Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW JERSEY CLAIMED MEDICAID HOSPICE SERVICES THAT WERE NOT IN COMPLIANCE WITH FEDERAL AND STATE REQUIREMENTS

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Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

New Jersey claimed at least $8.4 million in Federal Medicaid reimbursement from January 1, 2007, through July 31, 2008, for hospice services that did not comply with Federal and State requirements.

WHY WE DID THIS REVIEW

Hospice care is a program of palliative care that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family. The goal of such care is to achieve the highest quality of life as defined by the patient and his or her family through the relief of suffering and control of symptoms. Previous Office of Inspector General (OIG) reviews found that States did not always comply with Federal and State requirements for hospice claims.

The objective of this review was to determine whether New Jersey properly claimed Federal Medicaid reimbursement for hospice services in compliance with Federal and State requirements.

BACKGROUND

A hospice is a public agency, private organization, or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. Hospice care can be provided to individuals in a home, hospital, nursing home, or hospice facility.

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 a State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In New Jersey, the Department of Human Services (State agency) administers the Medicaid program.

For a beneficiary's hospice services to be covered under Medicaid, the hospice must ensure that (1) the beneficiary voluntarily elected hospice services in place of other Medicaid services related to the terminal illness, (2) the beneficiary's attending physician and the hospice's physician certified that the beneficiary has a terminal illness, and (3) the services were provided in accordance with a plan of care by appropriately qualified personnel.

HOW WE CONDUCTED THIS REVIEW

Our review covered 20,367 beneficiary-months for which the State agency claimed Medicaid reimbursement totaling $83,151,316 ($41,582,690 Federal share) for hospice services for beneficiary-months with payments over $100 for the period January 1, 2007, through July 31, 2008. A beneficiary-month includes all hospice services provided to a beneficiary during 1 month. We reviewed all Medicaid payments for hospice services related to our random sample of 150 beneficiary-months.

WHAT WE FOUND

The State agency claimed Federal Medicaid reimbursement for some hospice services that did not comply with Federal and State requirements. Of the 150 beneficiary-months in our random sample, 108 complied with Federal and State requirements, but 42 did not.

The deficiencies occurred because the State agency did not monitor hospices for compliance with certain Federal and State requirements until after our audit period, when it implemented a postpayment review process for hospice services. On the basis of our sample results, we estimated that the State agency improperly claimed at least $8,405,262 in Federal Medicaid reimbursement for hospice services that did not meet Federal and State requirements.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $8,405,262 to the Federal Government and
- continue to monitor hospices to ensure that they comply with Federal and State requirements.

STATE AGENCY COMMENTS

In an email dated April 2, 2015, State agency officials stated they would not be providing comments to our report but rather would respond to CMS after the OIG issues the final report.

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INTRODUCTION

WHY WE DID THIS REVIEW

Hospice care is a program of palliative care that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family. The goal of such care is to achieve the highest quality of life as defined by the patient and his or her family through the relief of suffering and control of symptoms. Previous Office of Inspector General (OIG) reviews found that States did not always comply with Federal and State requirements for hospice claims. (Appendix A lists related OIG reports on Medicaid hospice services.)

OBJECTIVE

Our objective was to determine whether New Jersey properly claimed Federal Medicaid reimbursement for hospice services in compliance with Federal and State requirements.

BACKGROUND

The Medicaid Program

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 a State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

In New Jersey, the Department of Human Services (State agency) administers the Medicaid program.

New Jersey's Medicaid Hospice Program

New Jersey defines hospice services as services to support a philosophy and method for caring for the terminally ill emphasizing supportive and palliative rather than curative care, and includes services such as home care, bereavement counseling, and pain control. Palliative care is patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

Federal and State Requirements Related to Hospice Services

To be allowable under a Federal award, costs must be authorized or not prohibited by State or local laws or regulations (2 CFR App. A, § C.1.c).

