Department of Health

Medicaid Program: Improper Medicaid Payments for Individuals Receiving Hospice Services Covered by Medicare

Report 2018-S-71 | December 2020

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 to providers on behalf of dual-eligible individuals receiving hospice care covered by Medicare. This audit covered the period January 1, 2015 through July 31, 2019.

About the Program

Hospice is a coordinated program of home and/or inpatient care that treats terminally ill individuals and their families. Hospice programs provide palliative care, including nursing, physician, and counseling services; home health aides; physical and occupational therapy; medical appliances and supplies; and drugs. When individuals are enrolled in both Medicaid and Medicare (referred to as dual-eligibles), Medicare is the primary payer for Medicare-covered hospice services, while Medicaid is the payer of last resort.

Several entities are responsible for coordinating services on behalf of individuals who are receiving hospice care. In addition to delivering services, hospice providers are responsible for developing a comprehensive plan of care and coordinating care and services needed by patients. Many dual-eligibles in hospice are also enrolled in Medicaid Managed Long-Term Care (MLTC) plans, which serve people who require nursing home or long-term home health care. When a Medicaid recipient is enrolled in a MLTC plan, the plan is required to coordinate care with other providers, including hospice providers, to avoid duplicative or excessive services and payments. When a recipient is enrolled in Medicaid fee-for-service, Local Departments of Social Services (LDSS) and/or Medicaid providers are generally responsible for authorizing appropriate services and coordinating care to avoid inappropriate Medicaid payments.

Key Findings

The audit identified about $50 million in actual and potential Medicaid overpayments, cost-savings opportunities, and questionable payments for services provided to dual-eligibles enrolled in Medicare-covered hospice, as follows:

- $5.5 million in actual and potential overpayments for services that are not allowed in conjunction with hospice (such as Assisted Living) and services that are covered by the Medicare hospice benefit (such as nursing care and drugs);
- $370,506 in actual and potential overpayments for personal care services in excess of 24 hours in a single day;
- $39.8 million in questionable payments for personal care (totaling $35.7 million) and durable medical equipment and supplies (totaling $4.1 million) that may have been eligible to be covered by the Medicare hospice benefit; and
- $4.3 million in unnecessary payments for nursing home room and board under managed care.

Key Recommendations

- Review the $5.9 million in actual and potential overpayments and ensure proper recoveries are made.

- Improve controls to prevent improper payments for services provided to dual-eligibles receiving Medicare-covered hospice care.
- Advise MLTC plans, LDSS, and hospice providers to coordinate care and financial obligations.

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

December 28, 2020

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 their resources efficiently and effectively and, by so doing, providing 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 *Improper Medicaid Payments for Individuals Receiving Hospice Services Covered by Medicare*. 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 would like to acknowledge auditors from the United States Department of Health and Human Services Office of Inspector General for their assistance provided during this audit.

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

Contents

Glossary of Terms 5

Background 6

Audit Findings and Recommendations 8

- Actual and Potential Overpayments 9
- Questionable Payments 12
- Nursing Home Room and Board Under Managed Care 14
- Recommendations 15

Audit Scope, Objective, and Methodology 17

Statutory Requirements 18

- Authority 18
- Reporting Requirements 18

Agency Comments 19

Contributors to Report 23

Glossary of Terms

Term	Description	Identifier
ALP	Assisted Living Program	*Key Term*
CHHA	Certified Home Health Agency	*Key Term*
CMS	Centers for Medicare & Medicaid Services	*Agency*
Department	New York State Department of Health	*Auditee*
DME	Durable medical equipment	*Key Term*
eMedNY	Department's Medicaid claims processing and payment system	*System*
FFS	Fee-for-Service	*Key Term*
LDSS	Local Departments of Social Services	*Key Term*
LTHHCP	Long-Term Home Health Care Program	*Key Term*
MCO	Managed Care Organization	*Key Term*
Medicare Hospice	Medicare-Funded Hospice Benefit	*Program*
MLTC	Medicaid Managed Long-Term Care	*Plan Type*
OMIG	Office of the Medicaid Inspector General	*Agency*
PACE	Program of All-Inclusive Care for the Elderly	*Plan Type*

Background

The New York State Medicaid program is a federal, state, and locally funded program that provides a wide range of medical services to individuals 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, 2019, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $67.4 billion. The federal government funded about 56.5 percent of New York's Medicaid claim costs, and the State and localities (the City of New York and counties) funded the remaining 43.5 percent.

