Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

RHODE ISLAND HOSPICE GENERAL INPATIENT CLAIMS AND PAYMENTS DID NOT ALWAYS MEET FEDERAL AND STATE REQUIREMENTS

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Regional Inspector General

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Office of Inspector General

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EXECUTIVE SUMMARY

BACKGROUND

The Rhode Island Executive Office of Health and Human Services, Office of Medicaid (State agency), is responsible for administering the Rhode Island Medicaid program, in compliance with Federal and State statutes and administrative policies. State agencies have the option of offering hospice care as a benefit to eligible Medicaid members.

A hospice is a public agency, private organization, or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. The hospice must provide services for the palliation and management of the terminal illness and related conditions. Each day of hospice care is classified under four levels of care: (1) routine home care, (2) continuous home care, (3) inpatient respite care, and (4) general inpatient care. In order to qualify for reimbursement at the general inpatient care level, the hospice must document that a beneficiary's need for pain control or chronic symptom management is beyond the routine home care level of care. Federal regulations require the State agency to use certain additional beneficiary financial contributions to reduce Medicaid payments. In addition, drugs related to the treatment of the hospice beneficiary's terminal condition are covered as part of the hospice benefit.

For each day that a Medicaid beneficiary is under the care of a hospice, the hospice will be reimbursed an amount applicable to the type and intensity of the services furnished by the hospice to the beneficiary.

The State agency made payments for general inpatient care to 8 hospices totaling $1,482,833 for 382 claims during calendar years 2007 through 2010 (January 1, 2007, through December 31, 2010). We limited our review to seven hospices providing hospice general inpatient care in nursing facilities, inpatient hospitals, and a hospice inpatient unit. At our request, the State agency performed a medical review of 34 general inpatient hospice claims totaling $178,096.

OBJECTIVE

Our objective was to determine whether payments for hospice care met Federal and State requirements.

SUMMARY OF FINDING

Hospice general inpatient care payments did not always meet Federal and State requirements. Specifically, 19 of the 34 claims did not meet the requirements for general inpatient care and should have been billed as routine home care. This resulted in an overpayment of $39,562 ($23,843 Federal share). All of the services related to 18 of these claims were provided in a nursing home setting. Hospice officials stated that they believed the claims for hospice general inpatient care were appropriate given the patients' conditions at the time of the upgrade from hospice routine home care to hospice general inpatient care.

We identified additional hospice payment errors relating to incorrect cost of care calculations and separate payments for drug claims. These errors resulted in an overpayment of $5,189 ($3,137 Federal share). These overpayments occurred because the State agency did not establish adequate procedures to detect these types of errors.

RECOMMENDATIONS

We recommend that the State agency:

- refund $26,980 to the Federal government;

- strengthen internal controls, such as issuing guidance to hospices that better define the circumstances for general inpatient care and implementing computer edits to the claims processing system to ensure that payments are reduced by the amount of beneficiaries' financial contributions and duplicate payments for drugs are not made, and

- consider performing additional medical reviews of inpatient hospice services performed in a nursing home.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings and recommendations. The State agency's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Rhode Island Executive Office of Health and Human Services, Office of Medicaid (State agency), is responsible for administering the Rhode Island Medical Assistance program, the Rhode Island Medicaid program.

Hospice Care

Hospice care is an optional benefit under the Medicaid program. A hospice is a public agency, private organization, or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. The hospice must provide services for the palliation and management of the terminal illness and related conditions. Each day of hospice care is classified under four levels of care: (1) routine home care, (2) continuous home care, (3) inpatient respite care, and (4) general inpatient care. In addition to basic hospice services, short-term general inpatient care may be provided in a hospice inpatient unit, general inpatient hospital, or nursing facility.

Hospice General Inpatient Care

In order to qualify for reimbursement at the general inpatient care level, the hospice must document that a beneficiary's need for pain control or chronic symptom management is beyond the routine home care level of care. Pursuant to 42 CFR § 418.104, each hospice beneficiary's clinical record must contain patient assessments, clinical notes, responses to medications, symptom management, treatments, and services. Pursuant to 42 CFR § 418.108, short-term inpatient care must be available for pain control, symptom management, or respite purposes.

Hospice Billing

The State agency reimburses hospices an amount applicable to the type and intensity of the services furnished to the beneficiary for each day. Pursuant to 42 CFR § 435, the State agency must reduce its payment to an institution for services provided to a Medicaid-eligible individual by the amount that remains after adjusting the individual's total income for a personal needs allowance and other considerations that the regulation specifies.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether payments for hospice care met Federal and State requirements.

Scope

We limited our review to Medicaid paid claims for hospice general inpatient care that were subject to the State agency payment requirements. The State agency made hospice general inpatient payments to 8 hospices totaling $1,482,833 for 382 claims during calendar years 2007 through 2010 (January 1, 2007, through December 31, 2010). We limited our review to seven hospices providing general inpatient care in nursing facilities, general inpatient hospitals, and a hospice inpatient unit. The 7 hospices received reimbursement for 162 claims for general inpatient care totaling $543,126.

