's. The four hospitals OSC recommended the Office of Medicaid Inspector General (OMIG) to follow up on were penalized $2,939,641 during State fiscal years 2010 through 2012 using this data. Given that claims from 2007 forward were being used to evaluate and penalize providers for PPRs, the OMIG feels to review and recover any of these claims would constitute a duplicate recovery on those claims identified in this report for the years 2007 through 2009.

The claims OSC reported for dates of service prior to 2007 totaled approximately $52,000, and date back as far as 2004. As of the date of this report, the statute of limitations for the OMIG to take action on any non-fraud related billing only would allow the OMIG to pursue recoveries for services billed in December 2006 on the remaining claims. As a result, it is the opinion of the OMIG that no further recovery would be applicable to this finding.

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.

Response #2:

The Department confirms agreement with this recommendation regarding diagnosis related group (DRG) billings.

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.

Response #3:

The Department confirms agreement with this recommendation regarding DRG billings.

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.

Response #4:

The Department confirms agreement with this recommendation regarding readmissions.

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.

Response #5:

The Department confirms agreement with this recommendation.