



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



October 25, 2021

TO: Daniel Tsai
Deputy Administrator and Director
Centers for Medicaid and CHIP Services

FROM: Amy J. Frontz /s/
Deputy Inspector General for Audit Services

SUBJECT: Office of Inspector General's Partnership With the Commonwealth of
Massachusetts Office of the State Auditor: Office of Medicaid (MassHealth)
Payments for Hospice-Related Services for Dual-Eligible Members
(A-01-20-00001)

This memorandum transmits the findings of the Commonwealth of Massachusetts Office of the State Auditor (State Auditor) audit report entitled, *Office of Medicaid (MassHealth) Payments for Hospice-Related Services for Dual-Eligible Members* (the State Auditor Report 2020-1374-3M1), issued July 20, 2021. The State Auditor conducts audits, investigations, and studies to promote accountability and transparency, improve performance, and make Government work better. It receives an annual appropriation for the operation of a Medicaid Audit Unit to help prevent and identify fraud, waste, and abuse in the Commonwealth's Medicaid program. This audit was conducted as part of the State Auditor's independent oversight of the State's Medicaid program.

The objective of the State Auditor's audit was to determine whether MassHealth administered payments to non-hospice providers for hospice-related services provided to dual-eligible members (individuals enrolled in Medicaid and Medicare) for the period January 1, 2015, through July 31, 2019, in compliance with State regulations.

As part of the Office of Inspector General's (OIG's) efforts to partner with State auditors and expand oversight coverage of the Medicaid program, OIG assisted the State Auditor with its audit by:

- matching Medicare hospice claims from the Centers for Medicare & Medicaid Services' (CMS's) National Claims History and Medicaid claims from the Transformed Medicaid Statistical Information System to identify all Medicaid

services provided to Medicare hospice beneficiaries and providing the resulting Medicaid matches to the State Auditor;

- assessing the reliability of select Medicare hospice claims data;
- attending key meetings with the State Auditor auditors; and
- monitoring the progress of the State Auditor's audit.

To accomplish its audit objective, the State Auditor analyzed the results of OIG's data match and reviewed four stratified random samples of 100 Medicaid claims (400 claims in total) for services provided to dual-eligible members during a period in which they were receiving Medicare hospice care.

The State Auditor found that for 223 (56 percent) of the 400 sampled claims, MassHealth did not ensure it had accurate information in its Medicaid Management Information System (MMIS) about dual-eligible members who chose to receive hospice services. For the 223 sampled claims, either MassHealth did not receive the member's MassHealth Hospice Election Form (Election Form), or MassHealth received the Election Form but did not update MMIS to show that the member elected the hospice benefit.

Based on its analysis, the State Auditor identified approximately \$56.6 million in claim payments at-risk of being improper. Of this amount, the State Auditor identified the following categories of at-risk payments:

- approximately \$45 million in claims for professional services, such as home health aide services, homemaker services, and companion care that were not coordinated by the members' hospice providers;
- approximately \$66,000 in claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) that were unnecessary because the DMEPOS were included in the members' plans of care and, therefore, should have been paid for by their hospice providers;
- approximately \$724,000 for DMEPOS that should have been, but were not, included in the members' plans of care and paid for by their hospice providers; and
- as much as \$203,000 that hospice providers may have been responsible for in ambulance and inpatient services for dual-eligible members.

The State Auditor concluded that the following factors contributed to the potential improper payments it identified:

- MassHealth did not have an effective monitoring process to ensure that hospice providers submit an Election Form;

- many hospice providers were unaware that they were required to send MassHealth an Election Form for all dual-eligible members when it was received;
- MassHealth did not ensure that its hospice providers explained to the members and their families that they are required to inform any non-hospice providers of the hospice election;
- hospice providers did not coordinate services with non-hospice providers to ensure proper service coordination and billing;
- MMIS did not have system edits in place to ensure claims that should have been billed directly to hospice providers were properly denied; and
- hospice providers had no knowledge that the services had been provided to some members.