Section 1905(a)(18) of the Social Security Act (the Act) authorizes states to receive federal financial participation for expenditures on hospice care. Section 1905(o) of the Act defines "hospice care" for purposes of Medicaid. Section 1905(o) of the Act relies on, in part, Medicare

definitions of hospice care in section 1861(dd) of the Act, including that hospice services must be provided by a hospice, a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals.

Under section 1905(o) of the Act and the CMS *State Medicaid Manual* § 4305, for a beneficiary's hospice services to be covered, the hospice must ensure that (1) the beneficiary voluntarily elected hospice services in place of other Medicaid services related to the terminal illness, (2) the beneficiary's attending physician and the hospice's physician certified that the beneficiary has a terminal illness,[1] and (3) the services were provided in accordance with a plan of care established and periodically reviewed by appropriately qualified personnel.[2]

In addition to the Federal statutory and manual requirements, New Jersey has implemented State regulations on Medicaid hospice services, which are codified in Title 10, chapter 53A, of the New Jersey Administrative Code (NJAC). For details on State requirements related to hospice services, see Appendix B.

HOW WE CONDUCTED THIS REVIEW

Our review covered 20,367 beneficiary-months for which the State agency claimed Medicaid reimbursement totaling $83,151,316 ($41,582,690 Federal share) for hospice services for beneficiary-months with payments over $100 for the period January 1, 2007, through July 31, 2008. A beneficiary-month includes all hospice services provided to a beneficiary during 1 month. We reviewed all Medicaid payments for hospice services related to our random sample of 150 beneficiary-months.

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 objectives.

Appendix C contains the details of our audit scope and methodology, Appendix D contains our statistical sampling methodology, and Appendix E contains our sample results and estimates.

FINDINGS

The State agency claimed Federal Medicaid reimbursement for some hospice services that did not comply with Federal and State requirements. Of the 150 beneficiary-months in our random sample, 108 complied with Federal and State requirements, but 42 did not. The following table

[1] Specifically, the beneficiary's attending physician and the hospice physician must sign a written certification that the beneficiary's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.

[2] Section 1861(dd)(1) of the Act requires that the written plan of care be established and periodically reviewed by the beneficiary's attending physician, the hospice medical director, and the hospice interdisciplinary team. Section 1861(dd)(2)(B) of the Act requires the interdisciplinary team to be composed of at least a physician, a registered nurse, a social worker, and a pastoral or other counselor.

summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

Table: Summary of Deficiencies in Sampled Beneficiary-Months

Deficiency	Number of Deficient Beneficiary-Months[a]
No physician's certification	17
No medical record	12
Election statement requirements not met	11
Services not provided in accordance with plan of care	6
Aide not licensed or supervised	4
Plan of care not reviewed and updated	1

[a] The total exceeds 42 because 7 beneficiary-months contained more than 1 deficiency.

The deficiencies occurred because the State agency did not monitor hospices for compliance with certain Federal and State requirements until after our audit period, when it implemented a postpayment review process for hospice services . On the basis of our sample results, we estimated that the State agency claimed at least $8,405,262 in Federal Medicaid reimbursement for hospice services that did not meet Federal and State requirements.

NO PHYSICIAN'S CERTIFICATION

A physician's certification from the beneficiary's attending physician and the hospice physician are required for the beneficiary's initial 90-day period in hospice care. For the second 90-day period, a physician's certification from the hospice physician or a member of the interdisciplinary team is required. For each subsequent 60-day period, certifications from the beneficiary's attending and hospice physicians are required (NJAC 10:53A-2.3(a)(4) & (5)).

For 17 of the 150 beneficiary-months in our sample, there were no applicable physicians' certifications.

NO MEDICAL RECORD

Hospices are required to maintain a complete medical record, including an Election of Hospice Benefits Statement (election statement), physicians' certifications, plan of care, and other service documentation, for each beneficiary (NJAC 10:53A-2.6).[3]

[3] In addition, section 1902(a)(27) of the Act mandates that States have agreements with Medicaid providers under which providers agree to keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the Medicaid State plan. Pursuant to Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Tribal Governments*, Att. A, § C.1.j (2 CFR § 225, App. A § C.1.j), costs must be adequately documented to be allowable under Federal awards. Pursuant to section 2500.2 of the CMS *State Medicaid Manual*, States are to report only expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is immediately available when the claim is filed.

