STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

OHIO MEDICAID PROGRAM

Opportunities to Reduce Overpayments to Ohio Medicaid Hospices

An Operational Review performed by the:

Fraud, Waste, and Abuse
Prevention Division

May 1999 ***AOS/FWAP-99-004R***

STATE OF OHIO
OFFICE OF THE AUDITOR
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Ms. Jacqui Romer-Sensky, Director
Ohio Department of Human Services
30 East Broad Street
Columbus, Ohio 43266-0423

Dear Director Romer-Sensky:

We are pleased to provide you with our report *Opportunities to Reduce Overpayments to Ohio Medicaid Hospices.* Our objectives were to identify systemic weaknesses, inefficiencies, and abuses in the hospice program and to recommend ways to help the Ohio Department of Human Services prepare to meet the current and future needs of this growing program.

This report identifies $2.5 million in overpayments, and more than $390,000 in accumulated interest losses because the overpayments were not detected and recovered in a timely manner. Recognizing that ODHS has an interest in supporting an efficiently managed, quality Hospice program, the report also recommends ways to reduce the risks of future overpayments and providers' failure to meet quality standards.

Copies of this report are being sent to members of the General Assembly, the Ohio Hospice Organization, the U.S. Department of Health and Human Services Office of Inspector General, and other interested parties. If you or your staff have any questions concerning the report or would like to discuss its contents further, please call John Butts, Chief Division of Fraud, Waste, and Abuse Prevention, at (614) 466-3212.

Yours truly,

JIM PETRO
Auditor of State

EXECUTIVE SUMMARY

The Ohio Department of Human Services (ODHS) asked the Auditor of State to review the soundness of Ohio's Medicaid Hospice Program. Hospice care recognizes that with impending death, a patient may choose a change in treatment from curative care to palliative care, which focuses on pain control, symptom management, and counseling for both the patient and family. This program is available as an optional Medicaid benefit to those who are terminally ill with a life expectancy of six months or less.

Our report discusses four broad issues: (1) whether providers billed and received inappropriate reimbursement for deceased Medicaid recipients; (2) whether ODHS adjusted and recovered overpayments from hospice providers; (3) whether non-terminal patients were enrolled or enrolled too early in the hospice program; and (4) whether program inspections and surveys are sufficient to ensure an efficient and effective hospice program.

The Bureau of Community Services of ODHS administers the state's rapidly growing hospice program. According to ODHS claims data, the number of Ohio hospice providers has increased from 53 to 91 between January 1, 1993, and December 31, 1998. These providers were paid a total of approximately $86.3 million in services during this period, when annual reimbursements to Ohio's hospice providers increased from just less than $5 million in 1993 to more than $20 million in 1997 before declining slightly to about $18 million in 1998.

To collect the essential information necessary for our review, we met with representatives from ODHS, Ohio's Department of Health, the Ohio Hospice Organization, Genesis Health Care Systems, and the Muskingum County Department of Human Services, as well as nurses, social workers, patients and families. These discussions yielded perspectives on the Ohio Hospice Program that enabled us to determine the areas in the hospice program at greatest risk for fraud, waste, and abuse. Also, to test the ODHS claims processing system, we designed a number of computerized programs, or "edits," that allowed us to determine what monies were being disbursed, for what reason, and to whom.

We found the following.

- ***ODHS overpaid providers more than $2.5 million between January 1, 1993, and December 31, 1997. These overpayments occurred because hospice providers billed and received inappropriate reimbursement for deceased Medicaid recipients, for inappropriate (excluded) combinations of services, and for dually eligible Medicaid and Medicare recipients. Overpayments also occurred because ODHS made duplicate payments to both nursing facilities and hospices for room and board.***

- ***ODHS had not adjusted and recovered the overpaid monies as of October 31, 1998. This unadjusted amount resulted in an estimated interest loss of $390,505 (at an annual compounded interest rate of 6 percent).***

- ***ODHS has also had concerns about payments to hospice providers. In 1996, it initiated a quality assurance project that identified and recouped about $1.1 million in payments for ancillary services that should have been included as part of the normal hospice payment. ODHS also advised us that another $800,000 in adjustments was being processed to recoup overpayments to nursing facilities for individuals receiving hospice services. Some of the latter adjustments may be for overpayments identified by our review.***

- ***Some patients may have been enrolled in hospice programs before their illness reached the required terminal stage – defined by Medicaid regulations as a life expectancy of six months or less. While we recognize the difficulty of attaching a certain date of death to a terminal diagnosis, our review showed that 451 (4.4 percent) of 10,268 benefit recipients were in the program longer than nine months. In fact, 248 recipients (2.4 percent) were in the program for periods ranging from a year to more than three years. The federal Department of Health and Human Services has reported nationally that some hospice providers may be enrolling patients prematurely to maximize Medicare or Medicaid reimbursements. ODHS said it is considering ways to assess the prevalence of early enrollment in Ohio.***

- ***Hospice providers are not subject to annual inspections. The Ohio Administrative Code (OAC) §3701-19-04 (B), does not require the Ohio Department of Health to inspect hospices annually. The only program oversight language states that ODHS will operate a quality assurance program to monitor compliance with code requirements (OAC §5101:3-56-04 but does not state the frequency or type of monitoring that should be conducted. According to the Bureau of Community Services, the last quality assurance review was conducted about three years ago. The Ohio Hospice Organization, which promotes the development and delivery of hospice care through its advocacy of hospice philosophy and standards, has voiced concern for its members and requests annual reviews.***

We are recommending that the ODHS take the following steps.

