New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Improper Medicaid Payments for Recipients in Hospice Care

Medicaid Program
Department of Health

Report 2017-S-76 December 2018

Executive Summary

Purpose

To determine whether Medicaid made improper payments to providers on behalf of recipients receiving hospice care. This audit covered the period January 1, 2013 through December 3, 2017.

Background

Hospice is a program that provides care to terminally ill individuals, with a focus on easing symptoms rather than treating the disease. Generally, when eligible Medicaid recipients elect hospice care, they waive their right to use Medicaid for curative services, and a hospice organization assumes responsibility for all medical care related to the terminal illness. Hospice can be provided in the home or in an inpatient setting and includes nursing and physician services, medical social services, drugs for symptom control and pain relief, counseling, and physical and occupational therapy. Medicaid reimburses hospice organizations an all-inclusive daily rate that covers all hospice services. From January 1, 2013 to December 3, 2017, the Medicaid program paid hospice providers about $184 million on behalf of 14,933 Medicaid recipients. Medicaid also paid about $54 million for other (non-hospice) medical services provided to the recipients while they were receiving hospice care.

Key Findings

Auditors identified about $8 million in inappropriate Medicaid payments for services provided to hospice recipients, as follows:

- $2.9 million was paid to non-hospice providers for services, such as private duty nursing, that were not allowed in combination with the daily hospice rate;
- $2.4 million was paid to non-hospice providers for drugs, durable medical equipment, home care, and other services that are covered under the daily hospice rate;
- $2.6 million was paid for hospice services that should have been covered by Medicare or a Medicaid managed care organization; and
- $107,141 was paid for hospice services while the patient was in the hospital.

Key Recommendations

- Review the $8 million and ensure proper recoveries are made.
- Clarify hospice program billing requirements and advise providers accordingly.
- Improve controls to prevent improper payments for services provided to recipients receiving hospice care.

Other Related Audits/Reports of Interest

Department of Health: Managed Care Premium Payments for Recipients With Comprehensive Third-Party Insurance (2016-S-60)

Department of Health: Medicaid Claims Processing Activity April 1, 2017 Through September 30, 2017 (2017-S-23)

State of New York
Office of the State Comptroller

Division of State Government Accountability

December 11, 2018

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by doing so, providing accountability for 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 *Improper Medicaid Payments for Recipients in Hospice Care*. 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.

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,

Office of the State Comptroller
Division of State Government Accountability

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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 (Department). For the State fiscal year ended March 31, 2018, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $62.9 billion. The federal government funded about 55.7 percent of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 44.3 percent.

Hospice is a program that provides care to terminally ill individuals, with a focus on easing symptoms rather than treating the disease. Generally, when eligible Medicaid recipients elect hospice care, they waive their right to use Medicaid for curative services, and a hospice organization assumes responsibility for all medical care related to the terminal illness. This coordinated program of home and/or inpatient hospice care includes nursing and physician services, medical social services, drugs for symptom control and pain relief, counseling, and physical and occupational therapy. In addition, hospices can provide home health aide and homemaker services, medical supplies and appliances, speech therapy, and short-term inpatient care. Hospice services must be provided according to a written plan of care.

Medicaid reimburses hospice organizations an all-inclusive daily rate, which is based on four levels of care: routine home care (lowest), continuous home care, general inpatient care, or inpatient respite care (highest). Medicaid also offers enhanced hospice rates for recipients with AIDS to cover the higher costs of care and, effective January 1, 2016, a routine home care service intensity add-on payment for services provided during the last seven days of life.

Medicaid reimburses health care providers, including hospices, either directly through a fee-for-service (FFS) arrangement or through managed care. Under the FFS method, providers submit claims for services rendered to Medicaid recipients to the Department's eMedNY computer system, which then processes the claims and generates payments for the providers. Under the managed care method, Medicaid pays managed care organizations (MCOs) a monthly premium for each enrolled Medicaid recipient and the MCO arranges for the provision of health care services and reimburses providers for those services. MCOs submit claims (referred to as encounter claims) to the Department's Encounter Intake System to inform the Department of each service provided to their enrollees.