For 12 of the 150 beneficiary-months in our sample, the hospices did not provide a medical record for the beneficiary.[4]

ELECTION STATEMENT REQUIREMENTS NOT MET

To be eligible for Medicaid hospice services, beneficiaries are required to voluntarily elect hospice services in place of other Medicaid services related to the terminal illness according to procedures established by the State (section 1905(o)(2) of the Act). State regulations require the beneficiary to file an election statement with the hospice that will provide services and to indicate which other Medicaid services are forfeited (NJAC 10:53A-1.2).

For 11 of the 150 beneficiary-months in our sample, the State agency claimed reimbursement for hospice services for beneficiaries for which there was no election statement (2 beneficiary-months), or the beneficiary's election statement did not indicate which other Medicaid services were to be forfeited (9 beneficiary-months).

SERVICES NOT PROVIDED IN ACCORDANCE WITH PLAN OF CARE

Hospice services are to be provided in accordance with the beneficiary's plan of care.[5] To be covered, services must be consistent with the plan of care.[6] State regulations also require, "if reasonable and necessary for palliative care," the following services to be provided to the beneficiary: nursing care, medical social services, counseling services, durable medical equipment (including drugs and biologicals), homemaker/home health aide services, physical therapy, occupational therapy, and speech-language pathology services. A hospice may receive payment for each day the patient is under care of the hospice.[7]

For 6 of the 150 beneficiary-months in our sample, hospice records indicated that the hospice did not provide either the number or type of services detailed in the beneficiary's plan of care. Specifically:

- For 4 beneficiary-months, hospices did not provide the number of services specified in the plan of care. For example, one beneficiary's plan of care specified that aide services were to be provided 2 to 5 times a week; however, the hospice did not provide a timesheet showing that any aide services were provided. Another beneficiary's plan of care specified that aide services were to be provided 5 times a week; however, timesheets indicated that the aide service were provided only 3 times in the entire month.

[4] For 11 beneficiary-months, officials from the corresponding hospice stated that records related to the associated beneficiaries were unintentionally destroyed by an offsite records management and storage facility. For one other beneficiary month, the hospice closed and records could not be located.

[5] Section 1905(o)(1) of the Act defines Medicaid hospice services as the care described in section 1861(dd)(1) of the Act. The list includes "any other service or item included in the plan of care for which payment may otherwise be made."

[6] CMS *State Medicaid Manual* § 4305.4.

[7] CMS *State Medicaid Manual* § 4306.

- For 1 beneficiary-month, the hospice billed 3 days at the general inpatient rate when it only documented that it provided a routine level of care.[8]

- For 1 beneficiary-month, the hospice records indicated that the beneficiary was not in the care of hospice for 1 day because he was hospitalized for a reason unrelated to the diagnosis that was the basis for his hospice care.

AIDE NOT LICENSED OR SUPERVISED

CMS requires hospice services to be provided by "appropriately qualified personnel." Specifically, home health aide services and homemaker services must be furnished by qualified aides and be provided under the general supervision of a registered nurse (section 4305.5 of the the CMS *State Medicaid Manual*). State regulations require home health aide and homemaker services to be certified by the New Jersey State Department of Law and Public Safety, Board of Nursing. (NJAC 10:60-1.2). Additionally, state regulations require a registered nurse to visit the beneficiary's home at least every 2 weeks when these services are provided to assess the services and provide education and supervision to the aide (NJAC 10:53A-3.4(d)).

During 4 of the 150 beneficiary-months in our sample, hospice services were performed by unlicensed (2 beneficiary-months) or unsupervised (2 beneficiary-months) homemaker/home health aides.