- ***Recover the overpayments identified in this report.***

- ***Create computer edits to (a) periodically match Medicaid Management Information System paid claims data with official death records from the state's Department of Health, (b) deny payments on claims resulting from non-allowable combinations of services, (c) minimize duplicate payments for hospice recipients residing in a nursing facility, and (d) deny claims that should be paid by Medicare when the hospice recipient is dually eligible for Medicaid and Medicare.***

- ***Revise OAC §5101:3-56-031(B) to impose a time frame by which each hospice provider must notify its County Department of Human Services of changes in a client's address or***

status. ODHS should also establish requirements for when county departments must enter the changes into the state computer data base.

- ***Propose a change to the Ohio Revised Code and enact new rules in the Ohio Administrative Code as to the duties, responsibilities, and frequency of hospice inspections, surveys, and quality assurance monitoring, as well as specifying the roles of the appropriate state agencies, establishing any and all necessary procedures, and, if needed, training for agency personnel who would conduct inspections and surveys and monitor quality assurance.***

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ABBREVIATIONS

OAC	Ohio Administrative Code
ODHS	Ohio Department of Human Services
OIG	Office of Inspector General

BACKGROUND

The United States Congress enacted legislation in 1982 creating a Medicare Hospice Program. By 1986, Congress was allowing individual states to add a hospice benefit to their state Medicaid plans. Because, according to the United States Census Bureau, the proportion of elderly Americans to the general population will grow over the next few decades, greater demand will be placed, in all likelihood, on individual hospice programs. Review and analysis of these programs can be the first critical step in making sure Ohio is able to meet those future needs.

The Ohio Department of Human Services (ODHS) established its Medicaid Hospice benefit in May of 1990. Between January 1, 1993, and December 31, 1998, ODHS made Medicaid payments totaling $86.3 million to 91 hospice providers. In 1993, hospice reimbursements were about $5 million, but rose to over $20 million by 1997, with a more than four-fold increase in the number of claims submitted for reimbursement. During 1998, hospice reimbursements declined slightly to $18 million, as did the number of claims for reimbursements (see Table 1). The total number of approved Ohio hospice providers rose from 53 in January 1993 to 91 by December 1998, for a total increase of about 72 percent over this 6-year period (see Table 2).

Table 1: TOTAL ANNUAL OHIO HOSPICE PROVIDER CLAIMS FOR 1993-1998

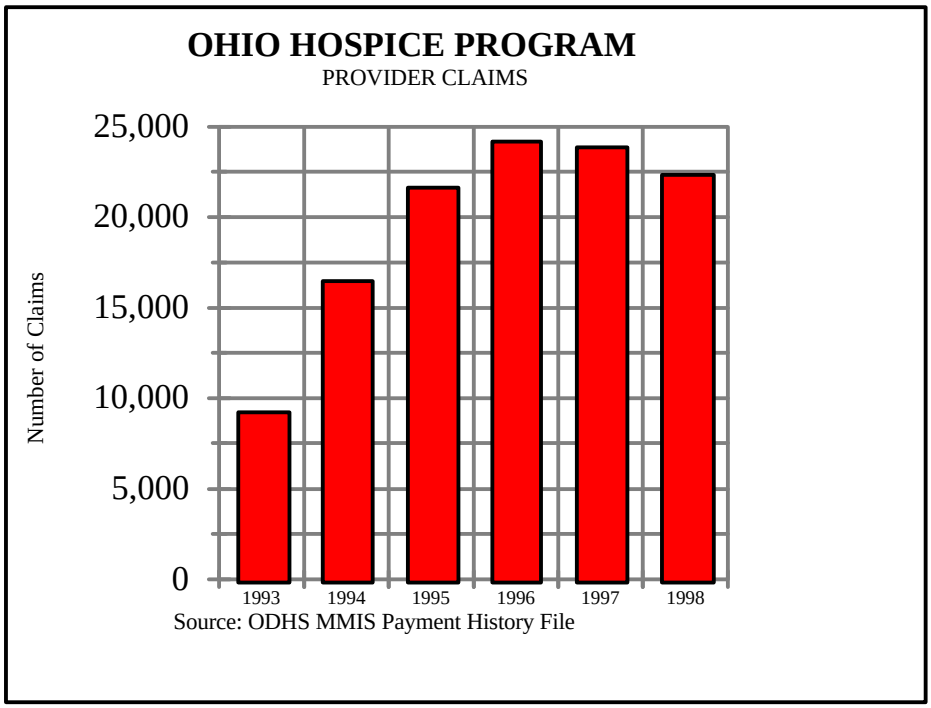
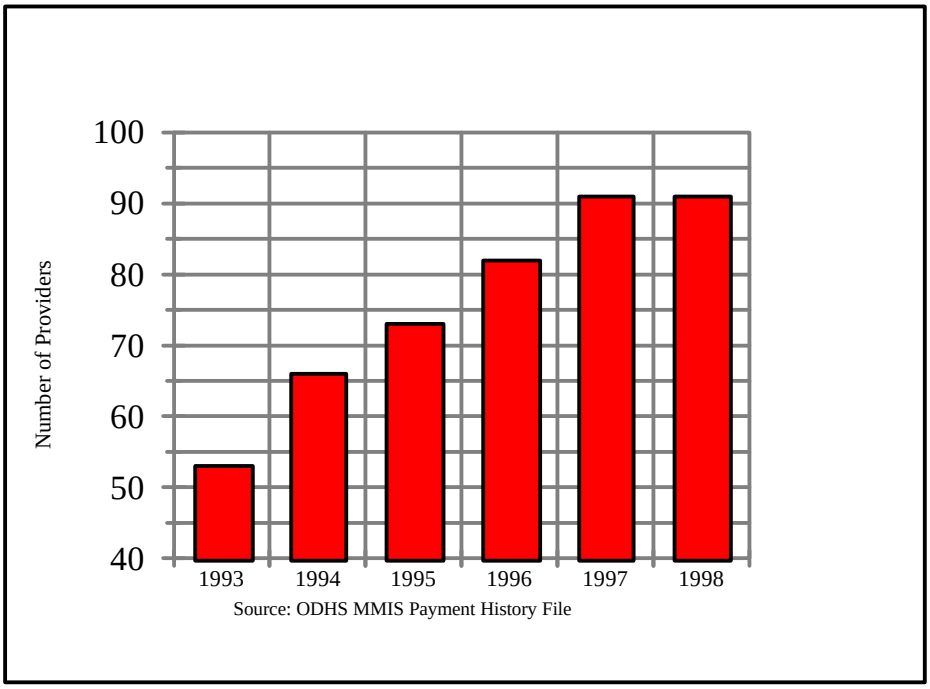