Many of the State's Medicaid recipients are also enrolled in Medicare, the federal health insurance program for the elderly and disabled. Medicare also covers hospice services. For "dual-enrolled" recipients, Medicare is the primary payer and Medicaid is the secondary payer. In these cases, Medicaid generally pays the dual-enrolled recipients' cost-sharing obligations of copayments, deductibles, and coinsurance. Medicare cost-sharing on hospice claims is limited to $5 per prescription drug and 5 percent of the Medicare payment for inpatient respite care days.

Hospice services must be provided and billed in compliance with various State and federal laws, rules, and regulations and Medicaid policies including, but not limited to, Title 10 of the New York Codes, Rules and Regulations (NYCRR) and Chapter 4 of the State Medicaid Manual issued by the Centers for Medicare & Medicaid Services (CMS). Both the NYCRR and the State Medicaid Manual establish rules that address hospice eligibility, election, admission, and discharge requirements, as well as the provision of hospice care services. Under 10 NYCRR § 793.4, for instance, hospices are responsible for directing, coordinating, and supervising the care and services provided to recipients by all hospice and non-hospice health care providers, and for sharing information with other non-hospice health care providers rendering services unrelated to the terminal illness.

From January 1, 2013 to December 3, 2017, the Medicaid program paid about $184 million for FFS and encounter claims for hospice care services on behalf of 14,933 recipients and about $54 million for other (non-hospice) medical services provided while recipients were receiving hospice care.

Audit Findings and Recommendations

We determined the Department has not established sufficient controls to prevent improper payments for medical services provided to recipients receiving hospice care. The payments included:

- $2.9 million to non-hospice providers for services, such as private duty nursing, that were not allowed in combination with the daily hospice rate;
- $2.4 million to non-hospice providers for drugs, durable medical equipment, home care, and other services that are covered under the daily hospice rate;
- $2.6 million for hospice services that should have been covered by Medicare or a Medicaid MCO; and
- $107,141 paid for hospice services while the recipient was in the hospital.

The Department does not have a process to identify and track Medicaid recipients receiving hospice care, nor does it notify providers of recipients' hospice status before services are provided. Because the eMedNY system does not track when a recipient transitions into or out of hospice, it does not have controls to prevent payments to non-hospice providers for services that are otherwise non-allowable or duplicative or when hospice claims should have been covered by other insurance. Furthermore, the Department has not provided sufficient guidance that clearly communicates Medicaid's billing policies: specifically, services that are disallowed in conjunction with the hospice benefit and circumstances when Medicaid is not the primary payer for hospice services. Instead, the Department relies on hospice and non-hospice providers to identify Medicaid recipients enrolled in hospice, to determine the primary payer, and to bill Medicaid properly. Without stricter controls and oversight, including coordination and communication with hospices and MCO providers, the Department continues to be at increased risk of making duplicate payments for overlapping services by hospice and other providers and improper payments for services that are covered by other insurance.

During the course of our audit, other issues also came to our attention:

- Overpayments of $124,221 for nursing facility room and board, where eMedNY did not apply the correct per diem rate.
- One hospice provider did not meet State and federal medical record requirements for 8 of 28 recipients we sampled (29 percent).

Duplicate Payments for Overlapping Services

Hospices are required to provide all services necessary to meet a recipient's needs related to their terminal illness. These services include, but are not limited to:

- nursing and physician services;
- pharmaceutical drugs and nutrition;
- physical and occupational therapy;

- home health and homemaker;
- pastoral care and social work;
- psychological;
- medical supplies and equipment;
- audiology; and
- respiratory therapy.

Medicaid pays hospice providers an all-inclusive daily rate that covers the cost of these services for each individual who elects hospice coverage. Accordingly, Medicaid should not pay another provider for these services since the services are already included in the daily hospice rate.

