NEW YORK STATE OF OPPORTUNITY. Department of Health

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Executive Deputy Commissioner

March 6, 2019

Mr. Kenneth Shulman
Assistant Comptroller
New York State Office of the State Comptroller
110 State Street, 10th Floor
Albany, New York 12236

Dear Mr. Shulman:

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 2017-S-76 entitled, "Improper Medicaid Payments for Recipients in Hospice Care."

Please feel free to contact Estibaliz Alonso, Assistant Commissioner, Office of Governmental and External Affairs at (518) 473-1124 with any questions.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Estibaliz Alonso

Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2017-S-76 entitled, "Improper Medicaid Payments for Recipients in Hospice Care"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2017-S-76 entitled, "Improper Medicaid Payments for Recipients in Hospice Care."

Recommendation #1:

Review the $5.4 million ($2.9 million + $2.4 million + $107,141) in overlapping services and ensure all overpayments are recovered.

Response #1:

The Office of the Medicaid Inspector General (OMIG) will review the identified overpayments and determine an appropriate course of action.

Recommendation #2:

Design and implement a process to identify and track all Medicaid recipients receiving hospice care and allow for providers to access this information before services are provided.

Response #2:

The Client Exception Code "C1 - Copay Exempt (Hospice)" in eMedNY identifies members receiving hospice services. The criteria used to create C1 exception code is based on existence of a paid claim with any hospice rate code (3945 through 3954). The first date of service that a client has a hospice claim is used as the effective date for setting up the exception code C1 in eMedNY.

Recommendation #3:

Determine what services are disallowed in conjunction with hospice services and update all Medicaid policy manuals accordingly. Ensure all Medicaid policy manuals reflect up-to-date hospice information, including the current definition of a terminal illness. Notify providers of all changes.

Response #3:

There is an automatic process in eMedNY to enter a Recipient Restriction/Exception (RRE) code (C1) on a client's file the first time a claim is filed with a category of "0165 (Hospice)". The code tags the client's file and indicates that pharmacy copays should be waived. Hospice patients may choose to leave hospice at any time and for those that stay in the program, they require recertification every six months. The C1 RRE code does not have an effective end date, so the system does not acknowledge that a client may have left the program or may not have recertified.

The Department will continue to collaborate with the Office of Primary Care and Health Systems Management (OPCHSM) on the feasibility of a requirement that all hospices report admissions, recertifications and withdrawals from the programs, and how those updated would be processed.

Recommendation #4:

Ensure controls are implemented that prevent duplicate payments (FFS and encounter claims) for overlapping services that should have been covered by the hospice all-inclusive daily rate.

Response #4:

Once the Department determines how to identify hospice recipients, additional edits can be added to prevent duplicate services that should be paid by the hospice from being approved as a fee-for-service (FFS) claim. The Department will update the Medicaid Hospice Manual when appropriate.

Recommendation #5:

Review the hospice payments totaling $2.6 million ($2.4 million + $203,375) and ensure all overpayments are recovered.

Response #5:

OMIG has recovered more than $314,000 and will continue to pursue recovery of any payment determined to be inappropriate.

Recommendation #6:

Formally advise the hospices that improperly billed Medicaid to bill Medicare or the recipient's MCO prior to Medicaid.

Response #6:

The Department will issue a Medicaid Update article and is currently updating the Hospice Billing Guidelines Manual to inform hospice providers to bill Medicare prior to Medicaid.

Recommendation #7:

Clarify Medicaid policies on billing the enhanced hospice rate for dual-enrolled recipients with AIDS and notify providers accordingly.

Response #7:

The Department will issue policy on billing the enhanced hospice rate for dual-eligible recipients with AIDS. The Department will inform hospice providers through a Medicaid Update article and through an update to the Hospice Billing Guidelines Manual.

Recommendation #8:

Conduct an on-site survey to investigate the deficiencies identified during our site visit to the hospice provider and ensure corrective action is taken, as appropriate.

Response #8:

OPCHSM will audit the hospices when they rotate to be visited in line with the federal guidelines. Staff will review the issues cited in the audit during these on-going hospice audit cycles.

Recommendation #9:

Review the $124,221 in room and board payments and ensure all overpayments are recovered.

Response #9:

OMIG will review the identified overpayments and determine an appropriate course of action.

Recommendation #10:

Formally advise the 49 providers in question not to bill Medicaid directly for room and board provided to recipients receiving hospice care.

Response #10:

The process of identifying active hospice clients and adding appropriate edits to eMedNY includes a denial for clients enrolled in a Managed Care or Managed Long-Term Care (MLTC) plan for nursing home charges paid under FFS. The Department sent guidance last year to all plans, hospices and hospice residences that authorization needs to be obtained from Managed Care and MLTC plans before a client is placed in a nursing facility. This guideline can be reinforced as needed, until the FFS billing stops, or directed at the hospices that are identified as repeat offenders for this problem.

Recommendation #11:

Ensure controls are implemented that prevent improper payments for room and board for hospice recipients.

Response #11:

The hospice category of service 0165 is currently set as a carved-out (carved out of MLTC plans) service on the Scope of Benefits (SOB) table, including the room and board for hospice recipients. The hospice SOB controls will be updated to include the room and board rate codes as a carved-in (responsibility of MLTC plans) service, with a "Deny" status to reject FFS claims. This change will be retroactive to an October 1, 2013 effective date. Any new room and board claims submitted to eMedNY after this change will result in a denial.

Office of the State Comptroller's Comments:

OSC Comment #1:

On August 1, 2018, we provided the Office of Primary Care and Health Systems Management with documentation supporting the deficiencies we identified during our site visit to the hospice provider (nearly two months before the Department received our draft audit report). We will reach out to the Office again to determine if any additional information is needed. We are

pleased the Department will conduct an on-site visit to investigate items within their surveillance protocol during the next standard survey.

Response to Comment #1:

OPCHSM will audit the hospices when they rotate to be visited in line with the federal guidelines. Staff will review the issues cited in the audit during these on-going hospice audit cycles.