NEW YORK STATE OF OPPORTUNITY. Department of Health

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Executive Deputy Commissioner

December 29, 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 Follow-Up Audit Report, 2019-F-59 entitled, "Improper Medicaid Payments for Recipients in Hospice Care."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Diane Christensen
Jonah Bruno
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Department of Health Comments on the Office of the State Comptroller's Follow-Up Audit Report 2019-F-59 entitled, "Improper Medicaid Payments for Recipients in Hospice Care" (Report 2017-S-76)

The following are the responses from New York State Department of Health (the Department) to the Office of the State Comptroller's (OSC) Follow-Up Audit Report 2019-F-59 entitled, "Improper Medicaid Payments for Recipients in Hospice Care (Report 2017-S-76)."

Recommendation #1:

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

Status – Not implemented

Agency Action - Medicaid pays hospice providers an all-inclusive daily rate that covers the cost of services necessary to meet a recipient's needs related to their terminal illness. Accordingly, Medicaid should not pay another provider for these services because the services are already included in the daily hospice rate. The initial audit found inappropriate Medicaid payments to non-hospice providers for services that were covered under the daily hospice rate and for services that were not allowed in combination with the daily hospice rate; as well as payments for hospice services while recipients were in the hospital. Following our audit, the Office of the Medicaid Inspector General (OMIG) established protocols for performing its own audits of hospice providers; however, officials were unable to provide evidence they reviewed or took action to recover any overpayments based on our findings.

Response #1:

To date, OMIG has recovered $11,469 and verified additional provider-initiated voids totaling $338,943. To ensure the data is complete and accurate, OMIG independently extracted data which included the OSC-identified overpayments, and is in the process of pursuing recovery of any payment it determines to be inappropriate as a result of that analysis (within the allowable six-year lookback period, as outlined in State regulations). Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

It is important to note that at the time OSC issued its Final Report, they included claims in their recommendation that would no longer be recoverable by the following month, as the claims would be beyond the six-year lookback period permitted by State regulations. Additionally, 118 out of the 26,762 impacted claims identified are not reviewable in response to this audit because they are already included in other OMIG audit universes.

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.

Status – Partially Implemented

Agency Action - According to officials from the Department's Division of Long-Term Care (DLTC), they are in the process of recommending two methods to identify hospice recipients. The first would be to rely on self-reporting by hospice agencies and, on a predetermined frequency, the agencies would send a roster of hospice care recipients to the Department. This information would then be entered in eMedNY with a new Recipient Restriction/Exception code and would be accessible by providers to identify hospice recipients. The second would require DLTC, in conjunction with the Department's Office of Primary Care and Health Systems Management (OPCHSM), to obtain a roster of hospice care recipients from Medicare. However, according to the Department, the earliest time frame for completion of either process would be February 2021.

Response #2:

The Department has requested system change 6948 to associate the hospice provider with the hospice recipients via eMedNY/ePACES. The system change request would incorporate the CMS data sent to the Department and use self-reporting by hospice agencies to the Department. This information would then be displayed in eMedNY/ePACES under Third Party and would be accessible by providers to identify hospice recipients. The Office of Health Insurance Programs (OHIP), in conjunction with OPCHSM, will work to establish a roster of hospice care recipients.

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.

Status – Not Implemented

Agency Action - Officials at DLTC informed us they still need to meet with OPCHSM staff to discuss the types of services that should be covered under the all-inclusive daily hospice rate. As such, the Department has not updated Medicaid policy manuals or notified providers of any changes.

Response #3:

The Department will identify what services should be covered by hospice and issue comprehensive guidelines to hospice providers via an article in *Medicaid Update* (the Department's official publication for Medicaid providers) and updating the Hospice Billing Guidelines Manual. The *Medicaid Update* will incorporate references to the updated hospice manual as well as the current definition of a terminal illness.

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.

Status – Not Implemented

Agency Action - According to DLTC officials, once it is determined which services should be covered by hospice, as noted in Recommendation 3, proper controls can be designed

and implemented to prevent payments for fee-for-service (FFS) and encounter claims for non-covered or duplicative services by non-hospice providers.

Response #4:

To address this recommendation, a two-part approach is required. Under system change request number 6948, the Department will identify the associated hospice provider with the hospice recipient to improve coordination of care. Separately, the Department will determine which services should be covered by hospice, as noted in Response #3, so proper controls can be designed and implemented to prevent payments for FFS and encounter claims for non-covered or duplicative services by non-hospice providers.

Recommendation #5:

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

Status – Partially Implemented

Agency Action - Our initial audit found that 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. We also found that Medicaid inappropriately paid 17 providers on 78 FFS claims totaling $203,375 for hospice services provided to mainstream managed care organization (MCO) recipients. During our initial audit, we provided OMIG with a file containing the improper payments. As of June 24, 2020, $971,530 of the overpayments we identified had been recovered, as shown in the table below.

