NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

June 5, 2025

Andrea Inman
Audit Director
Division of State Government Accountability
NYS Office of the State Comptroller
110 State Street, 11th Floor
Albany, New York 12236

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-13 entitled, "Medicaid Program: Overpayments for Medicare Part C Claims."

Please feel free to contact the Office of Governmental and External Affairs at (518) 473-1124 with any questions.

Sincerely,

Johanne E. Morne

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

Enclosures

cc: Alyssa DeRosa
Melissa Fiore
DOH Audit

# Department of Health Comments on the Office of the State Comptroller's Final Audit Report 2023-S-13 entitled, "Medicaid Program: Overpayments for Medicare Part C Claims"

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-13 entitled, "Medicaid Program: Overpayments for Medicare Part C Claims." Included in the Department's response is 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:**

OSC Use of A Judgmental Sample

OSC used a judgmental sample to select which payments they would review, which means the auditors selected the payments based on their professional judgement, opinion, and knowledge. As a result, the selected sample and any OSC findings or conclusions are not representative of the entire population.

**State Comptroller's Comment** – Judgmental samples–in this case, selected to focus on the highest risk—are routinely used and widely acceptable to reach audit conclusions. Additionally, the audit sampled 5 hospitals whose claims represented almost half (45%) of the total claim payments analyzed by the audit. As mentioned in the audit report, the judgmental sample review was supplemented with reviews of policies and procedures, interviews with various DOH and hospital officials, assessments of internal controls, and data analysis to reach audit conclusions and make the recommendations.

**Audit Recommendation Responses:**

**Recommendation #1**

Review the 30 (49 - 19) improperly billed claims totaling $704,989 from our sample that had not been adjusted by providers and recover overpayments, as appropriate.

**Response #1**

OMIG continues to perform analysis on the OSC-identified claims, as well as the methodology OSC used to calculate the potential overpayments. OMIG has developed a third-party liability audit project to encompass these Medicare Part C claiming patterns and will pursue recovery of any identified overpayments, where appropriate.

**Recommendation #2**

Perform ongoing monitoring of Part C claims billed by the hospitals identified in this report to

ensure the hospitals take actions to correct billing issues and any additional recoveries are made.

**Response #2**

OMIG continues to perform analysis on the OSC-identified claims, as well as the methodology OSC used to calculate the potential overpayments. OMIG has developed a third-party liability audit project to encompass these Medicare Part C claiming patterns and will pursue recovery of any identified overpayments, where appropriate.

**Recommendation #3**

Develop an ongoing process, using a risk-based approach, to identify and review hospitals that bill questionable Part C claims, such as those with a high volume of zero-filled claims and those that bill suspicious deductible amounts; recover identified overpayments; and ensure hospitals take steps to correct ongoing billing errors.

**Response #3**

OMIG has developed a third-party liability audit project to encompass these Medicare Part C claiming patterns and will pursue recovery of any identified overpayments, where appropriate.

**Recommendation #4**

Remind hospitals:

- To correctly report Part C cost-sharing liabilities;
- Of the cost-sharing reimbursement rules for Part C claims;
- That Part C benefits must be exhausted prior to billing Medicaid for services, including claims that are in the appeal stage; and
- To include all CARCs on Part C Plan EOBs.

**Response #4**

The Department issued a Medicaid Update to remind hospitals on the coordination of benefits billing protocols in the November 2024 Issue. New York State Medicaid Update - November 2024 Volume 40 - Number 12

**Recommendation #5**

Assess the feasibility of implementing eMedNY system changes that would require hospitals to report CARCs.

**Response #5**

The Department is reviewing the feasibility of implementing eMedNY system changes that would require hospitals to report Claims Adjustment Reason Codes. This includes the possible changes such as setting edit 02304 to pend for inpatient claims or designing new edits to

enforce Department policy.

**Recommendation #6**

Enhance eMedNY system controls to prevent unreasonable inpatient Part C deductible claim payments.

**Response #6**

As OSC acknowledges on Page 6 of their Final Report, *"While all Medicare recipients in Part A and Part B have the same deductible limits, the Part C cost-sharing liabilities, including deductibles, vary by Plan."*

The Department is committed to the prevention of overpayments for inpatient Part C deductible claims while avoiding inappropriate denials.

**Recommendation #7**

Prioritize the ongoing assessment of the functionality of applying edit 02304 "ZEROFILL PEND CRITERIA" to inpatient and clinic claims.

**Response #7**

The Department continues to assess the application and evaluate solutions to activating the zero-fill edit (edit 02304) for inpatient and clinic providers and make adjustments as necessary.

While this process is being evaluated, the Department has taken intermediate steps to evaluate similar claims identified in the audit. The provider identified in the audit was placed on Provider on Review (edit 1142), for zero-filled claims as a first step in the evaluation of edit 02304. Currently, twelve claims met the audit criteria and have been pended for additional documentation to complete the adjudication for payment. The Department has also run a report of paid claims that meet the audit criteria for the time frame July 1st, 2024, to December 31st, 2024. We are currently analyzing the data to determine if there are additional providers that show increased submissions of claims that would warrant pre-payment review using edit 1142.

**Recommendation #8**

Engage with stakeholders and assess the feasibility of using the Part C claim data in the APD to verify whether Part C cost-sharing information is properly reported on Medicaid claims.

**Response #8**

The Department will engage with stakeholders and assess the feasibility of using the Part C claim data to verify whether Part C cost-sharing information is properly reported on Medicaid claims.