Department of Health

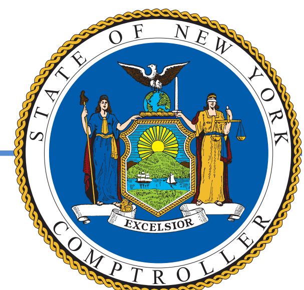
Medicaid Program: Overpayments for Medicare Part C Claims

Report 2023-S-13 | December 2024

OFFICE OF THE NEW YORK STATE COMPTROLLER

Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability



Audit Highlights

Objective

To determine whether Medicaid made improper payments on Medicare Part C claims for recipients covered by Medicare Advantage Plans. The audit covered the period from May 2018 through April 2023.

About the Program

Under Medicare Part C, private insurance companies administer Medicare benefits through different health care plans, known as Medicare Advantage Plans (Plans). Plans reimburse health care providers for services rendered to enrollees. Many Medicaid recipients are enrolled in these Plans (referred to as "dual-eligibles"). Generally, Medicaid is the secondary payer and covers cost-sharing balances that are not covered by the Plans, such as a deductibles, copayments, and coinsurance, as follows. Medicaid pays 100% of the deductibles. Medicaid pays 100% of the copayments and coinsurance on inpatient claims, and Medicaid pays 85% of the copayments and coinsurance on outpatient claims except for ambulance and psychology services, for which Medicaid pays 100%.

When Plans deny a claim or pay a different amount than what a provider billed (e.g., after netting out cost-sharing liabilities), Plans must communicate those actions to providers on the Explanation of Benefits (EOB) using Claim Adjustment Reason Codes (CARCs). Providers can submit claims for these unpaid amounts to Medicaid through eMedNY, the Department of Health's (DOH) automated claims processing and payment system. When submitting claims, providers are required to include the Plan-reported CARCs. The eMedNY system uses the CARCs to determine whether a billed service is eligible for payment as well as the correct payment amount.

Key Findings

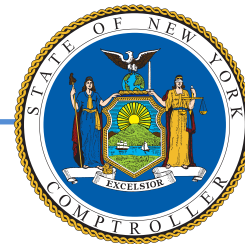
We analyzed Part C claims for hospital-based inpatient and outpatient services on behalf of dual-eligible recipients for the period May 2018 through April 2023 and identified $121.4 million in claims that fell into at least one of the following three high-risk categories for improper payment: claims with a high coinsurance amount compared to the reported Plan payment amount; claims with a high deductible amount compared to the allowed Medicare Part A or Part B deductible amount; or claims that indicated the Plan paid nothing for the service.

From a judgmental sample of 89 of these claims, totaling $1,325,452, from five hospitals, we determined Medicaid made improper payments for 49 claims (55%) totaling $881,233. (Note: 66 of the 89 claims [74%] were incorrectly billed, but 17 incorrect claims did not result in overpayments [e.g., inpatient claims billed as a deductible instead of a copayment were not overpaid because all inpatient cost-sharing is reimbursed at 100%].)

The improper Medicaid payments for Part C services occurred in part because hospitals misinterpreted State regulations and billing guidelines, did not properly submit CARCs on claims, or indicated Plans did not cover services when they actually did. We also found improvements are needed to eMedNY to prevent incorrect payments.

Key Recommendations

- Review the improperly billed claims we sampled and recover overpayments, as appropriate.
- Develop an ongoing process, using a risk-based approach, to identify and review hospitals that bill questionable Part C claims, including the hospitals identified in this report, and ensure corrective steps are taken.
- Enhance controls to help ensure Medicaid accurately pays Part C claims.



