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OFFICE OF THE STATE COMPTROLLER

February 13, 2023

James V. McDonald, M.D., M.P.H.
Acting Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Improper Medicaid Payments for Individuals Receiving Hospice Services Covered by Medicare
Report 2022-F-31

Dear Dr. McDonald:

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 (Department) to implement the recommendations contained in our audit report, *Improper Medicaid Payments for Individuals Receiving Hospice Services Covered by Medicare* (Report 2018-S-71).

Background, Scope, and Objective

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.

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 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 not in managed care, but rather enrolled in Medicaid fee-for-service (FFS), 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.

We issued our initial audit report on December 28, 2020. The audit objective was to determine whether Medicaid made improper payments to providers on behalf of dual-eligible individuals receiving hospice care covered by Medicare. The audit covered the period January

1, 2015 through July 31, 2019. We determined the Department had not established sufficient controls to ensure Medicaid payments were appropriate for dual-eligibles receiving care under the Medicare-funded hospice benefit. As a result, the initial 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.

The objective of our follow-up was to assess the extent of implementation, as of January 4, 2023, of the nine recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials had made some progress in addressing the problems we identified in the initial audit report; however, additional actions are needed. In particular, the Office of the Medicaid Inspector General (OMIG) had yet to materially recover the overpayments identified in the initial audit. The Department should also complete its assessment of the appropriateness of requiring Medicaid managed care organizations (MCOs) to pay 95% (as opposed to the current 100%) of the nursing home room and board rate for dual-eligibles enrolled in hospice. Of the initial report's nine audit recommendations, three had been implemented, five had been partially implemented, and one had not yet been implemented.

Follow-Up Observations

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.

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 & Medicaid Services (CMS) into eMedNY to help ensure Medicaid payments are made correctly.

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.

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.

Recommendation 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.

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.

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.

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.

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 reasons 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 hospice benefit (e.g., diagnoses, medical conditions) not related to the recipient's terminal illness.

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.

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 MCOs to pay 95% of the nursing home room and board for dual-eligibles 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.

Major contributors to this report were Thomas Sunkel, Emily Proulx, and Lindsey Winter.

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.

Sincerely,

Mark Breunig
Audit Manager

cc: Melissa Fiore, Department of Health
Frank Walsh, Jr., Acting Medicaid Inspector General