Table 2: NUMBER OF ENROLLED HOSPICE PROVIDERS



OHIO'S HOSPICE PROGRAM

Ohio's Medicaid Hospice program is an optional benefit available to Medicaid clients who are terminally ill. Clients are defined as terminally ill when their medical prognosis is a life expectancy of 6 months or less (given that the illness runs its normal course).

Who Runs the Program

In the State of Ohio, ODHS is responsible for overseeing the delivery of quality medical care for clients enrolled in a hospice program. The Bureau of Community Services at the ODHS discharges the specific responsibilities, duties, and coordination of efforts for all aspects of this program.

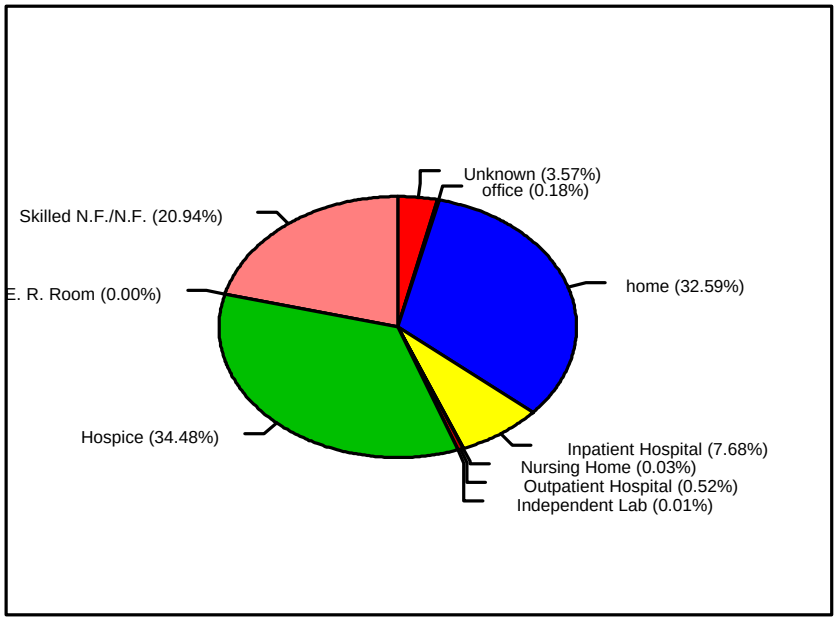
Who Receives Hospice Care

Hospices approach patient care with the recognition that impending death may warrant a change in treatment from curative to palliative care. Palliative care focuses on *pain control, symptom management, and counseling* for both patient and family. Thus, hospice care is a viable option for

patients who have become terminally ill.

Initially, hospice care was provided primarily in the home to avoid an institutional setting and improve the individual's quality of life until he or she dies. More recently, however, hospice care has been offered in a variety of settings, as illustrated in Table 3.

TABLE 3: HOSPICE BILLINGS BY PLACE OF SERVICE
For Calendar Year 1998



What Hospice Care Includes

In order for hospice care to be reimbursed by ODHS, OAC 5101:3-56-05 requires that the services must be reasonable and necessary for the palliation or management of a terminal illness, as well as related conditions, and be in accordance with 42 CFR, Sections 418.58 and 418.68.

OAC 5101:3-56-05 further provides that before the hospice begins caring for a patient, the hospice must establish a plan of care; once this plan is established, services must be consistent with that plan of care. All hospice care plans must cover the following services related to the terminal illness:

- **physician and nursing services; medical social services and counseling;** (Physician services, nursing care, medical social services and counseling are core hospice services and

must be provided directly by hospice employees.[1])

- **physical, occupational, and speech therapy;**
- **home health care and use of homemakers;** (Routine home care is covered when the client is at home and not receiving continuous care. The hospice may be reimbursed at the routine home care rate when providing care to clients who are receiving inpatient care for an illness or condition not related to the terminal illness. Continuous home care may consist of primary nursing care to achieve palliation or management of acute medical symptoms. A minimum of eight hours of care must be provided during a 24-hour day. This care need not be continuous. For example, 4 hours of care could be furnished in the morning and another 4 hours provided in the evening of the same day.)
- **medical supplies, including drugs and biologicals;** and
- **short-term inpatient care and respite care.** General inpatient care is covered during a period of health care crisis as long as it is provided in a participating hospice unit of a participating hospital or nursing facility. Both the hospital and nursing facility must meet hospice standards. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Services provided in an inpatient setting must conform to a written plan of care. Respite care is short-term inpatient care provided only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may only be provided on an occasional basis, and may not be reimbursed for more than 5 days at a time.