Payments to Non-Hospice Providers for Non-Reimbursable Services

The eMedNY Hospice Program Provider Manual (eMedNY Provider Manual) specifically states the following Medicaid services are not allowed in combination with the hospice benefit: private duty nursing, certified home health agency services, and long-term home health care program services. However, we found non-hospice providers received $2.9 million in Medicaid payments (totaling 1,797 FFS and encounter claims) for these services while recipients were in hospice care (see Table 1).

Table 1 – Medicaid Payments for Non-Reimbursable Services

Service	Improper Payment Amount	Number of Improper Claims
Private duty nursing	$2,870,325	1,772
Certified home health agency	55,091	24
Long-term home health care program	31	1
Totals	**$2,925,447**	**1,797**

Payments to Hospice Providers for Non-Reimbursable Services

The Department establishes all-inclusive hospital inpatient rates that generally cover the costs of all medical services provided to Medicaid recipients during a hospital stay. Under this type of arrangement, no additional payments should be made to hospices while recipients are hospitalized. However, we found that hospices received $107,141 in Medicaid payments for 173 FFS and encounter claims that had the same date of service as a general hospital inpatient claim.

For example, Medicaid reimbursed a hospice provider $6,330 for 30 days of routine hospice care. Medicaid also paid a hospital $9,735 for 13 days of general inpatient care during the same time period. As a result, Medicaid inappropriately reimbursed the hospice $2,743 for 13 days of hospice care that should not have been billed on a day a hospice recipient was in the hospital.

Payments to Non-Hospice Providers for Other End-of-Life Services

We identified an additional $2.4 million in Medicaid payments for other end-of-life services provided to hospice recipients that were billed by and paid to non-hospice providers (see Table 2). While these services are not specifically disallowed per the Medicaid policies (in the same way as the $2.9 million in findings previously discussed), they are included under the Medicaid hospice benefit and, therefore, any medical care related to the terminal illness would be covered under the all-inclusive daily hospice rate.

Table 2 – Medicaid Payments for Other End-of-Life Services

Service	Improper Payment Amount	Number of Improper Claims
Durable medical equipment (breathing, nutrition, incontinence)	$584,922	3,766
Attendant care, companion care, and homemaker	464,032	1,590
Pharmacy drugs (analgesic, anti-nausea, laxative, anti-anxiety)	247,242	6,811
Nursing care	303,304	486
Home health care	275,722	821
Health home	266,592	1,061
Therapy (psychotherapy, physical therapy, speech therapy, counseling)	66,641	1,065
Day care	55,871	76
Case management	40,675	541
Home infusion therapy	32,388	160
Respite	10,524	66
Pathology	3,047	29
Totals	**$2,350,960**	**16,472**

To determine whether these services should have been covered under the all-inclusive daily hospice rate paid to the hospice providers, we reviewed the clinical records from two hospices for a judgmental sample of 68 recipients for the duration of their care. For the 68 recipients, we determined Medicaid paid 1,934 FFS and encounter claims, totaling $421,497, for end-of-life services that were submitted by a non-hospice provider, in addition to the Medicaid all-inclusive daily rate paid to the hospice.

We found that 371 of the 1,934 services (19 percent), or $56,555 of the $421,497, were covered by the recipient's hospice plan of care. Therefore, the service should not have been rendered and billed by another provider. In addition, the hospices were not aware that another provider rendered 621 of the 1,563 (40 percent) remaining services not included in the recipient's plan of care. For example, Medicaid reimbursed one provider $710 per month for six months of health home targeted case management services (totaling about $4,260) for the same period

the recipient was in hospice care. We reviewed the hospice clinical records for this recipient and could not find any indication the hospice was aware that the recipient was receiving these services or any communication between the hospice and the health home case manager. While health homes do not provide medical care, similar to hospices, they are responsible for care coordination and case management services for recipients with complex medical conditions. If hospices are not aware of other providers rendering services to recipients in their care, it is unlikely the hospice would be able to fully coordinate the care and costs of the services provided by all hospice and non-hospice health care providers.