Office of the New York State Comptroller
Division of State Government Accountability

December 4, 2024

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

Dear Dr. McDonald:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the 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 Medicaid program entitled *Overpayments for Medicare Part C Claims.* 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,

Division of State Government Accountability

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Glossary of Terms

Term	Description	Identifier
DOH	Department of Health	*Auditee*
APD	DOH's All-Payer Database	*System*
CARC	Claim Adjustment Reason Code	*Key Term*
CMS	Centers for Medicare & Medicaid Services	*Federal Agency*
Dual-eligibles	Individuals enrolled in both Medicaid and Medicare	*Key Term*
eMedNY	DOH's Medicaid claims processing and payment system	*System*
EOB	Explanation of Benefits	*Key Term*
MCO	Managed care organization	*Key Term*
MDW	Medicaid Data Warehouse	*System*
OMIG	Office of the Medicaid Inspector General	*Agency*
Plan	Medicare Advantage Plan/Medicare Part C Plan	*Key Term*
Zero-filled	Claim indicating a Plan paid nothing for the service	*Key Term*

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). For the State fiscal year ended March 31, 2024, New York's Medicaid program had approximately 9.1 million recipients and Medicaid claim costs totaled about $87.5 billion. The federal government funded about 56.8% of New York's Medicaid claim costs, and the State and localities (the City of New York and counties) funded the remaining 43.2%.

DOH uses two methods to pay for Medicaid services: fee-for-service and managed care. Under the fee-for-service method, DOH, through its Medicaid claims processing and payment system (eMedNY), pays Medicaid-enrolled providers directly for services delivered to Medicaid recipients. When eMedNY processes claims, they are subject to various automated controls (or edits). The purpose of the edits is to determine whether the claims are eligible for reimbursement and whether the amounts claimed for reimbursement are appropriate. Under the managed care method, DOH makes monthly premium payments to managed care organizations (MCOs) for each enrolled Medicaid recipient and, in turn, the MCOs arrange for the provision of services and reimburse health care providers for those services.

Many of the State's Medicaid recipients are dually eligible for both Medicaid and Medicare, the federal health insurance program for those 65 years of age and older and people under age 65 with certain disabilities. Individuals enrolled in both programs are commonly referred to as "dual-eligibles." Medicare has multiple parts. Part A provides hospital insurance, including inpatient care. Part B provides medical insurance for doctors' services and outpatient care. Under Part C, private insurance companies administer Medicare benefits through different health care plans, known as Medicare Advantage Plans (Plans). Plans must include all traditional Parts A and B Medicare-approved services. Medicare pays the Plans a fixed amount every month for each Medicare Part C recipient enrolled in the Plans. Plans then reimburse health care providers for services rendered based on claims they submit to the Plans.

Generally, Medicare is the primary payer for health care services provided to dual-eligibles. Medicaid then typically pays for any remaining balance not covered by Medicare. These remaining cost-sharing balances include Medicare deductibles, coinsurance,[1] and copayments.

The federal Centers for Medicare & Medicaid Services (CMS) issues the deductible limits for Medicare Part A and Part B each year. For example, in 2023, the deductible amount for Medicare Part A was $1,600 per inpatient benefit period and $226 for Part B. 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.

1 The share of the costs of a health care service (after the deductible has been paid) that is the responsibility of the insured, typically calculated as a percent (e.g., 20%) of the allowed amount for the service.

Providers submit fee-for-service claims to Medicaid for reimbursement of Medicare Part C cost-sharing liabilities. Medicaid pays 100% of dual-eligibles' deductibles on Medicare Part C claims. Medicaid pays 85% of the coinsurance and copayments on Medicare Part C outpatient claims (such as practitioner and clinic services), except for ambulance and psychology services, for which Medicaid pays 100% of the coinsurance and copayments.[2] Medicaid also pays 100% of the coinsurance and copayments for inpatient services on Medicare Part C claims.

Plans must communicate the reason for an adjustment in payment to the provider (such as for cost-sharing liabilities) on the Explanation of Benefits (EOB) using universal Claim Adjustment Reason Codes (CARCs). Providers are required to report the CARCs from the EOB to eMedNY. The CARCs are essential for eMedNY to determine whether a billed service is eligible for payment by Medicaid as well as the correct payment amount.