Other *non-core* hospice services may be provided in accordance with contractual arrangements made with other providers. Individuals eligible for Medicaid may also reside in a nursing facility and choose to receive hospice care in that setting. Such care must still conform to hospice standards and to a written plan of care. However, the hospice must retain professional management for all contracted services.

How Medicare and Medicaid Cover Hospice Benefits

In order to elect the hospice benefit, a client must be eligible for Medicaid or Medicare or both and be diagnosed as terminally ill. If Medicare approves a Medicaid beneficiary for the hospice benefit, the beneficiary must elect the benefit simultaneously, on the same day, and under both Medicare and Medicaid. Medicare beneficiaries must be entitled to Medicare part A services, which includes hospice services. While hospice beneficiaries generally waive their rights to all related curative care during a terminal illness, Medicaid and Medicare will continue to pay directly for services by the patient's nonhospice attending physician and for treatment of conditions unrelated to the terminal illness.

[1]The narrative descriptions of hospice care services came from a July 1996 Hospice Review Project report prepared by ODHS' Bureau of Community Services.

Medicare's hospice payment schedule has several parts:

- **!** A payment rate for routine hospice services. This hospice rate does not include any payment for room or board, since most hospice services have traditionally been provided to patients in their homes.
- **!** A routine home care rate, for services provided to patients in a nursing facility. This is a fixed amount paid per day regardless of the volume or intensity of the services provided. In addition,
  - if the hospice patient resides in a nursing facility and is not Medicaid eligible, the patient remains responsible for payment of the nursing facility room and board charges.
  - if the client is dually eligible for both Medicaid and Medicare and a hospice and nursing facility are owned by the same organization, that organization would receive two payments each month for the same patient. The two payments would be made under different provider numbers; one from Medicaid for the nursing facility per diem rate (room and board) and one from Medicare for the routine hospice services.
  - for nursing facilities and hospices that are not owned by the same organization and who have patients who are dually eligible for both Medicare and Medicaid benefits, Medicaid pays the hospice for the patient's room and board. The hospice then pays the nursing facility at a rate determined by a contract between the nursing facility and the hospice for the patient's room and board. However, for the dually eligible, Medicare is at all times responsible for paying for the hospice benefit.
  - the hospice may pay the nursing facility for other non-core hospice services (i.e., those services which the hospice is not required by law to provide) to its hospice patients, depending on the arrangement that exists between the hospice and the nursing facility.

Medicaid has an initial benefit period prescribed by Ohio Administrative Code (OAC) §5101:3-56-01 (C) that cannot be greater than 90 days, followed by a subsequent 90-day period, then an additional 30-day period, and a subsequent extension of unlimited duration during the individual's lifetime. On the other hand, according to 42 CFR section 418.21, Medicare's hospice benefit, is divided into three benefit periods: (1) an initial 90-day period, (2) a subsequent 90-day period, and (3) an unlimited number of subsequent 60-day benefit periods as long as the patient continues to meet program eligibility requirements.

PURPOSE, SCOPE AND METHODOLOGY

The growth in Ohio's hospice program prompted the Ohio Department of Human Services (ODHS) to request that the Auditor of State review the status and operational soundness of the hospice program's operation. To do so, we focused our attention on three potential problem areas: identifying systemic weaknesses, inefficiencies, and abuses; ensuring oversight control of client services; and enhancing the program's overall efficiency and effectiveness.

Based on preliminary work, we decided to focus on the following areas.

1. Whether hospice providers billed and received inappropriate reimbursement for (a) deceased recipients, (b) inappropriate combinations of services (e.g., billing for nursing facility room and board simultaneous with Respite Care or General Inpatient Care billing), and (c) dually eligible Medicaid and Medicare recipients.

2. Whether ODHS made duplicate payments to both a nursing facility and hospice for room and board;

3. Whether ODHS has recovered or adjusted any overpayments from hospice providers;

4. Whether any non-terminal patients are being enrolled in the program; and

5. Whether program inspections and surveys are sufficient to ensure an efficient and effective hospice program.

To evaluate these 5 areas, we began by reviewing program rules, regulations, policies, and other agency reports on the hospice program, as well as program growth. We then assessed how the state processes claims; identified system, program, and provider issues affecting hospice payments and services; and determined whether the state proactively uses system controls and processes in preventing and detecting mispayments and fraud. We quantified program weaknesses we identified so as to help ODHS take corrective action. Finally, we determined best-practice standards and program compliance needs with the intent of offering recommendations to ODHS aimed at enhancing the efficiency and effectiveness of the hospice program.

We met with representatives from ODHS, including the Bureau of Community Services and the Bureau of Surveillance/Utilization Review and Medicaid Policy. We held field reviews and on-site meetings with the Executive and Communication Directors of the Ohio Hospice Organization; the Chief Financial Officer, Corporate Compliance Officer, and Director of Hospice of Genesis Health Care Systems, Inc.; and a representative from the Muskingum County Department of Human Services. These meetings yielded a great deal of information and allowed us to properly assess the

status of Ohio's Hospice Program and the adequacy of its process for paying hospice claims.