The Department uses two methods to pay health care providers for Medicaid services: fee-for-service (FFS) and managed care. Under the FFS method, the Department, through its Medicaid claims processing and payment system (eMedNY), pays health care providers directly for services rendered to Medicaid recipients. Under the managed care method, Medicaid pays managed care organizations (MCO) 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. Monthly premiums are influenced by the payments MCOs make to providers.

Hospice is a coordinated program of home and/or inpatient care that treats terminally ill individuals and their families. Hospice provides palliative care that can help manage the pain and symptoms of illness with a focus on comforting the recipient rather than curing the terminal illness. Hospice services include: nursing and short-term inpatient care; physician, counseling, and speech-language pathology services; home health aide and homemaker services; physical and occupational therapy; medical appliances and supplies; and drugs and biologicals. In addition to delivering services, hospice providers are responsible for developing a comprehensive plan of care and coordinating care and services needed by patients.

Many of the State's Medicaid recipients are also eligible for Medicare, the federal health insurance program for people age 65 or older and people under 65 with certain disabilities. Individuals enrolled in both programs are commonly referred to as "dual-eligible." When dual-eligibles elect hospice under Medicare, Medicare pays a daily rate to hospice providers for hospice services. In these cases, Medicare is the primary payer for services covered under Medicare, while Medicaid is the payer of last resort. Also, when dual-eligibles who reside in nursing homes elect hospice, Medicare will pay for hospice services while Medicaid pays for nursing home room and board.

Medicaid Managed Long-Term Care (MLTC) plans are MCOs that serve people who require nursing home or long-term home health care. MLTC plans develop plans of care, coordinate care, and authorize and pay for services such as durable medical equipment (DME), medical supplies, and home health care (including personal care services) for their enrollees. Some Medicaid services are excluded from the MLTC benefit package and may be paid separately by Medicaid FFS. Many dual-eligibles in

hospice are enrolled in MLTC plans. When a recipient is enrolled in a MLTC plan, the plan is required to coordinate care with other providers, including hospice providers, to avoid duplicative or excessive services and payments.

When a recipient is enrolled in Medicaid FFS, Local Departments of Social Services (LDSS) and/or Medicaid providers are generally responsible for authorizing appropriate services and for coordinating care with other providers, including hospice providers, to avoid inappropriate Medicaid payments.

Audit Findings and Recommendations

We found the Department has not established sufficient controls to ensure Medicaid payments (made via FFS and managed care) are appropriate for dual-eligibles receiving care under the Medicare-funded hospice benefit (herein referred to as Medicare hospice).

For the period January 1, 2015 through July 31, 2019, we identified about $50 million in payments that need the Department's review, as follows:

- $4.3 million in actual and potential overpayments for services not allowed in conjunction with hospice or that overlap with hospice-covered benefits
- $1.2 million ($1,093,617 + $74,693) in potential overpayments for services that likely should have been covered by hospice providers;
- $370,506 in actual and potential overpayments for unnecessary personal care services;
- $35.7 million in questionable payments for personal care services;
- $4.1 million in questionable payments for DME and supplies; and
- $4.3 million in unnecessary payments for nursing home room and board under managed care.

Medicare pays hospice providers a daily rate that covers the establishment of a comprehensive plan of care, coordination of care with non-hospice providers, and direct provision of all care for a patient's terminal illness and related conditions. According to guidance from the Centers for Medicare & Medicaid Services (CMS), services unrelated to the terminal illness should be exceptional, unusual, and rare. Medicare requires non-hospice providers who bill Medicare for services to document the diagnoses or conditions the hospice provider has determined are unrelated to the terminal illness. However, Medicaid does not specifically require providers to document why services are provided outside of the hospice benefit. In addition, the Department does not have a process to identify, track, or monitor dual-eligibles who elect the Medicare hospice benefit.