In certain circumstances, Plans may deny a claim (such as when a service was rendered without a Plan's required prior authorization). Additionally, certain claims for services that are not covered by a recipient's Plan can be submitted to Medicaid for payment. Providers can submit these claims to eMedNY indicating the Plan paid nothing for the service (referred to as zero-filled claims). The eMedNY system then makes a determination whether these claims should be paid.

2 According to the New York State Social Services Law, Section 367-a, effective July 2016.

Audit Findings and Recommendations

We audited Part C claims for services provided to dual-eligible recipients for the period May 2018 through April 2023. Our data analysis, which focused on hospital-based inpatient and outpatient services (excluding claims for mental and behavioral health services), identified 212,131 claims totaling almost $121.4 million that fell into at least one of the following three high-risk categories for improper payment by Medicaid (certain claims met the criteria for more than one category):

- Coinsurance: $63.2 million in claims with a high coinsurance amount compared to the reported Plan payment amount;
- Deductible: $21.6 million in claims with a high deductible amount compared to the allowed Medicare Part A or Part B deductible amount;
- Zero-filled: $36.7 million in claims indicating that the Plan paid nothing for the service.

We requested supporting documentation for a judgmental sample of 89 of these high-risk claims, totaling $1,325,452, from five hospitals. Based on our document review and discussions with hospital officials, we identified a total of $881,233 in improper Medicaid payments for 49 of the 89 claims (55%), as outlined in Tables 1 and 2. Note: We determined an additional 17 (of the 89) claims in the sample were improperly billed; however, the 17 improper billings did not result in an overpayment (e.g., inpatient claims billed as a deductible instead of a copayment [all inpatient cost-sharing is reimbursed at 100%]). In total, 66 (49 + 17) of the 89 claims (74%) were improperly billed.

Table 1 – Overview of Sample Results by Issue

Issue	Number of Sampled Claims	Medicaid Paid Amounts	Number of Overpaid Claims	Improper Payment Amounts	Overpaid Claims as a Percent of Sampled Claims
Coinsurance	20	$227,912	5	$19,948	25%
Deductible	47	305,121	25	84,587	53%
Zero-filled	22	792,419	19	776,698	86%
Totals	**89**	**$1,325,452**	**49**	**$881,233**	**55%**

Table 2 – Overview of Sample Results by Hospital

Hospital Name	Number of Sampled Claims	Medicaid Paid Amounts	Number of Overpaid Claims	Improper Payment Amounts	Overpaid Claims as a Percent of Sampled Claims
Hospital A	12	$49,728	7	$4,984	58%
Hospital B	12	155,865	6	70,348	50%
Hospital C	35	1,004,026	28	792,695	80%
Hospital D	12	78,209	1	12,235	8%
Hospital E	18	37,624	7	971	39%
Totals	**89**	**$1,325,452**	**49**	**$881,233**	**55%**

We determined that the improper Medicaid payments occurred for a variety of reasons, such as: hospital misinterpretation of State regulations and billing guidelines, hospital billing system limitations, hospitals that did not report CARCs, and incorrect reporting of cost-sharing amounts. During the audit, we expanded our sample review for one hospital, Hospital C, due to its high rate of inpatient zero-filled claims compared to the overall sample, and we found the hospital was improperly billing for services.

By the end of the audit fieldwork, 19 of the 49 overpaid claims we identified had been adjusted by the hospitals, resulting in a Medicaid savings of $183,570. The remaining 30 claims totaling payments of $704,989 were overpaid $697,663. DOH should follow up with the hospitals on these remaining 30 unadjusted claims and recover overpayments, as appropriate. DOH should also develop a risk-based approach to identify hospitals that improperly bill Part C claims, as well as remind hospitals of the correct way to bill Part C services to avoid future improper billings.

