NEW YORK STATE OF OPPORTUNITY. Department of Health

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March 21, 2023

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 Andrea Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Follow-Up Audit Report, 2022-F-31 entitled, "Improper Medicaid Payments for Individuals Receiving Hospice Services Covered by Medicare (Report 2018-S-71)."

Thank you for the opportunity to comment.

Sincerely,

Megan E. Baldwin
Acting Executive Deputy Commissioner

Enclosure

cc: Diane Christensen
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Department of Health Comments to Follow-Up Audit Report 2022-F-31 entitled, "Improper Medicaid Payments for Individuals Receiving Hospice Services Covered by Medicare" (Report 2018-S-71) by the Office of the State Comptroller

The following are the responses from the New York State Department of Health (the Department) to Follow-Up Audit Report 2022-F-31 entitled, "Improper Medicaid Payments for Individuals Receiving Hospice Services Covered by Medicare" by the Office of the State Comptroller (OSC).

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.

Status – Not Implemented

Agency Action – OMIG investigates and recovers improper Medicaid payments on behalf of the Department. OMIG officials indicated that $74,163 (under 2%) of the $5.9 million was recovered. However, OMIG did not act on the recommendation and the recoveries were not in response to our audit. (OMIG has separate audits regarding hospice currently in process.) We note that OMIG may have already lost the opportunity to recover overpayments we identified for calendar years 2015 and 2016 due to federal look-back provisions. We encourage the Department and OMIG to take prompt action on the improper payments we identified to prevent further loss of recoveries.

Response #1:

To date, OMIG has recovered more than $80,000 of the OSC-identified overpayments. OMIG has audit protocols to address the findings in this OSC report, including but not limited to overlapping services, services that should have been covered by hospice providers, and unnecessary personal care services. Through OMIG's audit process, providers have supplied documentation that support the Medicaid payments made by the State. Pursuant to State regulations, 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).

Status – Implemented

Agency Action – The initial audit determined the Department did not have a tracking system to identify dual-eligibles who elect Medicare hospice. In March 2022, the Department added a new exception code in eMedNY, the Department's Medicaid claims processing and payment system, to identify and track Medicaid recipients who elected to receive hospice care through Medicare. Additionally, in September 2022, the Department incorporated Medicare recipients' hospice date spans provided by the Centers for Medicare and Medicaid Services (CMS) into eMedNY to help ensure Medicaid payments are made correctly.

Response #2:

The Department confirms agreement with the status of this recommendation.

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.

Status – Partially Implemented

Agency Action – In February 2022, the Department established edit 02328 in eMedNY. This edit is for Hospice clients who are ineligible for certain FFS health care services (i.e., Certified Home Health Agency services, private duty nursing, and adult day health care services). The edit currently flags Medicaid claims that are duplicative of services covered by hospice providers, but does not deny them. The Department is still in the process of determining whether the edit can be set to deny claims automatically, due to concerns with the accuracy of the hospice date spans incorporated into this edit. Additionally, Department officials have drafted a Medicaid update to clarify which services should be covered by Hospice. As mentioned, the Department now has a tracking system to identify recipients who are receiving Medicare hospice services; Department officials stated this information is available to managed care plans for their use in preventing improper payments.

Response #3:

The Department will run tracking reports of members with the C2 code and also for member claims that are flagged with edit 02328 in eMedNY. Reports will be used to determine, respectively, start and end dates of members in hospice versus members' MLTC plan enrollment start and end dates, to assess if hospice claims are duplicative, and to refer to OMIG when hospice services are found duplicative.

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 [durable medical equipment] and supplies.

Status – Partially Implemented

Agency Action – Department officials drafted a notice to LDSS and MLTC plans regarding coordination of hospice services, but had not yet sent it.

Response #4:

The Department is conducting a final review of the MLTC Policy and General Information System (GIS) notice to the LDSS; they are expected to be distributed in the second quarter of 2023.

Recommendation #5:

Formally remind hospice providers of their role in coordinating services unrelated to recipient's terminal illnesses with Medicaid providers and MCO's, particularly personal care, DME, and supplies.

Status – Implemented

Agency Action – The initial audit found there was a lack of evidence that hospice providers and non-hospice entities were effectively coordinating care. The Department issued a notification to hospice providers in November 2022 introducing a new form (DOH-5778 Entity/Facility Notification of Hospice Non-Covered Items, Services, and Drugs). Hospice providers are expected to complete the form and share it with other medical providers and/or facilities that provide services to the patient. These entities are expected to incorporate the form into their records for appropriate care planning throughout the duration of treatment.

Response #5:

The Department confirms agreement with the status of this recommendation.

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).

Status – Partially Implemented

Agency Action – Department officials stated that, as part of their MLTC operational reviews, they now review a list of individuals who receive hospice benefits, and the related MLTC enrollee records, to determine whether the plan of care includes coordination with hospice providers and documentation of covered services. Additionally, the Department stated similar processes are being implemented to monitor LDSS through desk reviews. The Department's new form (DOH-5778 mentioned previously) will be incorporated into these review processes as well.

Response #6:

In November 2022 the Department added the review of the hospice DOH-5778 form into the enrollees' record review step of the MLTC plans' operational survey process. The Department will be incorporating hospice cases into their desk reviews to ensure LDSS are coordinating services and financial obligations with hospice providers and adhering to the guidance that is being issued in response to recommendation 4.

Recommendation #7:

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

Status – Implemented

Agency Action – The initial audit found that 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 did not specifically require providers to document why services are provided outside of the hospice benefit. In November 2022, the Department introduced a new form (DOH-5778, mentioned previously) that requires hospices to specifically indicate to non-hospice providers any services not covered by hospice and the reason why the services are not covered by hospice. The other medical providers and/or facilities that provide services to the hospice patient are expected to incorporate the form into their records for appropriate care planning throughout the duration of treatment. The form also states that hospice providers should encourage all non-hospice providers to document the reason a service is provided outside of the hospital benefit (e.g., diagnosis, medical conditions) not related to the recipient's terminal illness.

Response #7:

The Department confirms agreement with the status of this recommendation.

Recommendation #8:

Assess the appropriateness of requiring Medicaid MCO's 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.

Status – Partially Implemented

Agency Action – The initial audit found that Department policy allows MLTC plans to pay for nursing home services at 100% of the usual nursing home rate, which is in excess of the minimum amount required by federal regulations (95%). Department officials stated they are having ongoing discussions about whether changes to reimbursement can be made in this area. However, discussions have not progressed to an ultimate determination regarding whether to require Medicaid MCO's to pay 95% of the nursing home room and board for dual-eligibles enrolled in hospice.

Response #8:

The Department has reviewed this recommendation, conducted an analysis to assess the appropriateness, and initiated a three- month nursing home benefit limit for Partial Capitation members since late 2019. After this careful review and action, the Department has decided not to require Medicaid MCO's pay 95 percent of the nursing home room and board rate for dual-eligible enrolled in hospice.

Recommendation #9:

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

Status – Partially Implemented

Agency Action – The Department is in the process of updating the Medicaid Hospice manual to coincide with changes made in response to the original audit.

Response #9:

The Department is distributing the Medicaid Hospice manual in 2023, in alignment with the draft Medicaid Update, the Medicaid Hospice MLTC Policy, and the GIS communication to the LDSS.