The lack of service coordination and communication creates the risk that providers are rendering medical services that, in combination with hospice services, are potentially unnecessary, duplicative, or unsafe. For example, we found multiple instances of the opioid drugs methadone and oxycodone being provided by both a pharmacy and a hospice during the same time period. According to hospice officials, they were unaware another provider was also providing opioid drugs.

These payments for overlapping services occurred because the Department does not identify and track Medicaid recipients receiving hospice care. Accordingly, because the eMedNY system does not track when a recipient is in hospice, the system does not have controls to prevent other providers from rendering non-allowable or duplicative services. Currently, hospices are not required to notify the Department when they enroll a FFS recipient in hospice care and eMedNY does not flag hospice recipients. Instead, the Department relies on providers to identify Medicaid recipients enrolled in hospice and bill Medicaid properly. While the Department recently began requiring that hospices notify MCOs when a recipient elects hospice care, this enrollment information is not passed on to the Department. In addition, the three MCOs we interviewed lacked sufficient controls to prevent overlapping payments for services that should have been included in the daily hospice rate. While these MCOs require prior approval for hospice care, they do not have controls to prevent reimbursing other providers for overlapping services.

The Department also does not provide sufficient guidance to providers rendering services to recipients in hospice care. The primary billing guidance for hospice providers are the eMedNY Provider Manual and the Office of Health Insurance Program's Guidelines on Hospice Coverage in Mainstream Managed Care. The eMedNY Provider Manual was last updated in 2008, and Department officials agree that it needs to be revised. For example, the definition of a terminal illness was extended to a life expectancy of one year in 2015, but has not been updated in the manual. It is also unclear if the eMedNY Provider Manual applies to both FFS claims and MCO encounter claims. Furthermore, neither the eMedNY Provider Manual nor the Guidelines on Hospice Coverage in Mainstream Managed Care contain a detailed list of all specific services that are allowed to be billed in conjunction with the hospice rates. Department officials were unable to provide us with a list of covered services.

Recommendations

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

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.

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.

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.

Hospice Care Covered by Other Insurance

We determined Medicaid inappropriately paid $2.6 million in hospice claims that should have been covered either by Medicare or the recipient's MCO. As previously stated, we attribute the improper payments to the Department's lack of a process to track Medicaid recipients who are receiving hospice services.

Medicare

During the audit period, Medicaid inappropriately reimbursed 32 providers $2.4 million on 1,421 FFS and encounter claims for hospice services when eMedNY indicated the recipient was enrolled in Medicare. All but one of these claims, which was billed at the highest level of care (inpatient respite care), were for hospice services that should have been covered by Medicare. We selected a judgmental sample of 40 of the highest-paid claims from the four highest-paid providers to determine why they billed Medicaid for these services. According to the providers:

- 33 claims were never billed to Medicare. These claims should have been billed first to Medicare as the primary payer.
- 3 claims were denied by Medicare because the recipient was not eligible.

The remaining four claims were from a provider who billed Medicaid for the difference between the enhanced Medicaid AIDS rate and the amount paid by Medicare. While Medicaid offers an enhanced daily rate for hospice recipients with AIDS, Medicare does not (the standard Medicare rate is paid). Of the 1,421 hospice payments for recipients enrolled in Medicare, 202 claims totaling $489,362 were paid to the one provider for the enhanced daily rate. Department officials were unable to provide a policy on whether this is allowable, but stated they are working on clarifying the issue. Currently, as the secondary payer, Medicaid pays the lesser of the Medicare coinsurance amount or the difference between the Medicaid fee and the Medicare payment. Because there is no Medicare coinsurance on the two levels of care associated with enhanced Medicaid AIDS rates (routine home care and general inpatient care), Medicaid would not have paid these claims if the provider had billed properly.