The State Auditor recommended that MassHealth should:

- establish an effective monitoring process to ensure that hospice providers send an Election Form for every dual-eligible member who chooses to receive hospice services;
- consider collaborating with CMS to obtain CMS's hospice election information about dual-eligible members and determine whether all MassHealth hospice providers have submitted the required Election Forms;
- review MMIS for all members who have elected the hospice benefit to ensure that their Election Forms are accurately reflected in MMIS;
- ensure that its hospice providers coordinate professional services with non-hospice providers for dual-eligible members to ensure proper service coordination and billing;
- update its system edits in MMIS to detect and deny claims for dual-eligible members in hospice care that might be duplicative of services that should be paid for by hospice providers;
- ensure the information in MMIS about hospice election by dual-eligible members is accurate;
- ensure that its hospice providers explain to its members and their families that the members and families are required to inform any non-hospice providers that the members have elected the hospice benefit to ensure service coordination and billing; and
- ensure that the system edits in MMIS for claims for hospice services for dual-eligible members are effective in detecting and denying/ rejecting improper claims.

In its comments on the State Auditor's report, MassHealth generally agreed with the State Auditor's recommendations. MassHealth issued a Hospice Bulletin in October 2020 in response to an issue raised during this audit. This bulletin reminded hospice providers that they were required to submit both a MassHealth Election Form and a Medicare Hospice Election Form at certain times.

In addition, MassHealth indicated that it was developing additional measures to ensure it receives MassHealth Hospice Election Forms from hospice providers and plans to continue to provide education to MassHealth enrolled hospice providers on their obligation to coordinate the delivery of hospice services with other non-hospice services. MassHealth also indicated that it was implementing processes to identify dual-eligible members receiving Medicare coverage who have not executed an Election Form.

MassHealth agreed in part that the audited Medicare hospice providers failed to require the dual-eligible member to complete an Election Form in some cases. However, MassHealth disagreed with the State Auditor's findings of any "improper payments" and explained why it believes it would have paid the claims.

The State Auditor is responsible for the attached audit report and the conclusions expressed therein. We are not expressing an opinion on the report or its results; however, we encourage CMS to consider this report and its results, and to work with our State partners to: (1) ensure the Federal share of the improper Medicaid payments identified are refunded to the Federal Government and (2) prevent such payments from occurring in the future. Although we are not expressing an opinion, we did evaluate the independence, objectivity, and qualifications of State Auditor auditors. Our assessment disclosed no instances in which the State Auditor did not comply with generally accepted government auditing standards.

This report will be posted at <https://oig.hhs.gov>.

If you have any questions or comments about this memo, please do not hesitate to contact John Hagg, Assistant Inspector General for Audit Services, at John.Hagg@oig.hhs.gov. Please refer to report number A-01-20-00001 in all correspondence.

Attachment

cc:

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Deputy Director
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Karen Shields
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Commonwealth of Massachusetts
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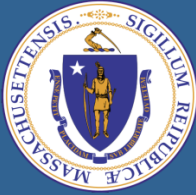
Making government work better

Official Audit Report – Issued July 20, 2021

Office of Medicaid (MassHealth)—Payments for Hospice-Related Services for Dual-Eligible Members

For the period January 1, 2015 through July 31, 2019





Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump

Making government work better

July 20, 2021

Ms. Marylou Sudders, Secretary
Executive Office of Health and Human Services
1 Ashburton Place, 11th Floor
Boston, MA 02108

Dear Ms. Sudders:

I am pleased to provide this performance audit of MassHealth's payments for hospice-related services for dual-eligible members. This report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, January 1, 2015 through July 31, 2019. My audit staff discussed the contents of this report with MassHealth management, whose comments are reflected in this report.

I would also like to express my appreciation for the cooperation and assistance provided to my staff during the audit.

Sincerely,

A handwritten signature in blue ink, appearing to read "SMB", written over a light blue circular background.

Suzanne M. Bump
Auditor of the Commonwealth

cc: David Lamir, Regional Inspector General, Office of Inspector General, United States Department of Health and Human Services
Richard Miller, Assistant Regional Inspector General, Office of Inspector General, United States Department of Health and Human Services
Stephen Conway, Director, Office of Inspector General, United States Department of Health and Human Services
Amanda Cassel Kraft, Director, Office of Medicaid
Alda Rego, Assistant Secretary for Administration and Finance, Executive Office of Health and Human Services
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LIST OF ABBREVIATIONS

CFR	Code of Federal Regulations
CMR	Code of Massachusetts Regulations
CMS	Centers for Medicare & Medicaid Services
CTI	Certification of Terminal Illness
DME	durable medical equipment
EOHHS	Executive Office of Health and Human Services
HCBS	home- and community-based services
HHS	United States Department of Health and Human Services
IDG	interdisciplinary group
MMIS	Medicaid Management Information System
OCA	Office of Clinical Affairs
OIG	Office of Inspector General
OSA	Office of the State Auditor
TMSIS	Transformed Medicaid Statistical Information System
TPL	third-party liability
USC	United States Code