In recent years, the Department issued guidance stating hospice providers must notify MLTC plans when recipients have elected hospice and coordinate care to prevent the duplication of services. MLTC plans were also urged to monitor encounters for potential hospice services that should be denied. However, the Department has not taken any additional steps to verify that all involved parties are adequately coordinating care with hospice providers to ensure Medicaid is paying only for services completely unrelated to the terminal illnesses for which Medicaid recipients entered hospice care.

Developing a comprehensive plan of care and coordinating care and services needed by patients are primary responsibilities of hospice providers. Non-hospice entities such as MLTC plans, LDSS, and Medicaid providers also have responsibilities, including: maintaining up-to-date care plans, authorizing services, and coordinating care.

We reviewed records obtained from hospice providers, MLTC plans, LDSS, and Medicaid providers for 50 cases where recipients were enrolled in Medicare hospice and also received large amounts of personal care services or DME and supplies from Medicaid. We found there was generally no delineation of the specific services needed for certain conditions unrelated to the terminal illness, such as delineation of the amount of personal care services required for non-terminal illness conditions (versus the amount required for the terminal illness). This information is necessary as part of the hospice provider's comprehensive plan of care and to ensure adequate coordination of care, which are primary responsibilities of hospice providers. Additionally, when MLTC plans, LDSS, or other Medicaid providers were responsible for authorizing services, maintaining care plans, or coordinating care, we found there was a lack of evidence of coordination between parties in the Medicaid program and hospice providers.

The absence of: a tracking system to identify dual-eligibles who elect Medicare hospice; details in the hospice, MLTC plan, and other provider records regarding the provision of, and coordination of, services unrelated to the terminal illness; and a specific requirement for non-hospice providers to document the reason a service is provided outside of the hospice benefit, create barriers to Department oversight.

During the course of our audit, we also identified a potential cost-savings opportunity regarding Medicaid payments for nursing home room and board for dual-eligibles enrolled in Medicare hospice and residing at a nursing home.

In response to our audit, Department officials stated they intend to establish an indicator in eMedNY to identify Medicaid recipients who have elected Medicare hospice. This indicator would allow the Department to monitor Medicaid services paid on behalf of these individuals and allow for proper oversight of coordination of care issues.

Actual and Potential Overpayments

We reviewed Medicaid FFS claims and managed care encounters for dual-eligibles enrolled in the Medicare hospice benefit for the period January 1, 2015 through July 31, 2019 and identified $5.9 million in actual and potential overpayments. The payments were for types of services already covered by hospice and occurred because the Department has not developed processes to identify these recipients and monitor the services provided to them under Medicaid.

Services Not Allowed During Hospice

Medicaid policy states that recipients are not allowed to be simultaneously enrolled in the Assisted Living Program (ALP) and hospice. ALP rates include personal care services; home health aides; nursing; physical, occupational, and speech therapy; and medical supplies and equipment – all services provided under the hospice benefit. Similarly, recipients enrolled in a Program of All-Inclusive Care for the Elderly (PACE) managed care plan are required to disenroll from the plan prior to electing

hospice care. PACE plans include end-of-life services that would duplicate hospice benefits.

The eMedNY Hospice Program Provider Manual states the following Medicaid services are not allowed in combination with the Medicaid hospice benefit: private duty nursing, adult day health care, certified home health agency (CHHA) services, and long-term home health care program (LTHHCP) services (CHHA and LTHHCP services include nursing care and home health aides). According to Department officials, there are no differences in the services covered by a hospice program under Medicaid coverage versus a hospice program under Medicare coverage. Medicaid payments made for such services could potentially duplicate the services offered by hospices funded by Medicare.

A summary of the findings by type of service is listed in Table 1.

Table 1 – Services Included in the Hospice Benefit

Type of Service	Payment Amount	Number of Claims
Actual Overpayments		
Programs for All-Inclusive Care for the Elderly (PACE)	$463,699	92
Assisted Living Program (ALP)	448,191	4,101
Subtotal – Actual Overpayments	$911,890	4,193
Potential Overpayments		
Certified Home Health Agency (CHHA)/Home Health Aide	$1,837,922	6,632
Private Duty Nursing/Other Nursing Care	890,989	3,516
Adult Day Health Care	660,180	2,898
Adult Day Health Care Transportation	24,455	385
Subtotal – Potential Overpayments	$3,413,546	13,431
Totals	**$4,325,436**	**17,624**

In response to our audit, Department officials stated they will establish a work group to review these issues and develop monitoring and/or control activities to ensure services are appropriately paid for individuals enrolled in hospice. In addition, the work group will review and update, as needed, the Medicaid billing and policy guidelines.