PLAN OF CARE NOT REVIEWED AND UPDATED

Hospice services are to be provided in accordance with a plan of care established and periodically reviewed by the attending physician, the hospice medical director, and the hospice interdisciplinary team.[9] State regulations require the plan of care to be reviewed and updated at least once per month by the beneficiary's attending physician, the hospice medical director or physician designee, and the hospice's interdisciplinary team (NJAC 10:53A-3.6(b)(3)).

For 1 of the 150 beneficiary-months in our sample, the hospice's medical director and interdisciplinary team had not reviewed the beneficiary's plan of care.

[8] In accordance with the CMS *State Medicaid Manual* §§ 4305 & 4306, hospice services are reimbursed at one of four levels of care: routine care, continuous home care, inpatient respite care, and general inpatient care. The general inpatient care rate is reimbursed when provided in a hospital or nursing facility during periods of acute medical crisis, for palliative care, for pain control, or management of acute and severe clinical problems which cannot be managed in another setting.

[9] Section 1905(o)(1) of the Act. The section of the Act also defines Medicaid hospice services as the care described in section 1861(dd)(1). Section 1861(dd)(1) defines hospice care as certain services provided by a hospice to a terminally ill individual under a written plan established and periodically reviewed by the individual's attending physician, the hospice medical director, and the interdisciplinary team.

CONCLUSION

The deficiencies occurred because the State agency did not monitor hospices for compliance with certain Federal and State requirements until after our audit period, when it implemented a postpayment review process for hospice services. On the basis of our sample results, we estimated that the State agency claimed at least $8,405,262 in Federal Medicaid reimbursement for hospice services that did not meet Federal and State requirements.

RECOMMENDATIONS

We recommend that the State agency:

- refund $8,405,262 to the Federal Government and
- continue to monitor hospices to ensure that they comply with Federal and State requirements.

STATE AGENCY COMMENTS

In an email dated April 2, 2015, State agency officials stated they would not be providing comments to our report but rather would respond to CMS after the OIG issues the final report.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Ohio Did Not Always Properly Claim Medicaid Reimbursement for Hospice Claims	A-05-12-00087	5/22/2014
Rhode Island Hospice General Inpatient Claims and Payments Did Not Always Meet Federal and State Requirements	A-01-12-00002	8/13/2012
Rhode Island Did Not Always Comply With State Requirements on Medicaid Payments for Hospice Services	A-01-11-00005	3/26/2012
Review of Medicaid Hospice Payments to Evercare Hospice & Palliative Care for State Fiscal Years 2007 Through 2009	A-01-10-00012	9/23/2011
Review of Medicaid Hospice Payments Made by Massachusetts for State Fiscal Years 2007 and 2008	A-01-10-00004	2/18/2011

APPENDIX B: STATE REQUIREMENTS RELATED TO HOSPICE SERVICES

In New Jersey, State regulations on Medicaid hospice services are codified in Title 10, chapter 53A of the NJAC. In part, the regulations require the following:

- The beneficiary must file an election statement with the hospice that will provide services, indicating which other Medicaid services are forfeited.[10]

- Dually eligible Medicaid and Medicare beneficiaries must elect to use the Medicaid and Medicare hospice benefits simultaneously.

- Physicians must certify that the beneficiaries' prognosis is for a life expectancy of 6 months or less if the terminal illness runs its course and recertify after an initial 90-day period in hospice care, a second 90-day period, and every 60 days thereafter.[11] The certification and recertification periods relate to the duration of the Medicaid hospice benefit.

- The beneficiary's attending physician, the hospice's medical director, and the hospice's interdisciplinary team must review and update the beneficiary's plan of care at least once per month.

- Hospices must maintain a complete medical record, including an election statement, physicians' certifications, plan of care, and other service documentation, for each beneficiary.

- Hospice services must be provided in accordance with the beneficiary's plan of care. Specifically, the scope and frequency of services needed to meet the needs of the beneficiary and family must be stated in detail in the plan of care.