To meet our systems and processing objectives, we designed computer programs to test potentially vulnerable program areas. Data captured by the Medicaid Management Information System allowed us to both analyze program areas of greatest risk and identify the billing patterns of hospice providers. We also developed specific programs that enabled us to test individual transactions of every Medicaid hospice provider in Ohio; by doing so, we were able to develop data that addressed our specific review objectives. In regards to inspections and the lack of survey work, we reviewed rules and regulations and talked to representatives from the Ohio Department of Health to assess the status of inspections and surveys.

RESULTS

Our data collection and testing showed the following results:

- inappropriate and/or excessive reimbursements to providers,
- non-recovery of overpayments and interest from providers,
- participation of ineligible patients in the program, and
- deficiencies in program oversight, inspections, and surveys.

INAPPROPRIATE REIMBURSEMENTS TO PROVIDERS

ODHS has made reimbursements to providers for deceased Medicaid recipients, inappropriate combinations of services, dually eligible Medicaid and Medicare recipients, and duplicate reimbursements to multiple providers.

Payments for Deceased Recipients

Once a patient is deceased, hospice providers should not, and should not be able to, file claims for services, that have a date of service after the date of death. However, using a computer program that matched official death information from the Bureau of Vital Statistics at the Ohio Department of Health with hospice reimbursements that occurred during the audit period, we identified billings for dates of services after recorded dates of death. In order to evaluate the accuracy and consistency of the date of death recorded by the County Department of Human Services, we compared vital statistics data to county records and with death information recorded in the state's Medicaid Management Information System. We also reviewed and matched System medical records that contained the documented date and time of death.

For instance, some providers apparently did not contact the County Department of Human Services in a timely manner; in other cases, we found that the County Department of Human Services had

entered incorrect data into the Client Registry Information System-Enhanced (or CRIS-E). Testing in this area identified $114,131.84 in payments made to providers during our audit period for services apparently given to recipients after their dates of death.

Non-allowable Combinations of Services

According to the 42 CFR, Section 418.302(e)(2), payment to providers can only be made for one category of allowable hospice care for a hospice recipient for any particular day, as described in Section 418.302(b). In addition, 42 CFR Section 418.302(b)(2) distinguishes categories by ("Levels of Care") such as, Routine Home Care (Level A), Continuous Home Care (Level B), Inpatient Respite Care (Level C), and General Inpatient Care (Level D). 42 CFR further states in Section 418.302 (e): "For each day that a Medicare beneficiary is under the care of a hospice, the hospice is reimbursed an amount applicable to the type and intensity of the services furnished to the beneficiary for that day. For Levels A, C, and D, only one rate is applicable for each day. For Level B, the amount of payment is determined based on the number of hours of continuous care furnished to the beneficiary on that day." Any other billing for combinations of services is considered unallowable. OAC 5101:3-56-06 applies these same rules to Ohio Medicaid services.

Applying the above criteria, we used computerized programs to look for and quantify incorrect billings for inappropriate combinations of services. Our results indicate that $291,307 had been wrongly paid to providers during the period January 1, 1993, to December 31, 1997 for the following inappropriate combinations of services.

- nursing facility room and board (code X0105), which should not be billed with Respite Care (code X0103) or General Inpatient Care (code X0104).
- Respite Care (code X0103), Continuous Care (code X0102), and Routine Home Care (code X0101), which should not be billed with General Inpatient Care.

The $291,307 had not been recovered and remained outstanding as of October 31, 1998.

Our testing also included checks for incorrect billings for ancillary services (laboratory and x-ray services as well as durable medical equipment and other areas), which should all be included in and covered by the predetermined rate for terminal illness services paid to the hospice. The tests did not show significant overpayments. We believe this may be due to a quality assurance effort initiated by ODHS in 1996 that identified and recovered about $1.1 million in overpayments for ancillary services related to the terminal illness.

Dually Eligible Medicaid and Medicare Recipients

According to OAC §5101:3-1-08, providers must pursue third-party payment liability before billing

ODHS. Medicaid recipients who choose hospice care and are dually eligible for both Medicaid and Medicare could receive different benefits under each of the programs. For example, Medicare pays the hospice for the Routine Home Care (code X0101), while Medicaid pays for room and board in a nursing facility. A provider should not bill and be reimbursed by Medicaid for hospice benefits, other than room and board, if the recipient is Medicare-eligible.

We created a computer program to identify all Medicaid hospice recipients who were at least 65 years old and who received hospice services other than room and board during 1997. We then forwarded a list of all 272 Medicaid recipients identified by this program to Medicare officials to have them verify the Medicare eligibility of the recipients and to confirm whether Medicare hospice payments had been made for those recipients. Medicare officials verified that 250 of the recipients listed were Medicare beneficiaries, and that Medicare had paid hospice benefits on behalf of 245 of those recipients. (Medicare was unable to locate a Medicare number for the remaining 22 recipients.) Thus, we confirmed that overpayments had been made to hospice providers for these 245 Medicare-eligible recipients and that these claims should only have been paid by Medicare.

Based on Medicare's information, we identified the amount which should have been paid by Medicare for these 245 recipients, as well as the ratio of the overpayments amount to the total payments made. We then applied this ratio to the population of recipients who were at least 65 years old during the period January 1, 1993, and December 31, 1997, to estimate the total dual-eligibility overpayments that ODHS made. We have estimated this overpayment to be about $1.6 million for hospices services.