Mainstream Medicaid Managed Care

Effective October 1, 2013, hospice services provided to enrollees in mainstream managed care became the responsibility of the MCO. Accordingly, Medicaid should not reimburse providers for hospice services on FFS claims for mainstream MCO recipients who enroll in hospice after October 1, 2013. However, we found that Medicaid inappropriately paid 17 providers on 78 FFS claims totaling $203,375 for hospice services provided to mainstream MCO recipients. We reviewed a judgmental sample of ten claims with the highest overpayments (from three providers) to determine why they billed Medicaid for these services. Of the ten claims reviewed:

- Nine claims were billed to Medicaid because the provider was unaware the recipient was enrolled in mainstream managed care.
- One claim was billed to Medicaid because the hospice did not know it was supposed to bill the MCO first.

Recommendations

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

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

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

Other Issues

Medical Record Requirements

Hospice providers must meet certain State and federal documentation requirements related to eligibility, election, admission, and discharge requirements as well as the provision of hospice services. For instance:

- Medicaid recipients may elect to receive hospice care for two 90-day periods and an unlimited number of 60-day periods. According to both 10 NYCRR § 793.2 and the CMS State Medicaid Manual, to be eligible for hospice care under Medicaid, the hospice must ensure the recipient is certified as terminally ill for each election period.
  - For the recipient's first hospice period of coverage, the hospice must obtain a certification of terminal illness (CTI) from both a hospice physician as well as the individual's attending physician, if they have one, within two days of the election period.
  - For all subsequent periods, the hospice must obtain a CTI from only the hospice physician, unless there is a break in care.

- A written CTI must be obtained before the hospice submits any claim for payment.
- Each recipient's comprehensive assessment and plan of care must be updated at least every 15 days and consider changes that have taken place, and include information on the recipient's progress toward desired outcomes.

During the course of our audit, we examined records for a judgmental sample of 68 recipients at two hospices, and identified documentation irregularities at one of them. Further examination showed the one hospice did not comply with eight requirements for 8 of the 28 recipients we sampled there. Specifically, we found:

- For four recipients, the attending physician did not sign the initial CTI; instead, the designated attending physician's name was crossed off, and the CTI was signed by a hospice physician.
- For two recipients, the hospice certified the recipient as terminally ill for more than two 90-day election periods.
- For one recipient, a written CTI was not obtained before claims were submitted to Medicaid.
- For one recipient, the plan of care was not updated within 15 days.

We also observed that one recipient's required medical records were not signed by a physician in a timely manner. This recipient's plan of care for a 60-day period ended February 10, 2015 was not signed by the physician until June 11, 2015 – more than four months after the services were rendered. In addition, the discharge order for this recipient, also dated February 10, 2015, was not signed by the physician until November 19, 2015 – more than nine months after the recipient was discharged. In order to demonstrate that medical services have been accurately and completely documented and reviewed by the physician, medical orders should be validated with the physician's signature before services are rendered.

The Department's Office of Primary Care and Health Systems Management (OPCHSM) is responsible for ensuring that hospice care provided to State residents meets federal and State requirements. OPCHSM conducts a hospice recertification survey every three years to determine the quality of care provided and ensure compliance with State and federal regulations.

OPCHSM also reviews complaint allegations against hospices and, when warranted, conducts on-site surveys. For complaint allegations that are substantiated during the on-site survey, OPCHSM issues a Statement of Deficiency, and the hospice must respond with an acceptable plan of correction. OPCHSM verifies the correction of the identified deficiency either on a follow-up visit or during the next recertification survey. The hospice provider we identified in this audit was last recertified in November 2015, and since then, OPCHSM has substantiated complaint allegations with supporting evidence during two on-site surveys, and in March 2017 and February 2018 issued Statements of Deficiencies related to plan of care, provision of medical supplies, and patient rights.

Room and Board Payments for Hospice Recipients

When hospice care is provided in a nursing facility, the hospice is responsible for the management of the recipient's hospice care, while the nursing facility provides room and board care. The hospice is required to bill Medicaid for both the hospice care (i.e., the all-inclusive daily hospice rate) and the room and board provided to the recipient, which is paid at 95 percent of the nursing facility's per diem rate. The hospice then reimburses the nursing facility for the room and board services.