We requested that the State agency conduct a medical review of 34 judgmentally selected claims totaling $178,096 for 15 beneficiaries out of the 162 claims for hospice general inpatient care. We analyzed the proportion of the claims reimbursed from each hospice as part of a judgmental claim selection process. We then selected at least one beneficiary from each hospice and reviewed all of the claims hospice general inpatient care. As part of the selection process, we included beneficiaries that had inpatient stays from one day to several months. We also reviewed beneficiaries who had multiple inpatient stays in different months. We selected additional beneficiaries at two hospices that submitted and received a greater proportion of general hospice inpatient reimbursements than the other hospices reviewed.

In performing our review, we established reasonable assurance that the claims data were accurate. We did not, however, assess the completeness of the Rhode Island paid claims file from which we obtained the data. We limited our review of internal controls to obtaining an understanding of State agency's procedures for reimbursing hospice services and hospices' procedures for billing general inpatient services provided to hospice beneficiaries.

We performed fieldwork in February through June 2012 at State agency offices in Cranston and Warwick, Rhode Island, seven hospices located in Warwick, Pawtucket, Lincoln, and Portsmouth, Rhode Island, and Charlestown, Massachusetts, and the CMS Regional Office in Boston, Massachusetts.

Methodology

To accomplish our objective, we:

- reviewed Federal and State requirements;

- held discussions with State agency officials to gain an understanding of the hospice program and the State agency's role in reimbursing hospice claims;

- evaluated State agency payment files to identify 382 hospice claims for general inpatient care totaling $1,482,833 paid to 8 hospices provided to Medicaid beneficiaries in calendar years 2007 through 2010;

- identified 162 paid claims from 7 hospices totaling $543,126 for hospice general inpatient care provided at nursing facilities, general inpatient hospitals, and a hospice inpatient unit;

- reviewed hospice and nursing home billing invoices and remittance advices to validate payment information and determine whether the 7 hospices correctly billed the sampled claims;

- reviewed 38 claims to verify that the State agency adjusted its payment by the amount of the beneficiary's cost of care contribution;

- selected a judgmental sample of 34 claims for 292 general inpatient days totaling $178,096 for 15 beneficiaries;

- requested the State agency to perform a medical review of the selected judgmental sample of 34 claims;

- conducted site visits at 7 hospices to discuss hospice internal controls and determine the place of service prior, during, and after the general inpatient stay;

- evaluated hospice contracts with nursing facilities and hospitals;

- verified whether various hospice employees had been excluded from federally funded health programs; and

- discussed the findings with the State agency and CMS.

We conducted this 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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATION

Hospice general inpatient care payments did not always meet Federal and State requirements. Specifically, 19 of the 34 claims did not meet the requirements for general inpatient care and should have been billed as routine home care. This resulted in an overpayment of $39,562 ($23,843 Federal share). All of the services related to 18 of these claims were provided in a nursing home setting. Hospice officials stated that they believed the claims for hospice general inpatient care were appropriate given the patients' conditions at the time of the upgrade from hospice routine home care to hospice general inpatient care.

We identified additional hospice payment errors relating to incorrect cost of care calculations and separate payments for drug claims. These errors resulted in an overpayment of $5,189 ($3,137 Federal share). These overpayments occurred because the State agency did not establish adequate procedures to detect these types of errors.

HOSPICE CLAIMS DID NOT ALWAYS MEET LEVEL OF CARE REQUIREMENTS

The Rhode Island Department of Human Services' *Medical Assistance Program Hospice Manual* (Manual) states that for each day that a Medicaid beneficiary is under the care of a hospice, the hospice will be reimbursed an amount applicable to the type and intensity of the services furnished for that day.

The Manual further states that hospice routine home care is for beneficiaries who require hospice services but need less than 8 hours of care per day. The State agency covers hospice general inpatient care when it is necessary for pain control or acute symptom management.

Pursuant to 42 CFR § 418.104, each hospice beneficiary's clinical record must contain patient assessments, clinical notes, responses to medications, symptom management, treatments, and services.

Of the 34 claims for hospice general inpatient care in our review, 19 did not contain sufficient documentation to justify upgrading beneficiaries from routine home care to general inpatient care.[1] These errors resulted in an overpayment of $39,562.

An Example of a General Inpatient Claim Not Meeting Requirements

Beneficiary A received hospice routine home care from April 1, 2009, to April 14, 2009, at a nursing facility. On April 15, 2009, beneficiary A began receiving hospice general inpatient care at the same nursing facility. The review of the medical records supporting the general inpatient care claims revealed that there was no documented change in beneficiary A's status regarding pain control and acute or chronic symptom management. Therefore, the hospice provider's claim of general inpatient care was unjustified, and the hospice should have continued to claim routine home care for beneficiary A.