Category	Findings	Recovered
Payments for claims that should have been paid by Medicare	$2,440,602	$955,218
Payments for claims that should have been paid by an MCO	203,375	16,312
Totals	**$2,643,977**	**$971,530**

According to OMIG officials, the additional overpayments we identified ($1.67 million) still need to be reviewed.

Response #5:

To date, OMIG has recovered $922,351, verified additional provider-initiated voids totaling $39,977, and is in the process of pursuing recovery of any payment it determines to be inappropriate (within the allowable six-year lookback period, as outlined in State regulations). Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

It is important to note that at the time OSC issued its Final Report, they included claims in their recommendation that would no longer be recoverable by the following month, as the claims would be beyond the six-year lookback period permitted by State regulations. Additionally, 29 out of the

1,715 impacted claims identified are not reviewable in response to this audit, because they are already included in other OMIG audit universes.

Recommendation #6:

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

Status – Not Implemented

Agency Action - In its response to our initial audit, the Department indicated it would issue an article in *Medicaid Update* (the Department's official publication for Medicaid providers) and update the Hospice Billing Guidelines Manual to inform hospice providers to bill Medicare prior to Medicaid. However, the Department was unable to provide evidence that such action was taken. Likewise, subsequent to the initial audit, no guidance was issued advising hospices to bill MCOs prior to Medicaid.

Response #6:

The comprehensive guidelines, noted in response #3, will inform hospice providers how to bill Medicare or the recipient's managed care organization (MCO) prior to Medicaid. In addition, the Department has drafted a *Medicaid Update* article reminding providers, including hospices, to bill Medicare or other insurances as primary prior to submitting a claim to Medicaid, consistent with coordination of benefit requirements. The tentative publication date is November 2020 issue of *Medicaid Update*.

Recommendation #7:

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

Status – Not Implemented

Agency Action - Medicaid offers enhanced hospice rates for recipients with AIDS to cover the higher costs of care. However, Medicare does not (the standard Medicare rate is paid). 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. During our initial audit, we identified one provider who billed Medicaid for the difference between the enhanced Medicaid AIDS rate and the amount paid by Medicare, which resulted in higher Medicaid reimbursement amounts than if the provider had billed under standard Medicaid rules. At the time of the initial audit, Department officials were unable to provide a policy on whether this is allowable, but stated they were working to clarify the issue. During our follow-up review, Department officials were unable to provide any evidence that such clarification had been sent to providers.

Response #7:

The comprehensive guidelines, noted in Response #3, will clarify the billing of enhanced rate for dual-enrolled recipients with AIDS.

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.

Status – Implemented

Agency Action - 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. We reviewed records for a judgmental sample of recipients at two hospice providers during our initial audit and identified documentation irregularities at one of the providers. During our follow-up review, OPCHSM provided a post-certification survey report for the provider dated April 2, 2019. The survey documented that corrective actions were implemented to comply with the State and federal requirements.

Response #8:

Implemented – no response required.

Recommendation #9:

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

Status – Partially Implemented

Agency Action - 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.

Our original audit found Medicaid overpaid $89,808 to 24 hospices because eMedNY applied the incorrect room and board per diem rate. Medicaid also overpaid 49 nursing facilities $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. At the time of our follow-up review, OMIG had recovered only $348 (less than 1 percent) of the overpayments we identified. We encourage OMIG to pursue the remaining $123,873 in overpayments.

Response #9:

To ensure the data is complete and accurate, OMIG independently extracted data which included the OSC-identified overpayments. OMIG is in the process of pursuing recovery of any payment it determines to be inappropriate as a result of that analysis (within the allowable six-year lookback

period, as outlined in State regulations). Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

It is important to note that at the time OSC issued its Final Report, they included claims in their recommendation that would no longer be recoverable by the following month, as the claims would be beyond the six-year lookback period permitted by State regulations.

Recommendation #10:

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

Status – Not Implemented

Agency Action - The Department was unable to provide evidence it advised any of the 49 nursing facilities (discussed in Recommendation 9) of the proper way to bill for room and board services on behalf of hospice recipients.

Response #10:

OHIP, in conjunction with OPCHSM, will address this recommendation in discussions regarding hospice audit concerns identified in recommendations 2, 3, 4, 6, 10 and 11.

Recommendation #11:

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

Status – Not Implemented

Agency Action - Implementation of this recommendation first requires that the Department be able to identify all recipients enrolled in hospice care. As stated in Recommendation 2, Agency Action, the Department has not yet developed a method to identify these recipients in eMedNY.

Response #11:

Implementation of this recommendation requires that the Department be able to identify all recipients enrolled in hospice care. Please see response #2 for the method the Department intends to use to identify these recipients in eMedNY/ePACES.