Hospice Covered Services – Related Diagnosis

Hospice providers are responsible for providing hospice services when they are reasonable and necessary for the palliation and management of the terminal illness as well as related conditions. To determine if Medicaid services were related to a recipient's terminal illness, we compared the principal diagnosis on Medicare hospice claims to the primary and secondary diagnosis codes on Medicaid FFS claims and managed care encounters. We identified $1.1 million in payments for services that appear to be related to the hospice terminal diagnoses. These services likely should not have been paid by Medicaid, but rather should have been covered under

the Medicare hospice benefit. For example, the principal diagnosis on a Medicare hospice claim was Chronic Obstructive Pulmonary Disease (COPD), yet we also identified a Medicaid encounter claim for $900 for the same recipient with the same primary diagnosis code. A summary of the payments by type of service is listed in Table 2.

Table 2 – Medicaid Payments for Services Related to Hospice Terminal Diagnoses

Type of Service	Payment Amount	Number of Claims
Durable Medical Equipment	$527,397	14,083
Physician	235,327	6,626
Inpatient	154,668	1,735
Respite Care	81,632	281
Ambulance	59,010	1,382
Pain and Symptom Management	26,372	345
Physical Therapy	9,211	114
Totals	**$1,093,617**	**24,566**

Hospice Covered Services – Drugs

CMS issued guidance to Medicare Part D drug prescription plans encouraging them to implement controls to prevent paying for analgesics, anti-nauseants, laxatives, and anti-anxiety drugs when recipients are in hospice because these types of drugs are usually covered by the Medicare hospice benefit. Similarly, Medicaid likely should not be paying for these drugs when recipients are in hospice. During the audit period, Medicaid made payments totaling $74,693 on 8,782 claims and encounters for these types of drugs.

Excessive Personal Care Services

We analyzed claims for Medicare home health aide (i.e., hospice aide) services provided by hospices and Medicaid personal care services and identified 5,745 occurrences – on behalf of 426 different individuals – where an individual received over 24 hours of combined (Medicare and Medicaid) aide services in a day. We calculated $370,506 in Medicaid payments on behalf of the 426 individuals for aide services exceeding 24 hours a day.

We judgmentally selected seven recipients from our findings and reviewed records from hospices, MLTC plans, LDSS, and Medicaid personal care providers for the period of overlapping service dates (dates where both hospice aide hours and Medicaid personal care hours were billed.) We found no explanation of why two overlapping aides were necessary for five of the seven recipients. In each of these five cases, we confirmed two aides were present simultaneously and found some of the same duties were performed by both aides. For example, in one case, both the hospice aide and the Medicaid personal care aide indicated they provided assistance

with hygiene (shower, hair care, shampoo, and skin care), housekeeping, and meals (preparation of meals and snacks and spoon feeding) in the same day. For these five recipients, Medicaid paid $70,976 for aide services exceeding 24 hours in a day. For the remaining two (of seven) cases, we found some evidence of coordination of care – a note was made in the MLTC records indicating the two aides were necessary for transferring the patient in and out of bed.

Questionable Payments

Personal Care Services

For the period January 1, 2015 through July 31, 2019, Medicaid paid $330.8 million on nearly 1.3 million FFS claims and managed care encounters for personal care services on behalf of recipients in Medicare hospice. Hospice provides home health aide services, which include personal care (bathing, walking, feeding, toileting, etc.) and homemaker services (cleaning, laundry, shopping, etc.). Medicaid's personal care services can be similar to those provided by hospices as both include tasks to assist recipients with daily living. Hospice providers should likely provide or cover some of the cost of personal care services, unless all personal care tasks are completely unrelated to the terminal illness.

Our review of Medicaid and Medicare claims data found that hospices paid by Medicare were less likely to provide dual-eligibles with a home health aide if Medicaid was paying for personal care services. For example, our analysis determined hospices provided dual-eligibles with a home health aide 47 percent of the time when the individual did not receive any personal care services from Medicaid, but only 26 percent of the time when Medicaid did provide personal care services. Further, when hospices provided a home health aide to dual-eligibles who were also receiving Medicaid personal care services, we calculated they did so for an average of 11 hours of aide services per week.