While we know that providers incorrectly billed Medicaid for many dually eligible recipients, we could not determine whether our findings are the result of inappropriate billing of Medicaid when providers should have billed Medicare, or whether providers intentionally, and perhaps fraudulently, billed both programs for the same service. We plan to pursue this area further and have contacted the U.S. Department of Health and Human Services**,** Assistant Regional Inspector General for Investigations, to obtain the dates of service billed for Medicare reimbursement that can be compared with the dates of service billed for Medicaid reimbursement. We have also discussed the follow on work with ODHS' Office of Medicaid staff. The results of the follow on work will be reported at a later date.

Duplicate Reimbursements to Providers

When hospice recipients reside in a nursing facility, the nursing facility must notify the County Department of Human Services to discontinue the Medicaid vendor payment to the nursing facility. If the nursing facility does not contact the county with this information, and/or if the county fails to notify ODHS, the nursing facility will continue to receive payments from ODHS for the recipient's room and board even as the hospice bills ODHS for the same room and board.

Our testing revealed that both nursing facilities and hospice providers were being paid for room and board for the same recipient and the same dates of service. Internal control weaknesses created an overpayment of at least $525,297, and perhaps as much as $1.8 million. (Without knowing the exact dates of the recipient's participation in the hospice program for a particular month—as well as other financial factors—we can include here only a conservative estimate of overpayment.) Moreover, the overpayment described here accounts only for duplicate days, while in many instances the nursing facility was paid for an entire month and, in fact, should not have been paid at all.

Some of these overpayments may have been identified through a 1996 quality assurance review conducted by ODHS' Office of Medicaid. Office of Medicaid staff advised us that as a result of their review, $800,000 in overpayments to nursing facilities for individuals receiving hospice services had been found and forwarded for adjustment and recovery. However, as discussed below, these adjustments remained outstanding as of October 1998.

NONRECOVERY OF OVERPAYMENTS AND ADJUSTMENTS FROM PROVIDERS

According to the OAC §5101:3-1-198 ("Payment Errors and Overpayments"), ODHS must recover overpayments, duplicate payments, or payments for services not rendered from providers (excluding payments to long-term care facilities, as provided in OAC Chapter 5101:3-3) as soon as it discovers these errors unless the provider exercises appeal rights under the Ohio Revised Code Chapter 119 and under OAC §5101:3-1-31. By recouping overpayments from providers on a timely basis, ODHS can help the state avoid lost interest it could earn on these funds and avoid a situation where providers have free use of funds that could benefit the citizens of Ohio.

Of the overpayments we identified, 100 percent remained unadjusted as of October 31, 1998. This unadjusted amount has an estimated potential loss of $390,505 (interest earnings) had this money been invested at an annual compounded interest rate of six (6) percent.[2] All recoverable amounts are subject to an interest charge in accordance with OAC §5101:3-1-25. Table 4 shows the lost interest due to these overpayments.

Table 4: Potential Interest Income From Unadjusted Overpayments

[2] We used a 6 percent rate because that is the rate currently used by ODHS' Surveillance and Utilization Section when it recovers interest on Medicaid overpayments made to providers.

Category	1993	1994	1995	1996	1997	Total Overpay-ment	Total Interest Lost
Deceased Recipients	$524	$4,790	$37,371	$18,823	$52,624	$114,132	$14,057
Non Allowable Comb. Of Services	$20,662	$15,689	$84,356	$99,030	$71,570	$291,307	$42,755
Duplicate Reimb.	$12,662	$73,439	$70,789	$170,255	$198,379	$525,524	$70,028
Dual Eligibility	$176,399	$268,917	$289,306	$371,453	$528,815	$1,634,890	$263,665
Total	$210,247	$362,835	$481,822	$659,561	$851,388	$2,565,853	$390,505

Source: ODHS' Medicaid Management Information System Claims History File

INAPPROPRIATE ENROLLMENT AND ELIGIBILITY OF RECIPIENTS

Patients are defined as terminally ill (and therefore eligible for hospice care) when their medical prognosis is a life expectancy of 6 months or less (given that the illness runs its normal course). Several reports from Health and Human Services, Office of the Inspector General (OIG)[3] indicate, however, that hospices may be enrolling patients into the program who are not terminally ill under this definition; others are enrolled before they meet the 6-month prognosis criterion. The OIG further reports that a providers' incentive for early enrollment is to maximize its Medicare or Medicaid reimbursements; accordingly, many diagnoses or medical prognoses have not appeared consistent with a life expectancy of 6 months or less.

We tested the possible incidence of early enrollment by creating a computer edit (program) that identified providers with recipients enrolled in their hospices more than six months. Our results showed that, during the 5-year period from 1993 to 1997, 914 (8.9 percent) of 10,268 Medicaid recipients were in the program longer than 6 months, 451 (4.4 percent) recipients were in the program longer than 9 months, and 248 recipients (2.4 percent) were in the program for periods ranging from a year to more than three years. In all, 77 percent of all Ohio Medicaid Hospice

[3] OIG--REPORT # OEI-05-95-00250 (Hospice Patients in Nursing Homes ,September 1997), and OIG - REPORT # A-05-96-00023 (Enhanced Controls Needed to Assure Validity of Medicare Hospice Enrollments, November 1997)

Providers had recipients in their programs for longer than the 6-month period. Moreover, 25 percent of the patients of two of these providers exceeded the 6-month criterion.

At a minimum, our findings appear to call into question the accuracy of the prognosis for many of these patients. During our review, we found that some of the more questionable diagnoses for these recipients included Alzheimer's Disease, Human Immunodeficiency Virus, heart failure, stroke, and Parkinson's Disease. Although we did not conduct on-site reviews of the providers who had the largest number of individual cases of early enrollment, we plan to forward our analysis to ODHS, including information on the previously mentioned two providers, for follow up action, if warranted.