Provider Billing Errors

Improper Deductible and Coinsurance Payments

We found that provider misinterpretation of Medicaid Part C cost-sharing reimbursement guidance, as well as limitations with certain providers' billing systems, contributed to the improper payments we identified in the high deductible sample review. For example, as Hospital C officials explained to us, their understanding of Part C reimbursement rules was that Medicaid pays 100% of deductibles, copayments, and coinsurances for all claim types, not just inpatient services (however, as previously stated, the Medicaid payment rules changed to 85% of coinsurance and copayments on most Medicare Part C outpatient claim types effective July 2016). Officials also explained that their billing system does not allow for reporting copayments, and all copayment amounts are entered as deductibles. Due to their confusion with reimbursement rules, hospital officials did not think this limitation impacted payment.

Of the 47 claims we sampled due to a high deductible amount, we determined 25 claims were improperly billed, resulting in overpayments totaling $84,587. For example, 14 of the 47 were billed by Hospital C, and of these, 13 were billed incorrectly, of which nine resulted in overpayments. Eight of the nine overpaid claims were billed as a deductible (which Medicaid reimburses at 100%) instead of a copayment or coinsurance (which Medicaid reimburses at 85%), resulting in overpayments of $35,095. We also found one inpatient claim for a deductible, for which Medicaid paid $42,210, was for a service that the Plan initially denied but then paid upon Hospital C's appeal. The hospital improperly billed Medicaid during the appeal process and did not adjust the claim until our inquiry, resulting in a Medicaid savings of $41,321. The remaining four claims (of Hospital C's 13 incorrectly billed claims) were for inpatient services and, although billed incorrectly, did not result in an overpayment (and, therefore, were not part of the 25 overpaid claims).

DOH's eMedNY system has various edits and processes in place meant to ensure the appropriate reimbursement on Part C claims, such as claims with invalid Medicare Part C amounts and claims when the reimbursement amount exceeds certain parameters. For example, eMedNY system edit 02255 "PAYOR CD 16 AMOUNTS INVALID" is designed to deny claims exceeding certain deductible limits; however, we found this edit does not apply to inpatient claims.

We shared DOH billing guidelines with Hospital C officials, and they agreed with our findings. Subsequently, Hospital C adjusted eight of the nine claims with overpayments, resulting in Medicaid savings totaling $76,397. The one remaining overpaid claim still needed to be adjusted as of the end of our audit fieldwork. Officials also stated they were making internal adjustments to ensure the correct patient responsibility classification was reported on claims, and they were in the process of upgrading to a new billing system. However, until these changes are instituted, including a new billing system, Hospital C will continue to be at risk of submitting improper claims and receiving overpayments from Medicaid.

We found other providers in our sample also reported system issues as the cause for misclassifying cost-sharing liability amounts. For example, Hospital B had five billed claims in the deductible risk category, all of which were overpaid by a total of $5,227. According to Hospital B officials, an internal system issue inappropriately mapped coinsurance and copayment amounts as deductibles. They stated that education has been provided to those responsible for patient accounting to ensure patient liabilities are appropriately applied going forward.

Similarly, of 18 claims billed by Hospital E that we identified as high risk, 16 were incorrectly billed as a deductible instead of a coinsurance or copayment—seven resulted in overpayments of $971 and nine were for inpatient services and thus did not result in an overpayment. Hospital E officials explained that their current billing system only has one field to report patient cost-sharing liability amounts. A patient responsibility code is added to the claim to indicate whether the amount is for coinsurance, copayment, or a deductible. This information is sent to a third-party biller, which then submits the claim to eMedNY on behalf of the provider. In response to our review, officials stated they will re-educate their staff on the billing guidelines for properly submitting Part C cost-sharing liabilities to Medicaid. Officials also stated they will determine if there is a way to separate cost-sharing liabilities into different fields within their existing billing system until the system is replaced.