We estimated questionable Medicaid payments totaling $35.7 million in personal care services for dual-eligibles when hospice did not provide any aide services. To calculate this estimate, we identified all instances where recipients received Medicaid personal care services, but no hospice aide services. Next, we identified the cost, per hour and by recipient, of the Medicaid personal care services, determined the number of weeks of care, and then multiplied it by the average hospice aide hours (11 hours per week). About $5.9 million of the $35.7 million in personal care FFS claims and managed care encounters listed primary or secondary diagnoses that were likely related to the hospice terminal illness. We also note that the most common diagnoses listed on personal care claims and encounters were generic diagnoses such as "illness, unspecified" – these types of diagnoses were listed for more than half of the $330.8 million in Medicaid personal care services.

Hospice providers are responsible for coordinating necessary patient care, including personal care services, whether the services are related to the terminal illness or not. As such, hospice providers are responsible for communicating with non-hospice

providers about the plan of care. In cases where services are not related to the recipient's terminal illness, the hospice should communicate to other providers the reasons why the services are completely unrelated to the terminal illness.

We reviewed records from hospice providers, MLTC Plans, LDSS, and Medicaid providers for 35 cases where individuals received Medicaid personal care services during hospice care. We found the non-hospice entities responsible for authorizing services, maintaining care plans and/or coordinating care (e.g., MLTC plans, LDSS, or other providers) were usually aware recipients were in hospice. However, there was a lack of evidence indicating hospice providers and non-hospice entities were effectively coordinating care, including ensuring Medicaid was the payer of last resort for personal care services. These records also did not contain an explanation of whether the personal care needs were for conditions completely unrelated to the recipient's terminal illness.

In our review of records for the 35 cases where individuals received personal care services from Medicaid, we found the following:

- 32 cases where the MLTC plan, LDSS, or other responsible provider had no documentation of coordination of personal care services with hospice; and
- 3 cases where the MLTC plan noted it would request that the hospice provide some aide hours, but no further documentation.

Additionally, in 10 of 35 cases, the hospice records indicated hospice aide services were offered, but the patient or patient's family declined. Generally, the hospice aide services were declined because the patient was approved for or already had a personal care aide from Medicaid. We interviewed Department, MLTC plan, and hospice officials and learned there are challenges to coordinating the financial obligations with Medicaid for personal care services when patients decline hospice aide services. If a recipient prefers to have the Medicaid personal care aide rather than the hospice aide, the MLTC plan would be obligated to provide the Medicaid personal care aide to ensure delivery of needed services. Ideally, this personal care aide's time would be "split-billed" with the hospice provider so Medicaid is paying only for the services needed outside of the Medicare hospice benefit. However, the aides performing services under Medicaid must also meet Medicare conditions of participation to provide personal care and homemaker services under the Medicare hospice benefit. In order to meet these conditions, the Medicaid personal care aide must be certified as a home health aide to provide personal care services, or attend a hospice orientation program to provide homemaker services. Furthermore, hospices may have to individually contract with Medicaid personal care aides who are not part of the hospice organization.

Federal regulations state that hospices can arrange (via a written agreement) for other agencies, individuals, or organizations to furnish services as long as they retain administrative and financial management and oversight of staff and services to ensure the provision of quality care. Additional efforts by the Department, LDSS, and MLTC plans may be needed to ensure hospices are fulfilling their responsibility

to organize, manage, and administer their resources to provide the hospice care and services necessary for the palliation and management of the terminal illness and related conditions.

Durable Medical Equipment and Supplies

Hospice services include DME and medical supplies for self-help and personal comfort items for the palliation or management of symptoms. The most common Medicaid-paid DME provided to hospice recipients were incontinence supplies, such as diapers and pads (around 77 percent of Medicaid payments), and enteral formula (around 9 percent of Medicaid payments). We identified Medicaid payments of $4.1 million on 93,283 FFS claims and managed care encounters for DME for which we could not determine if the diagnosis related to the terminal illness. We note the most common diagnoses listed on claims and encounters were “incontinence” and generic diagnoses such as “illness, unspecified.” Although we could not determine if these services were related to the recipient’s terminal illness, we question whether Medicare-funded hospice providers, and not Medicaid providers, should have provided these items.