EXECUTIVE SUMMARY

The Office of the State Auditor (OSA) receives an annual appropriation for the operation of a Medicaid Audit Unit to help prevent and identify fraud, waste, and abuse in the Commonwealth's Medicaid program. This program, known as MassHealth, is administered under Chapter 118E of the Massachusetts General Laws by the Executive Office of Health and Human Services, through the Division of Medical Assistance. Medicaid is a joint federal-state program created by Congress in 1965 as Title XIX of the Social Security Act. At the federal level, the Centers for Medicare & Medicaid Services (CMS), within the United States Department of Health and Human Services (HHS), regulate Medicaid services and work with state governments to administer their Medicaid programs. Additionally, CMS administers the Medicare program, which is a federally funded health insurance program for individuals over the age of 65, individuals under the age of 65 with certain disabilities, and people of all ages with end-stage renal (kidney) disease.

In collaboration with the HHS Office of Inspector General's Boston office, OSA has conducted an audit of claims paid by MassHealth for dual-eligible members (members who are enrolled in both the federal Medicare program and the state's Medicaid program) who were receiving hospice care for the period January 1, 2015 through July 31, 2019. During this period, MassHealth paid \$620,584,171 in claims for hospice-related services to non-hospice providers¹ for dual-eligible members. The purpose of this audit was to determine whether MassHealth effectively administered payments for hospice-related services in accordance with applicable state and federal requirements, including ensuring that Medicaid was the payer of last resort (i.e., that it only paid for covered services if no other payer existed) for hospice services. The audit was conducted as part of OSA's ongoing independent statutory oversight of the state's Medicaid program.

Below is a summary of our findings and recommendations, with links to each page listed.

1. Non-hospice providers deliver medical or other services to members who have chosen to receive hospice care. They can enter into contracts with hospice providers to render these services.

Finding 1 Page 14	MassHealth did not ensure that it had accurate information in its Medicaid Management Information System (MMIS) about dual-eligible members who chose to receive hospice services.
Recommendations Page 15	<ol style="list-style-type: none">1. MassHealth should establish an effective monitoring process to ensure that hospice providers send it a MassHealth Hospice Election Form for every dual-eligible member who chooses to receive hospice services.2. MassHealth should consider collaborating with CMS to obtain CMS's hospice election information about dual-eligible members and determine whether all MassHealth's hospice providers have submitted the required MassHealth Hospice Election Forms.3. MassHealth should review MMIS for all members who have elected the hospice benefit to ensure that their MassHealth Hospice Election Forms are accurately reflected in MMIS.
Finding 2 Page 21	MassHealth paid for professional services that were not coordinated by hospice providers.
Recommendations Page 23	<ol style="list-style-type: none">1. MassHealth should ensure that its hospice providers coordinate professional services with non-hospice providers for dual-eligible members to ensure proper service coordination and billing.2. MassHealth should update its system edits in MMIS to detect and deny claims for dual-eligible members in hospice care that might be duplicative of services that should be paid for by hospice providers.
Finding 3a Page 29	MassHealth paid for durable medical equipment (DME) that was included in members' plans of care.
Finding 3b Page 30	MassHealth paid for DME that should have been included in members' plans of care.
Recommendations Page 32	<ol style="list-style-type: none">1. MassHealth should ensure that information in MMIS about hospice election by dual-eligible members is accurate.2. MassHealth should ensure that the system edits in MMIS for claims for hospice services for dual-eligible members are effective in detecting and rejecting improper claims.
Finding 4 Page 34	MassHealth unnecessarily paid for ambulance and inpatient services for dual-eligible members.
Recommendations Page 36	<ol style="list-style-type: none">1. MassHealth should ensure that its hospice providers explain to its members and their families that the members and families are required to inform any non-hospice providers that the members have elected the hospice benefit to ensure service coordination and billing.2. MassHealth should ensure that the system edits in MMIS for claims for hospice services for dual-eligible members are effective in detecting and denying improper claims.

Post-Audit Action

In response to the issue raised in [Finding 1](#), in October 2020 MassHealth issued Hospice Bulletin 15. This bulletin reminded hospice providers that they were required to submit both a MassHealth Hospice Election Form and a Medicare Hospice Election Form at certain times. Specifically, according to Section 437.412 of Title 130 of the Code of Massachusetts Regulations, the forms must be submitted when a dual-eligible member chooses to receive hospice services (referred to in the regulation and this report as “electing the hospice benefit”) or chooses to end them (referred to as “revoking the hospice benefit”).