We also determined that, of the 20 claims in the coinsurance risk group, five were improperly billed by the hospitals, resulting in overpayments totaling $19,948. According to Hospital C officials, billing errors led to three of the five improper payments totaling $19,174. The remaining two claims were further adjudicated by Plans subsequent to Hospital A's Medicaid claim submissions, but the Medicaid claims were not adjusted to reflect the new Plan payments, resulting in overpayments of $774.

Of the 30 improper payments we identified from our deductible and coinsurance risk categories, 15 were adjusted by the end of our fieldwork, resulting in a Medicaid

savings of $85,996. We encourage DOH to review the remaining high-risk claims we identified for the hospitals, recover overpayments as appropriate, and monitor the hospitals' future claims to ensure that corrective measures have been taken.

Zero-Filled Claims

In some cases, providers submit claims to eMedNY with a zero in the Plan payment field, indicating the Plan did not make a payment for the service provided. According to a July 2023 Medicaid Update (DOH's official notification to providers), for any zero-filled claims that are submitted to Medicaid, providers must retain evidence that the claims were initially billed to Medicare and/or a third-party insurer and were denied for payment prior to seeking reimbursement from Medicaid. The exception to this policy is for services and items that are statutorily not covered by Medicare, in which case the provider is responsible for providing the statutory exemption, upon request.

For our audit scope, we sampled 22 zero-filled claims (18 inpatient and four outpatient), and determined that 19 claims were improperly billed, resulting in overpayments totaling $776,698. Hospitals A, B, and D each billed one of the improper claims, resulting in overpayments totaling $79,592. The remaining 16 claims totaling $697,106 in overpayments were billed by Hospital C. According to EOBs from Hospital C, the claims (15 inpatient and one outpatient) were denied by the recipients' Part C Plans for the following reasons:

- Four were denied due to no prior authorization. For example, for one claim, according to Hospital C officials, an unforeseen procedure during the medical service resulted in a slight coding change between the time of the original service prior authorization and the billing of the claim. They stated that Plans only allow for one appeal of a denial, and because the Plan upheld the denial, they submitted a zero-filled claim to Medicaid for $3,946. When we presented this example to DOH officials, they stated that the provider improperly billed this claim to Medicaid because it didn't include the CARC code indicating the Plan denial. According to DOH guidance, providers are required to submit all CARCs as reported on the EOB when the prior payer has adjudicated the claim.
- Twelve were denied due to not meeting inpatient level of care. For example, in one case, the Plan advised Hospital C to rebill the claim as an outpatient service. However, Hospital C officials disagreed with the Plan's assessment and insisted the services were appropriately billed at the inpatient level of care. Instead of resubmitting the claim as the Plan advised (as an outpatient service), Hospital C submitted a zero-filled inpatient claim to Medicaid and received a payment of $96,302. We provided the claim detail to DOH officials, who confirmed the inpatient claim should not have been submitted to Medicaid because Medicaid honors the primary insurance denial. DOH officials referenced a policy that states Medicaid payment should not be made for services rejected or disallowed by Medicare based on finding that the services were not medically necessary.

Hospital C officials stated they disagreed with the Plan denials because the denials conflicted with the Medicare rules, and explained that they experience a higher rate of denials with certain Plans. Our sample review did confirm that some of Hospital C's claims initially denied by Plans were later overturned and reimbursed; however, the Medicaid claims were not adjusted to reflect the updated EOBs. For example, we reviewed an EOB for one inpatient claim billed as a deductible of $21,737 and found the EOB showed a deductible amount of $0 and a copayment amount of $806. Hospital C officials explained this claim was submitted to Medicaid for payment while they were appealing the denial with the Plan. As a result of our review, the hospital adjusted the claim, saving Medicaid $20,931. Hospital officials also stated their Patient Financial Services division will no longer bill clinical denials to Medicaid until the appeal process is completed.

