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October 15, 2020

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

Re: Improper Medicaid Payments for Recipients in Hospice Care
Report 2019-F-59

Dear Dr. Zucker,

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 have followed up on the actions taken by officials of the Department of Health to implement the recommendations contained in our audit report, *Improper Medicaid Payments for Recipients in Hospice Care* (Report 2017-S-76).

Background, Scope, and Objective

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. Medicaid reimburses hospice organizations an all-inclusive daily rate that covers all hospice services. However, if a Medicaid recipient is also enrolled in Medicare, 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.

We issued our initial audit report on December 11, 2018. The audit objective was to determine whether Medicaid made improper payments to providers on behalf of recipients receiving hospice care. The audit covered the period January 1, 2013 through December 3, 2017. We determined the Department of Health (Department) did not establish sufficient controls to prevent improper payments for medical services provided to recipients receiving hospice care. For example, the Department's claims processing and payment system (eMedNY) did not identify Medicaid recipients receiving hospice care or track when recipients transitioned into or out of hospice. Therefore, eMedNY did not have controls to prevent payments to non-hospice providers for services that were non-allowable or duplicative or hospice claims that should have been covered by other insurance. Furthermore, the Department did not provide sufficient guidance that clearly communicated 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. As a result, the Department made over $8 million in improper Medicaid payments for medical services provided to recipients receiving hospice care.

The objective of our follow-up was to assess the extent of implementation, as of June 24, 2020, of the 11 recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials have not made much progress in addressing the problems identified in the initial audit report, and significant action is still required to prevent future Medicaid overpayments. Of the initial report's 11 audit recommendations, 1 was implemented, 3 were partially implemented, and 7 were not implemented.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

Major contributors to this report were Salvatore D'Amato, Aissata Niangadou, Linda Thipvoratrum, and Yueting Luo.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Christopher Morris
Audit Manager

cc: Mr. Robert Schmidt, Department of Health
Ms. Erin Ives, Acting Medicaid Inspector General