OVERVIEW OF AUDITED ENTITY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services, through the Division of Medical Assistance, administers the state's Medicaid program, known as MassHealth. MassHealth provides access to healthcare services for approximately 1.8 million eligible low- and moderate-income children, families, seniors, and people with disabilities annually. In fiscal year 2019, MassHealth paid healthcare providers more than \$16 billion, of which approximately 50% was funded by the Commonwealth. Medicaid expenditures represent approximately 39% of the Commonwealth's total annual budget. According to the Centers for Medicare & Medicaid Services (CMS), the fiscal year 2020 national Medicaid improper payment rate estimate is 21%, representing over \$86 billion in improper payments.

MassHealth is responsible for paying for all medically necessary services that are provided to dual-eligible members in hospice and are not paid for by Medicare. Medicare is the primary payer for hospice services, paying for all goods and services related to a member's terminal illness; MassHealth pays for any goods and services provided to a member that are not related to the member's terminal illness as determined by the member's hospice provider. For example, MassHealth would pay for a visit to a dentist or eye doctor for a member with a terminal illness related to congestive heart failure, as neither visit is related to the terminal illness. During the audit period, January 1, 2015 through July 31, 2019, MassHealth paid claims totaling more than \$620 million² for hospice-related services provided to 38,568 dual-eligible members, as detailed below.

Total Payments Made to Non-Hospice Providers

Calendar Year	Total Payments	Members Served
2015	\$ 119,637,456	15,357
2016	138,667,368	16,383
2017	159,053,107	17,691
2018	174,539,941	17,822
2019*	28,686,299	6,370
Total	<u>\$ 620,584,171</u>	<u>38,568†</u>

2. This amount includes payments made by MassHealth directly to non-hospice providers, as well as payments made by MassHealth's contracted managed care organizations. However, for our audit, we only tested payments made by MassHealth directly to non-hospice providers.

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- * This row includes claims submitted from January 1, 2019 through July 31, 2019 that have been paid. Because of the timing of payments, it does not include claims submitted during that period that have not been paid.
 - † This number represents the unduplicated member count over the entire audit period.

Hospice Program Enrollment, Services, and Payments

A hospice program is a coordinated program of both home and inpatient palliative care designed to help manage pain and provide comfort to individuals who have terminal illnesses. According to Section 437.402 of Title 130 of the Code of Massachusetts Regulations (CMR), an individual is considered to have a terminal illness if s/he has “a medical prognosis of a life expectancy of six months or less if the illness runs its normal course.” The goods and services offered through hospice programs include healthcare by physicians and nurses, counseling, durable medical equipment (DME), home health aide services, and physical and occupational therapy. Hospice programs do not offer curative care (treatment intended to improve patient health to its condition before the terminal illness) or treatment for any injury or complication unrelated to a member’s terminal illness. Hospice services can be provided through outpatient palliative care clinics, at home, in nursing homes, in assisted-living facilities, or in group homes.

To enroll a MassHealth member in a hospice program, a hospice provider is required to complete a Certification of Terminal Illness (CTI) form for the member. The CTI must be signed by the member’s attending physician and the hospice provider’s medical director or another hospice physician. The signers certify that the member has a terminal illness and a life expectancy of six months or less. The CTI also includes a narrative that describes the member’s terminal illness and an attestation statement from both the member’s attending physician and hospice medical personnel that they composed the narrative based on a review of the member’s medical record or, if applicable, a physical examination of the member. After a member chooses to receive hospice services, hospice medical staff members must periodically recertify that a member receiving hospice still has a terminal illness and therefore is eligible to remain in the program. These recertification periods occur after 90 days, after 180 days, and every 60 days thereafter.

For dual-eligible members, in addition to the CTI, the hospice provider must also complete both a Medicare Hospice Election Form and a MassHealth Hospice Election Form for the member. The Medicare Hospice Election Form must be submitted to CMS, and the MassHealth Hospice Election Form must be submitted to MassHealth. These forms notify CMS and MassHealth that the member is

choosing to receive hospice services. By making this choice, the member waives his/her rights to MassHealth paying for any services related to his/her terminal illness, because such services are now covered by the member's hospice provider, according to 130 CMR 437.412(B).