OTHER PAYMENT ERRORS

Pursuant to 42 CFR § 435, the State agency must reduce its payment to an institution for services provided to a Medicaid-eligible individual by the amount that remains after adjusting the individual's total income for a personal needs allowance and other considerations that the regulation specifies. In addition, the Manual states that drugs are covered under the hospice benefit when used for symptom control related to a beneficiary's terminal illness.

The State agency did not adjust four Medicaid payments to two hospices by the amount of the beneficiaries' cost-of-care contributions from resources, such as Social Security and pensions.

[1] The hospice services associated with these claims were provided at nine skilled nursing facilities.

Furthermore, the State agency also made 64 separate payments for drugs related to hospice beneficiaries' terminal conditions that were covered under the hospice benefit. These errors resulted in an overpayment of $5,189.

AMOUNT OWED TO THE FEDERAL GOVERNMENT

The State agency overstated its Federal claim for Medicaid payments for the period January 1, 2007, through December 31, 2010, by $44,751 ($26,980 Federal share).

CAUSE OF INCORRECT HOSPICE CLAIMS AND PAYMENT ERRORS

The incorrect hospice general inpatient care claims occurred because hospice officials stated that they believed the hospice claims were appropriate given the patients' conditions at the time of the upgrade from hospice routine home care to hospice general inpatient care. Furthermore, the State agency did not establish adequate procedures to detect other payment errors.

RECOMMENDATIONS

We recommend that the State agency:

- refund $26,980 to the Federal government,

- strengthen internal controls, such as issuing guidance to hospices that better define the circumstances for general inpatient care and implementing computer edits to the claims processing system to ensure that payments are reduced by the amount of beneficiaries' financial contributions and duplicate payments for drugs are not made, and

- consider performing additional medical reviews of inpatient hospice services performed in a nursing home.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings and recommendations. The State agency's comments are included in their entirety as the Appendix.

APPENDIX

Steven M. Costantino

Secretary of Health and Human Services
STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
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July 24, 2012

Report Number A-01-12-00002

Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Inspector General
Department of Health and Human Services
John F. Kennedy Building, Room 2425
Boston, MA 02203

Dear Mr. Armstrong:

This letter responds to your request for written comments on the review of the draft report on Medicaid payments made by Rhode Island for state fiscal years 2007 through 2010 (Report Number: A-01-12-00002). Our comments in response to the recommendations are:

Finding:
Hospice general inpatient care payments did not always meet Federal and State requirements. Specifically, 19 of the 34 claims did not meet the requirements for general inpatient care and should have been billed as routine home care. This resulted in an overpayment of $39,562 ($23,843 Federal share). All of the services related to 18 of these claims were provided in a nursing home setting. Hospice officials stated that they believed that claims for hospice general inpatient care were appropriate given the patients' condition at the time of the upgrade from hospice routine home care to hospice general inpatient care.

We identified additional hospice payment errors related to incorrect cost of care calculations and separate payments for drug claims. These errors resulted in an overpayment of $5,189 ($3,137 Federal share). These overpayments occurred because the State agency did not establish adequate procedures to detect these types of errors.

Recommendation:

1) Refund $26,980 to the Federal government
2) Strengthen internal control, such as issuing guidance to hospices that better define the circumstances for general inpatient care and implementing computer edits to the claims processing system to ensure that payments are reduced by the amount of beneficiaries' financial contributions and duplicate payments for drugs are not made, and
3) Consider performing additional medical reviews of inpatient hospice services performed in a nursing home.

Rhode Island Medicaid Response:

The current Rhode Island medical assistance program manual for hospice states that hospice routine home care is for beneficiaries who require hospice services but need less than 8 hours of care per day. The manual further states hospice general inpatient care is available when it is necessary for pain control or acute symptom management.

Drugs related to the hospice condition should be covered by the hospice agency. Determining if a drug is related to the hospice condition would require medical record review in each case as opposed to a general system edit.

Corrective Action:

1) The State concurs with the finding and will adjust its Federal claim by $26,980.
2) The State will strengthen internal controls through:
    a. State will develop more definitive guidelines defining routine care vs. general inpatient care and provide the guidance to all hospice providers.
    b. State will re-examine the policy and system calculation to validate the beneficiary's financial contribution and adjust processes if appropriate.
    c. State will provide education to hospice agency as to appropriate billing for drugs that should be covered under the hospice benefit. Random retrospective reviews will be performed to ensure compliance .
3) State will perform quarterly medical reviews of inpatient hospice performed in a nursing home.

Thank you for the opportunity to comment. The team led by Curtis Roy and John Sullivan made every effort to keep the State informed of the status throughout the review and ensured that the information on which findings were based was the correct information.

If you have any questions or need additional information, please do not hesitate to contact Elena Nicolella at 401-462.0854 or via e-mail at ENicolella@ohhs.ri.gov.

Sincerely,

Steven M. Costantino

c: Elena Nicolella
Alda Rego