We reviewed hospice and MLTC plan records for a judgmental sample of 15 cases where recipients received large amounts of DME or medical supplies from Medicaid. In all 15 cases, we found a lack of evidence of MLTC plans coordinating care with hospices to ensure Medicaid only provided services completely unrelated to the terminal illness. In 9 of 15 cases, the hospice plan of care or other notes indicated the hospice authorized or provided supplies similar to those provided by the MLTC plan (indicating that the Medicare-funded hospice may have been required to pay for the supplies that the Medicaid MLTC paid for). In the remaining 6 cases, although hospices are required to coordinate services (related and unrelated to the terminal illness), there was no evidence the hospice providers authorized, or were aware of, the DME or medical supplies provided by Medicaid. The Department and MLTC plans must ensure Medicaid is only paying for DME and medical supplies for conditions completely unrelated to the hospice terminal illness.

In response to our audit, the Department indicated it will work with the MLTC plans to ensure they coordinate care and to ensure the MLTC plan of care documents the services that should be covered by hospice and by the MLTC, potentially including specific diagnoses related to the service being provided. The Department also agreed to issue new guidance specifically reminding MLTCs and LDSS to coordinate services and financial obligations with hospice providers, particularly for DME and supplies and personal care services.

Nursing Home Room and Board Under Managed Care

When dual-eligibles who reside in nursing homes elect hospice, Medicare will pay for hospice services while Medicaid pays for nursing home room and board. Medicaid FFS pays for the room and board at 95 percent of the normal Medicaid

fee for residents at the nursing home. The payment is reduced because hospices generally would cover a portion of the services nursing homes typically provide, such as DME and nursing care. According to Department officials, MLTC plans have established contracted rates with nursing homes that do not factor in hospice care, so Department policy allows MLTC plans to pay for nursing home services at 100 percent of the usual nursing home rate. As such, the Medicaid program is paying for these nursing home services in excess of the minimum amount required by federal regulations, which require payments to nursing homes for room and board of hospice recipients to be at least 95 percent of the normal rate. For the period January 1, 2015 through July 31, 2019, we identified Medicaid MCO payments of $85 million for nursing home services provided to dual-eligibles enrolled in Medicare hospice. Approximately, $4.3 million (5 percent of $85 million) could have been saved if Medicaid's nursing home room and board payment policy under managed care was the same as Medicaid FFS.

Recommendations

1. Review the $5.9 million ($4.3 million + $1.1 million + $370,506 + $74,693) in actual and potential overpayments and ensure proper recoveries are made.
2. Design and implement a process to identify and track all Medicaid recipients who elect Medicare-covered hospice care (coordinate with CMS, as appropriate).
3. Establish controls to prevent Medicaid FFS and managed care payments for services that should be covered by Medicare hospice, particularly for the types of services identified in this audit.
4. Formally remind MLTC plans and LDSS (for recipients not enrolled in MLTC plans) to coordinate services and financial obligations with hospice providers, particularly for personal care and DME and supplies.
5. Formally remind hospice providers of their role in coordinating services unrelated to recipients' terminal illnesses with Medicaid providers and MCOs, particularly personal care and DME and supplies.
6. Monitor MLTC plans and LDSS to ensure they maintain adequate documentation of hospice recipients' conditions and services that are unrelated to the terminal illness that should be covered by Medicaid when approving services (such as personal care services and DME and supplies).
7. Consider requiring non-hospice service providers to document the reason a service is provided outside of the hospice benefit (e.g., diagnoses or conditions) and, accordingly, not related to a recipient's terminal illness.
8. Assess the appropriateness of requiring Medicaid MCOs to pay 95 percent of the nursing home room and board rate for dual-eligibles enrolled in hospice and, if warranted, take steps to implement any changes.

9. Update relevant Medicaid policies to coincide with new billing, payment, and policy changes made in response to this audit.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether Medicaid made improper payments to providers on behalf of dual-eligible individuals receiving hospice care covered by Medicare. This audit covered the period January 1, 2015 through July 31, 2019.