We found that Medicaid overpaid 238 claims for room and board totaling $89,808 to 24 hospices because eMedNY applied the incorrect room and board per diem rate. Medicaid also overpaid 49 nursing facilities on 318 claims totaling $34,413 because the nursing facilities billed Medicaid directly. Because the hospice did not bill Medicaid for room and board, eMedNY failed to properly reduce the room and board rate to 95 percent.

Recommendations

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.

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

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

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

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether Medicaid made improper payments to providers on behalf of recipients receiving hospice care. This audit covered the period January 1, 2013 through December 3, 2017.

To accomplish our audit objective and assess relevant internal controls, we interviewed officials from the Department and four MCOs; examined the Department's relevant Medicaid policies and procedures; and reviewed applicable federal and State laws, rules, and regulations. We used recipient and claims data from the Medicaid Data Warehouse and eMedNY to identify Medicaid recipients receiving hospice care, and then extracted and analyzed paid FFS claims and encounter claims for those recipients during the period they were in hospice care. Our review focused on nursing home, pharmacy, durable medical equipment, home health, practitioner, and inpatient FFS and encounter claims for recipients age 21 and over.

We conducted site visits to two hospices and reviewed required medical documentation for a

judgmental sample of 68 recipients. Our sample included recipients who had the highest total overlapping payments as well as recipients with relatively long lengths of stay, who were discharged alive, or who were discharged and subsequently readmitted to the hospice. The documentation we reviewed at each hospice included hospice election statements, CTIs, clinical assessments and notes, plans of care, patient visit records, and financial records related to pharmacy drugs and durable medical equipment for the period the hospice cared for the recipient.

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. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. 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 independent audits of program performance.

Authority

This 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.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of the report. In their response, Department officials generally concurred with the audit recommendations and indicated that certain actions have been and will be taken to address them. Our response to one Department comment is included in the report's State Comptroller's Comment.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner 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.

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Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews, and evaluations of New York State and New York City taxpayer-financed programs.

Agency Comments

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

October 18, 2018

Ms. 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 Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2017-S-76 entitled, "Improper Medicaid Payments for Recipients in Hospice Care."

Thank you for the opportunity to comment.

Sincerely,

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

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Department of Health
Comments on the
Office of the State Comptroller's
Draft 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) Draft 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 Department is considering the feasibility of designing and implementing a process to identify and track recipients receiving hospice care and notifying providers before services are provided.

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

The Department is exploring the possibility of determining what services are disallowed in conjunction with hospice services, updating the eMedNY Provider Manual accordingly and notifying providers of any changes if necessary.

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

The Department is in the process of determining an appropriate course of action to design and implement controls to prevent duplicate payments for overlapping services that should be covered by the hospice all-inclusive daily rate.

Recommendation #5

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

Response #5

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

Recommendation #6

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

Response #6

The Department will provide a reminder to Hospice providers to bill Medicare prior to Medicaid, consistent with existing policy. Reminders will be provided through a Medicaid Update article and an update to the Hospice Billing Guidelines Manual.

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 an update to the Hospice Billing Guideline 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

The Office of Primary Care and Health Systems Management will conduct on-site visits to investigate items within their surveillance protocol during the next standard survey of the facility once OSC provides supporting information to the Department.

* Comment 1

*See State Comptroller's Comment, Page 20.

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 Department began assessing issues that existed with reimbursements for hospice care within a nursing facility in 2016 and, through formal approval of the Legislature, developed a plan to examine the existence and frequency of such issues and to issue guidance where appropriate. The Department released guidance to all Managed Long-Term Care plans, providers, and facilities in October of 2017 clarifying billing practices, including room and board.

Recommendation #11

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

Response #11

The Department is in the process of determining an appropriate course of action to design and implement controls to prevent improper payments for room and board for hospice recipients.

State Comptroller's 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.