ODHS has over the last several years, at times, sent educational notices to hospice providers regarding the issue of early enrollment. ODHS' Office of Medicaid staff believe that incidents of early enrollment have decreased as a result of these notices. ODHS stated that it wants to continue studying this issue.

The Ohio Hospice Organization also raised the issue of LATE enrollment. According to them, an increasing number of physicians are waiting too long before enrolling patients in the hospice program, because they are apprehensive about misrepresenting a patient's condition as terminal when a prognosis is not clear-cut, and thus being targeted for submitting a false claim to Medicare or Medicaid.

Late enrollment results in a patient not fully benefitting from the comprehensive nature of a hospice program. Physicians who do not enroll patients in a hospice program in a timely manner preclude the program's ability to give patients the optimum benefits of hospice care. Generally, in these instances, only 4 of the 11 hospice services come into play. These four services are the same services (possibly not given with the same frequency, knowledge, or intensity) given non-hospice patients near the end of life. Although we did not attempt to determine the extent that late enrollment may be occurring, we did note during our inspection of hospice records that some patients were enrolled in hospice programs only a very short time before death.

INADEQUATE INSPECTION AND SURVEY POLICIES AND PRACTICES

Although the Ohio Department of Health is responsible for annually inspecting most Medicaid provider facilities, OAC §3701-19-04 (B) does not require that the Department of Health conduct annual inspections of hospices. Further, ODHS has an Interagency Agreement (A-99-07-135, dated September 15, 1998) that delegates certain responsibilities to the Department of Health, including inspections of Long-term Care Facilities, but this agreement does not mention the word "hospice" in any of its language.

OAC §5101:3-56-04 contains the only actual program oversight requirements for hospices, stating

that "ODHS shall operate a quality assurance program to monitor compliance with the requirements of this chapter." However, this section does not state the frequency or type of monitoring that should be conducted by the ODHS. ODHS' Bureau of Community Services advised us that it conducted its last quality assurance review of hospices about 3 years ago. Since then, the only reviews conducted have been desk reviews performed by ODHS' Bureau of Surveillance/Utilization Review.

The Ohio Hospice Organization voiced concerns about the lack of program oversight when it indicated that its provider members had been requesting annual inspections in order to assess program compliance and quality of care. The Organization stated that without these inspections, its members cannot gage whether they are correctly following the regulations established by the Ohio Revised Code Chapter 3712 and industry "Standards of Care". Moreover, the Organization voiced a concern that in the absence of more frequent visits, inspection teams were not adequately trained in hospice rules and regulations. It volunteered to work with all interested parties to discuss training and educational opportunities.

CONCLUSIONS AND RECOMMENDATIONS

The overall responsibility of the hospice program and the management of Ohio's Medicaid program lies with ODHS. Without clear and explicit instructions from ODHS on how hospice programs should be run, and frequent and effective oversight of specific programs, we can only expect the overpayments and abuses of the Ohio program to deteriorate further over time, resulting in the loss of millions of dollars and the provision of poor care to those who most need it.

We make the following recommendations to ODHS to address the current hospice program problems we have identified in this report, and to help ODHS better prepare for future program growth. Implementing these recommendations should help eliminate program overpayments and improve the quality of Ohio hospice services. We recommend that ODHS:

- Recover the overpayments identified in this report. (AOS staff will provide details of the overpayments under separate cover.)

- Create computer edits to (a) periodically match Medicaid Management Information System paid claims data with official death records from the state's Department of Health, (b) deny payments on claims resulting from non-allowable combinations of services, (c) minimize duplicate payments for hospice recipients residing in a nursing facility, and (d) deny claims that should be paid by Medicare when the hospice recipient is dually eligible for Medicaid and Medicare.

- Revise OAC §5101:3-56-031(B) to impose a time frame by which each hospice provider must notify its County Department of Human Services of changes in a client's address or status.

ODHS should also establish requirements for when county departments must enter the changes into the state computer data base.

- Propose a change to the Ohio Revised Code and enact new rules in the OAC as to the duties, responsibilities, and frequency of hospice inspections, surveys, and quality assurance monitoring, as well as specifying the roles of the appropriate state agencies, establishing any and all necessary procedures, and, if needed, training for agency personnel who would conduct inspections and surveys and monitor quality assurance.

ODHS' RESPONSE

To provide an opportunity for review and comment, a draft of this report was sent to the Director of ODHS on April 16, 1999. ODHS' responded on April 30 that a 1996 review conducted by a Quality Assurance Team had revealed areas of concern with the fast growing hospice program and that the Department had begun the process of implementing changes, including some of the suggestions mentioned in the draft report.

In response to one of our recommendations, ODHS stated that it is not possible to recover the overpayments identified in the report if ODHS had already reviewed the providers and closed the time period in question. While we understand it is ODHS' customary practice not to re-open closed audits, we believe it is important that all overpayments are recouped in any instance where a settlement has not covered the type of overpayment identified. Therefore, we disagree with ODHS' position.

ODHS commented that the issue of early enrollment is a difficult one given that life expectancy is not an exact science. The Department added that it are considering ways to assess the prevalence of early enrollment. Our methodology for assessing early enrollment and our results are available to the Department as it plans its review.

ODHS indicated that our overpayment calculations for dually eligible consumers may not have considered that a consumer may enroll in the Medicaid hospice program before he obtains Medicare eligibility. Our calculations took into consideration the date of eligibility and only identified overpayments occurring after the consumer met Medicare eligibility.