To accomplish our objective and assess relevant internal controls, we interviewed officials from the Department, the Office of the Medicaid Inspector General (OMIG), and four MLTC plans; examined the Department's relevant Medicaid policies and procedures; and reviewed applicable federal and State laws, rules, and regulations. To identify Medicaid recipients receiving Medicare hospice care, we received results of a data match performed by auditors from the United States Department of Health and Human Services Office of Inspector General, who compared Medicare hospice claims from CMS' National Claims History and Medicaid claims from New York's Transformed Medicaid Statistical Information System. We then extracted and analyzed paid FFS and encounter claims from the Medicaid Data Warehouse for recipients during the period they were in hospice care.

We extracted Medicare hospice enrollment periods for Medicaid recipients from files the Department receives from CMS. We then reviewed records from hospices, MLTC plans, LDSS, and Medicaid providers for a judgmental sample of 50 cases: 35 cases where individuals received a large amount of personal care services from Medicaid, and 15 cases where individuals received a large amount of DME or medical supplies from Medicaid. These were the top types of services paid by Medicaid while recipients received Medicare hospice care. The records we reviewed included plans of care from hospices and MLTC plans, case notes, clinical notes, progress notes, and service authorizations. We also reviewed hospice, MLTC plan, LDSS, and personal care aide records for an additional judgmental sample of 7 recipients who received over 24 hours of combined hospice aide services and Medicaid personal care aide services on the same day (note: we were unable to obtain the MLTC plan notes for 1 of the 7 selected recipients). Because the samples were judgmentally selected, the results cannot be projected to the population as a whole. We shared our methodology and findings with officials from the Department and OMIG during the audit for their review.

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 duties do not affect our ability to conduct independent audits of program performance.

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 agreed 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

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

December 10, 2020

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report **2018-S-71** entitled, "**Improper Medicaid Payments for Individuals Receiving Hospice Services Covered by Medicare**."

Thank you for the opportunity to comment.

Sincerely,

Lisa J. Pino, M.A., J.D.
Executive Deputy Commissioner

Enclosure

cc: Diane Christensen
Theresa Egan
Brett Friedman
Geza Hrazdina
Daniel Duffy
James Dematteo
James Cataldo
Jonah Bruno
Jill Montag
Brian Kiernan
Timothy Brown
Amber Rohan
Robert Schmidt
Lori Conway
Michael Spitz
OHIP 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 2018-S-71 entitled, "Medicaid Program: Improper Medicaid Payments for Individuals Receiving Hospice Services Covered by Medicare"

The following are the responses from New York State Department of Health (Department) to the Office of the State Comptroller's (OSC) Draft Audit Report 2018-S-71 entitled, "Medicaid Program: Improper Medicaid Payments for Individuals Receiving Hospice Services Covered by Medicare."

Recommendation #1:

Review the $5.9 million ($4.3 million + $1.1 million + $370,506 + $74,693) in actual and potential overpayments and ensure proper recoveries are made.

Response #1:

The Office of the Medicaid Inspector General (OMIG) has audit protocols, which address the findings in this OSC draft audit report, including but not limited to overlapping services, services that should have been covered by hospice providers, and unnecessary personal care services. OMIG has previously performed audits of the hospice program. To ensure the data is complete and accurate, OMIG pulled its own data to include the OSC-identified overpayments. OMIG will pursue recovery of any payments it determines to be inappropriate as a result of that analysis (within the allowable six-year audit lookback timeframe, as outlined in State regulations). Pursuant to the regulations of the Department, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Recommendation #2:

Design and implement a process to identify and track all Medicaid recipients who elect Medicare-covered hospice care (coordinate with CMS, as appropriate).

Response #2:

The Department has requested a system change to associate the hospice provider with the hospice recipients via MedNY/ePACES. The change request identification number is 6948. The system change request incorporates the Centers for Medicare & Medicaid Services data sent to the Department and uses self-reporting by hospice agencies to the Department. This information is then be displayed in eMedNY/ePACES under Third Party and would be accessible by providers to identify hospice recipients in connection with billing. In conjunction with the Office of Primary Care and Health Systems Management, the Department is establishing a roster of hospice care recipients.

Recommendation #3:

Establish controls to prevent Medicaid FFS and managed care payments for services that should be covered by Medicare hospice, particularly for the types of services identified in this audit.