Notably, Hospital C accounted for a significant number of the zero-filled inpatient claims on behalf of Part C recipients that were billed during our audit scope. Of the 1,866 such claims in our audit population, totaling $31.5 million, 1,365 claims (73%), totaling $25.7 million (82%), were billed by Hospital C. We determined that 1,331 of the 1,365 claims (98%), totaling almost $25 million, did not contain a CARC. Further, 14 of 15 of Hospital C's improper zero-filled inpatient claims in our sample had a CARC on the EOB but not on the Medicaid claim. In response, Hospital C officials stated that the omission of the CARCs did not impact the financial reimbursement of the claims.

Providers are required to report any CARCs to eMedNY. Additionally, eMedNY system logic specifies which CARCs are deemed payable and not payable by Medicaid. We identified five different CARCs on the EOBs corresponding to Hospital C's 14 overpaid zero-filled inpatient claims. We provided the five CARCs to DOH officials, who confirmed that all are non-payable by Medicaid and eMedNY would have denied the 14 claims if Hospital C correctly billed them with the appropriate CARC.

In response to our preliminary report, DOH officials stated they are assessing how CARC codes are reported and used to bill Medicaid for remaining patient responsibility amounts and they will strengthen system controls, if necessary. DOH should also remind all Medicaid providers that CARCs are required to be on any Medicaid claims that involve other payer adjudications to prevent future improper Medicaid payments. In addition, we encourage DOH to conduct a comprehensive review of the remaining 1,350 zero-filled inpatient claims totaling about $25 million submitted by Hospital C that were not in our sample and recover overpayments, as appropriate. As a result of our audit, Hospital C officials stated they learned CARCs can be added to the electronic billing files sent to Medicaid and they will include them going forward.

We also identified an area of improvement among an existing eMedNY edit. DOH implemented eMedNY system edit 02304 "ZEROFILL PEND CRITERIA" to flag certain zero-filled claims and require submission of supporting documentation prior to payment. However, the edit was set to pay for inpatient and clinic claims. According to DOH officials, while the edit was designed for all claim types, the implementation

was staged to address claim types that represented a higher risk of improper payment. DOH has started the evaluation process to apply this edit to other claim types; however, at the time of our audit, officials could not provide an estimate of when it would be applied to inpatient or clinic claims.

All-Payer Database

DOH's All-Payer Database (APD) contains third-party payment information, including claim information from Part C Plans. We met with DOH officials in September 2023 to discuss obtaining claim data from the APD for our sampled claims. DOH officials stated that member data (such as name and date of birth) wasn't expected to be available in the APD until March 2024 and, without that data, they could not identify specific members to fulfill our request. Upon the completion of our audit fieldwork, we followed up with DOH to confirm the APD's timeline, which was still on schedule.

According to DOH officials, however, while the APD system will have the functionality to associate a member's data with that specific member's encounters, because it was designed to support policy making and research, members would be de-identified due to privacy and confidentiality requirements. Furthermore, DOH has a data use agreement with Medicare, which governs specific uses and releases of Medicare data. DOH officials stated the APD program continues to work toward establishing formal policies and procedures for data release. Due to member de-identification and specific data release agreements, our request could not be satisfied. In response to our preliminary findings report, DOH stated that if Part C cost-sharing information is required to support administration of the Medicaid program, APD staff can assist the Medicaid program with executing a data use agreement with CMS to bring that data into the appropriate Medicaid system. We encourage DOH to explore using this valuable resource to validate Part C claim submissions instead of relying on providers to accurately report cost-sharing information.

Recommendations

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.
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.
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.

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.
5. Assess the feasibility of implementing eMedNY system changes that would require hospitals to report CARCs.
6. Enhance eMedNY system controls to prevent unreasonable inpatient Part C deductible claim payments.
7. Prioritize the ongoing assessment of the functionality of applying edit 02304 “ZEROFILL PEND CRITERIA” to inpatient and clinic claims.
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.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether Medicaid made improper payments on Medicare Part C claims for recipients covered by Medicare Advantage Plans. The audit covered the period from May 2018 through April 2023.