Regarding the issue of duplicate payments made to Nursing Facilities for room and board, ODHS commented that the report makes an unclear distinction between days and months. We made this distinction to arrive at a conservative overpayment estimate. For example, if a NF was paid the full month, and the Hospice was paid only a partial month, the calculation was made only on the number of Hospice days billed. A full month's overpayment might occur, however, if a hospice patient died in mid month and the nursing facility was reimbursed for an entire month.

See page 16 for ODHS' detailed response.

Bob Taft
Governor

Jacqueline Romer-Sensky
Director

Ohio Department of Human Services
30 East Broad Street, Columbus, Ohio 43266-0423

April 30, 1999

Jim Petro, Auditor of State
State of Ohio, Office of the Auditor
88 East Broad Street
P.O. Box 1140
Columbus, Ohio 43216-1140

Dear Auditor Petro:

Thank you for the opportunity to respond to your draft report entitled "Opportunities to Reduce Overpayments to Ohio Medicaid Hospices". Hospice is a relatively new program in Ohio. Although the Department of Human Services (ODHS) began implementation in 1990, enrollment in the program didn't take off until 1993. As the program matured and utilization of services increased, the Department, through a Quality Assurance Team, conducted a study of the program in 1996. The goal of the study was to perform quality assurance and rule compliance reviews of selected hospice agencies, to enforce remedies when necessary, and to recommend program or rule changes.

Our review revealed areas of concern and potential improvement, which were shared with staff from the Office of the Auditor, Fraud, Waste, and Abuse Prevention Division. This is not unusual given the complexities of the Medicaid program. We have begun the process of implementing findings from our quality review as well as some of the suggestions mentioned in the Auditor of State's report. Unfortunately, because of staff constraints and limited information system capacity due to the Y2K problem, we have not been able to implement these changes as quickly as we would like.

Attached are additional comments and suggested revisions identified by the Office of Medicaid staff. The comments/suggested revisions relate to the four broad issues in the report: 1) whether providers billed and received inappropriate reimbursement for deceased Medicaid recipients; 2) whether ODHS adjusted and recovered overpayments from hospice providers; 3) whether non-terminal patients were enrolled or enrolled too early in the hospice program; and 4) whether program inspections and surveys are sufficient to ensure an efficient and effective hospice program.

If you have questions or need additional information, please contact Barbara Edwards, Deputy Director, Office of Medicaid at 466-4443.

Sincerely,

Jacqueline Romer-Sensky/dw

Jacqueline Romer-Sensky, Director
Department of Human Services

C: Barbara Edwards, ODHS
John Butts, Auditor of State, FWAP Division

Attachment

Comments on the Opportunities to Reduce Overpayments to Ohio Medicaid Hospices
Ohio Department of Human Services, Office of Medicaid
April 30, 1999

- On page ii and on page 13, the report recommends that overpayments are collected from Medicaid hospice providers as identified by the Auditor of State. Recoupment is not possible to the extent that the Ohio Department of Human Services has reviewed these providers and closed periods.

- On page ii, the report addresses the 1996 Quality Assurance Project and the ongoing SUR desk reviews as a single project. These are separate initiatives that have focused, respectively on the quality of services and the appropriate reimbursement of hospice providers.

- On page ii and page 11, the report addresses early enrollment. This is a difficult issue given that predicting life expectancy is not an exact science. It is important to note that only an MD or a DO can certify that a consumer has less than six months to live. We are discussing ways to assess the prevalence of early enrollment including a review of the average length of enrollment.

- On page iii, the report recommends that survey, inspection and quality assurance processes be implemented. Medicaid is supportive of efforts to ensure quality of care for our consumers. However, resources for such initiatives are limited.

- On page 1, the report suggests that an increase in the elderly population will drive hospice enrollment. This connection is unclear since hospice is intended for all individuals in the last stages of terminal illness, regardless of age.

- On page 5, the report addresses the reimbursement of room and board for consumers receiving hospice services while residing in a NF. The second bullet could be deleted. The third bullet applies whether or not the hospice and NF are related.

- On page 5, the report addresses the inconsistencies in enrollment periods between the Medicare and Medicaid hospice programs. The Office of Medicaid is currently working toward rule revisions which will establish Medicaid enrollment periods which are consistent with Medicare enrollment periods.

- On page 8, the program calculates overpayments made on behalf of dually eligible consumers. However, we cannot assume that payments for hospice services by Medicaid and Medicare within the same 12 month period results in an overpayment. For example, a consumer may enroll in the Medicaid hospice program before he obtains Medicare eligibility.

- On page 9, the report addresses duplicate payments for room and board to NFs and hospice providers. This discussion seems to differentiate between duplicate days and duplicate months. The nature and reason for this distinction is unclear. In addition, the Office of Medicaid is working with MMIS and CRIS-E to reduce the number of payments to NFs when a NF vendor payment span ends.

- On page 10, the report calculates interest lost as a result of the overpayment. However, the interest may be overstated because the overpayments are calculated using a number of critical assumptions.

- On page 12, the report raises the issue of late enrollment and suggests that physicians are reluctant to enroll consumers in hospice in a timely fashion. However, hospice is a voluntary program, and it is impossible to define the reasons for late enrollment from the data available. Consumers may not choose to enroll in hospice until shortly before death.

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OHIO MEDICAID HOSPICE
STATEWIDE

CLERK'S CERTIFICATION

This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

By: Susan Babbitt
Clerk of the Bureau

Date: MAY 20 1999