Response #3:

To address this recommendation, a two-part approach is required and is currently being implemented. First, under the system change request number 6948, the Department can identify the associated hospice provider with the hospice recipient to improve coordination of care and add controls to eMedNY's claim system in order to prevent improper fee-for-service payments billed by non-hospice providers. Second y, the Department is clarifying which services should be covered by hospice and issue comprehensive guidance to hospice providers via a *Medicaid Update* (the Department's official publication for Medicaid providers) and updates to the Hospice Billing and Program Policy Guidelines.

Recommendation #4:

Formally remind MLTC plans and LDSS (for recipients not enrolled in MLTC plans) to coordinate services and financial obligations with hospice providers, particularly for personal care and DME and supplies.

Response #4:

The Department is issuing a Managed Long-Term Care (MLTC) policy and General Information System (GIS) message to remind MLTCs and Local Departments of Social Services (LDSS) to coordinate services and financial obligations with hospice providers, particularly durable medical equipment/medical supplies and personal care services.

Recommendation #5:

Formally remind hospice providers of their role in coordinate services unrelated to recipients' terminal illnesses with Medicaid providers and MCOs, particularly personal care and DME and supplies.

Response #5:

The Office of Primary Care and Health Systems Management is drafting a "Dear Administrator Letter" (DAL) to issue to all hospice providers reminding them of the Medicare Conditions of Participation requirement to coordinate all services provided to individuals electing the hospice benefit. The DAL is a companion to the Department's directive for MLTC plans and LDSS' in response to Recommendation #4.

Recommendation #6:

Monitor MLTC plans and LDSS to ensure they maintain adequate documentation of hospice recipients' conditions and services that are unrelated to the terminal illness that should be covered by Medicaid when approving services (such as personal care services and DME and supplies).

Response #6:

The Department is working with the MLTCs to ensure that they comply with Article V.J.9.c.ix of the Managed Long-Term Care Partial Capitation Contract where it states:

Enrollees who have been served by the Contractor and who subsequently elect hospice as a result of a qualifying illness or condition may continue to be enrolled in the MLTCP. Upon hospice enrollment, the Contractor must reevaluate its Person Centered Service Plan in consultation with the hospice in order to coordinate Person Centered Service Plans and avoid duplication or conflict.

In addition, the Department is working with the MLTCs to ensure that Person Center Service Plans accurately document what is covered by the MLTC as opposed to hospice and is expanding its survey process to include a sample review of said documentation.

Recommendation #7:

Consider requiring non-hospice service providers to document the reason a service is provided outside of the hospice benefit (e.g., diagnoses or conditions) and, accordingly, not related to a recipient's terminal illness.

Response #7:

The MLTC policy and GIS message referenced in the Department's response #4 addresses this recommendation by including guidance to non-hospice providers who are servicing hospice consumers.

Recommendation #8:

Assess the appropriateness of requiring Medicaid MCOs to pay 95 percent of the nursing home room and board rate for dual-eligibles enrolled in hospice and, if warranted, take steps to implement any changes.

Response #8:

The Department already evaluates the viability of having Medicaid Managed Care Organizations pay ninety-five percent of the nursing home rate for room and board, and will continue to do so.

Recommendation #9:

Update relevant Medicaid policies to coincide with new billing, payment, and policy changes made in response to this audit.

Response #9:

The Department is reviewing and updating guidance and policies, as needed, including:

- New York State UB04 Billing Guidelines dated 6/1/2011; and
- New York State Medicaid Program Hospice Program Policy Guidelines dated 3/1/2008.

Contributors to Report

Executive Team

Tina Kim - *Deputy Comptroller*

Ken Shulman - *Assistant Comptroller*

Audit Team

Andrea Inman - *Audit Director*

Chris Morris - *Audit Manager*

Mark Breunig - *Audit Supervisor*

Wendy Matson - *Examiner-in-Charge*

Suzanne Loudis, RN - *Supervising Medical Care Representative*

Fiorella Seminario - *Staff Examiner*

Andrea Majot - *Senior 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

Like us on Facebook at facebook.com/nyscomptroller
Follow us on Twitter @nyscomptroller
For more audits or information, please visit: www.osc.state.ny.us/audits/index.htm