To accomplish our audit objective and assess related internal controls, we interviewed officials from DOH, the Office of the Medicaid Inspector General (OMIG), and providers, and examined DOH's relevant Medicaid policies and procedures as well as applicable federal and State laws. We also analyzed claims from the Medicaid Data Warehouse (MDW) and eMedNY. Our review focused on fee-for-service claims for hospital-based inpatient and outpatient services (excluding claims for mental and behavioral health services) on behalf of recipients with Medicare Part C coverage on the date of service.

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. Our sample, which is discussed in detail in the body of our report, comprised a sample of five hospitals that were among the highest in total claim payment amounts for one of three risk areas. The three risk categories we identified were: high deductible billing, reported coinsurance of more than 20% of the Plan's allowed amount, and zero-filled claims. We requested EOBs from the hospitals for a judgmental sample of 89 claims to assess the appropriateness of reported Part C cost-sharing liabilities. Claims were selected for review from each high-risk category based on highest dollar amount.

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. We shared our methodology and claim findings with the providers, DOH, and OMIG during the audit for their review. We took their comments into consideration and adjusted our analysis as appropriate.

Statutory Requirements

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.

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 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 this independent performance audit of DOH's oversight of fee-for-service Medicaid payments for recipients with Part C coverage.

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 concurred with the audit recommendations and indicated that certain actions have been and will be taken to address them.

Within 180 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department 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.

Agency Comments

Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

November 7, 2024

Andrea Inman
Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 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-13 entitled, "Medicaid Program: Overpayments for Medicare Part C."

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
Andrea Martin
James Dematteo
James Cataldo
Brian Kiernan
Timothy Brown
Amber Rohan
Michael Atwood
OHIP Audit
DOH Audit

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

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

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 is in the process of developing 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 is in the process of developing 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 continues to perform analysis on the OSC-identified claims, as well as the methodology OSC used to calculate the potential overpayments. OMIG is in the process of developing 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 will remind providers, via a Medicaid Update, to correctly report Part C cost-sharing liabilities and to include Claim Adjustment Reason Codes on Medicaid claims, as appropriate.

Recommendation #5

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

Response #5

The Department is in the process of assessing how Claim Adjustment Reason Codes are reported by primary insurance to the provider which are then used to bill Medicaid as the payer of last resort. At the completion of the analysis, any needed system changes will be initiated to require the reporting of Claim Adjustment Reason Codes by hospitals. This is an ongoing voluminous process, and the review has not yet been completed.

Recommendation #6

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

Response #6

The Department is evaluating ways of preventing unreasonable inpatient Part C deductible claim payments to all providers, including hospitals, after which changes to claims processing can be implemented.

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 evaluate solutions to activating the zero-fill edit (edit 02304) for inpatient and clinic providers. During the evaluation process, the Department will monitor the

information obtained by the edit and will selectively place providers on the Provider on Review edit (edit 1142). This action will be based on an analysis of edit 02304 information to identify providers who are outliers that show increased volume of claims hitting the edit. The Department will begin this process with the providers identified in the OSC audit.

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.

Contributors to Report

Executive Team

Andrea C. Miller - *Executive Deputy Comptroller*

Tina Kim - *Deputy Comptroller*

Stephen C. Lynch - *Assistant Comptroller*

Audit Team

Andrea Inman - *Audit Director*

Christopher Morris - *Audit Manager*

Rebecca Chromey - *Audit Supervisor*

Yueting Luo - *Examiner-in-Charge*

Linda Thipvoratrum - *Senior Examiner*

Fiorella Seminario - *Senior Examiner*

Mary McCoy - *Supervising Editor*

Contact Information
(518) 474-3271
StateGovernmentAccountability@osc.ny.gov
Office of the New York State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

For more audits or information, please visit: www.osc.state.ny.us/state-agencies/audits