- The following services (if reasonable and necessary for palliative care) must be provided to the beneficiary: nursing care, medical social services, counseling services, durable medical equipment including drugs and biologicals, homemaker/home health aide services, physical therapy, occupational therapy, and speech-language pathology services.

[10] The election statement includes the name of the hospice that will provide care to the beneficiary, the scope of services and conditions under which hospice services are provided, which other Medicaid services are forfeited when choosing hospice services, the beneficiary or his/her representative's acknowledgment that he/she has been given a full understanding of hospice care, and the effective date of the statement.

[11] The initial physician's written certification, if not obtained within 2 days of the start of care, must be preceded by a verbal certification obtained no later than 2 days from the start of care and the written certification must be obtained no later than 8 days from the start of care. Although the hospice only needs to obtain for the second 90-day period a written certification from its medical director, for all subsequent 60-day periods the hospice must obtain a written certification from the beneficiary's attending physician as well as from its medical director. All physician certifications from the second 90-day period forward must be obtained within 2 days of the beginning of the coverage period.

- Certain hospice services (i.e., home health aide/homemaker services) must be provided by licensed individuals supervised by a registered nurse. The registered nurse must visit the beneficiary's home at least every 2 weeks to supervise the homemaker/home health aide.

APPENDIX C: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered the State agency's claims for Medicaid hospice services for the period January 1, 2007, through July 31, 2008. During this period, the State agency claimed $83,151,316 ($41,582,690 Federal share) for hospice services for 20,367 beneficiary-months with payments over $100. A beneficiary-month includes all hospice services for a beneficiary for 1 month.

We did not assess the overall internal control structure of the State agency or the Medicaid program. Rather, we limited our internal control review to those controls related to the objective of our audit. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information System file for our audit period, but we did not assess the completeness of the file.

We performed fieldwork at the State agency's offices in Trenton, New Jersey, and at 37 hospices throughout New Jersey.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with State agency officials to gain an understanding of the State agency's hospice services program;
- ran computer programming applications that identified a sampling frame of 20,367 beneficiary-months, totaling $83,151,316 ($41,582,690 Federal share), submitted by 52 hospice providers;
- selected a simple random sample of 150 beneficiary-months from our sampling frame, and for each beneficiary-month, obtained and reviewed the related hospice's documentation to determine whether hospice services were provided in accordance with Federal and State requirements;
- estimated the unallowable Federal Medicaid reimbursement paid in the sampling frame of 20,367 beneficiary-months; and
- discussed our findings with State agency officials.

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 objectives.

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population was Medicaid payments for beneficiary-months of service totaling $100 or more made by the State agency to providers for hospice services provided from January 1, 2007, through July 31, 2008, that the State agency claimed for Federal Medicaid reimbursement.

SAMPLING FRAME

The sampling frame was a computer file containing 20,367 beneficiary-months of service totaling $100 or more. The Medicaid paid amount totaled $83,151,316 ($41,582,690 Federal share). The data for the beneficiary-months of service were extracted from the State's Medicaid Management Information System.

SAMPLE UNIT

The sample unit was a beneficiary-month—the group of those paid claim lines for services provided to a single beneficiary with service starting dates within a single calendar month.

SAMPLE DESIGN

We used a simple random sample to evaluate the population of Medicaid hospice service payments.

SAMPLE SIZE

We selected a sample of 150 beneficiary-months.

SOURCE OF THE RANDOM NUMBERS

We used the Office of Inspector General, Office of Audit Services (OAS), statistical software to generate the random numbers.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the 20,367 beneficiary-months. After generating 150 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to appraise the sample results. We estimated the overpayment associated with the unallowable services at the lower limit of the 90-percent confidence interval.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Beneficiary-Months in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Beneficiary-Months with Unallowable Services	Value of Unallowable Services (Federal Share)
20,367	$41,582,690	150	$307,934	42	$84,601

Estimates of Unallowable Costs
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$11,487,109
Lower limit	8,405,262
Upper limit	14,568,956