Once MassHealth receives a member's MassHealth Hospice Election Form, it updates the member's record in its Medicaid Management Information System³ with the code HSPC, which indicates that the member has now elected the hospice benefit. This code subjects all claims submitted on the member's behalf to system edits intended to ensure that MassHealth is the payer of last resort and does not pay for any goods or services that should be paid for by Medicare directly or by the hospice provider. MassHealth may still pay for services that are provided to a member and are not related to his/her terminal illness as determined by the hospice provider. For example, if a member lives in a nursing facility, MassHealth pays 95% of the monthly rate to the hospice provider for room and board. The hospice provider then pays the full 100% of the monthly rate to the nursing facility. Hospice providers must also complete hospice election forms if the member wishes to modify or revoke his/her hospice benefit.

According to *Federal Register* 48, No. 243 (1983),⁴ hospice care is a covered service through Medicare Part A medical insurance coverage (one of the four parts of the federal Medicare Program), also referred to as "hospital insurance." Authorized through Title XVIII of the Social Security Act, Medicare Part A covers hospice and additional services such as inpatient hospital care, skilled nursing facility care, and home healthcare. Additionally, in *Federal Register* 83, No. 89 (2018), CMS states,

Hospice services are comprehensive and we have reiterated since 1983 that "virtually all" care needed by the terminally ill individual would be provided by hospice. We believe that it would be unusual and exceptional to see services provided outside of hospice for those individuals who are approaching the end of life.

Medicare pays hospice providers a per diem rate for days when a dual-eligible member is enrolled in hospice. As noted above, this rate is intended to cover all the costs the hospice provider has determined that the member needs in relation to his/her terminal illness as documented in the member's plan of care.⁵ The per diem rates that Medicare pays to hospice providers are based on four different levels of

3. This is the information technology system MassHealth uses to process claims and other member information.

4. The *Federal Register* is a daily journal by the federal government that contains current and proposed rules for federal agencies and organizations, as well as presidential proclamations and executive orders.

5. A plan of care is a written plan that details the specific medical, psychological, spiritual, and emotional needs of a member who is receiving hospice care. (See the "[Hospice Plans of Care and Service Coordination](#)" section of this report.)

care: routine home care, continuous home care, inpatient respite care, and general inpatient care. A member's level of care is determined by the location and frequency of the services provided under the hospice benefit. Routine home care is the most common level.

For routine home care, there are two per diem rates based on the amount of time the member receives hospice services; the rate for the first 60 days is higher. As of federal fiscal year 2021, the daily rates are \$199.25 for the first 60 days and \$157.49 beginning on day 61. In addition, for registered nurse and social worker visits in the last seven days of a member's life, Medicare makes supplemental payments in addition to paying the daily rate. For continuous home care,⁶ the payment is an hourly rate (\$59.68 as of federal fiscal year 2021).

When a member spends less than five days at an inpatient facility, Medicare pays the facility the per diem rate for general inpatient care, which is \$1,045.66 as of federal fiscal year 2021. Medicare pays inpatient hospice facilities the per diem rate for inpatient respite care, which is \$461.09 as of federal fiscal year 2021, when a member has spent at least five days at the facility.

Per diem rates are geographically adjusted based on member location and are annually updated by CMS in accordance with Sections 1814(i)(1)(C)(ii)(VII) and 1814(i)(2)(D) of the Social Security Act.

A hospice provider may discharge a patient for the following reasons:

- The patient decides to seek curative care.
- The patient moves out of the service area.
- The patient no longer meets hospice criteria because his/her health has improved.
- The patient passes away.

After the discharge, the hospice provider must file a Notice of Termination with Medicare within five calendar days, according to Section 20.2.1.3 of CMS's *Medicare Benefit Policy Manual*.

MassHealth's Office of Clinical Affairs (OCA) reviews complaints it receives about hospice providers. When OCA receives a complaint, it reviews the provider's claims and may audit the provider.

6. Continuous care is nursing care that is provided to a hospice member. Unlike routine care, which does not have a required number of hours, it must be provided for at least 8 hours in any given 24-hour period.

Hospice Plans of Care and Service Coordination

Hospice providers serving dual-eligible members are required by Section 418.200 of Title IV(B)(F) of the Code of Federal Regulations (CFR) to develop a comprehensive plan of care for each member in hospice. According to this regulation, hospice providers cannot bill Medicare for hospice services until a plan of care has been developed. The services included in a member's plan of care are targeted to enhance the quality of the member's life while minimizing his/her pain or suffering as much as possible. Plans of care are created by a hospice's interdisciplinary group (IDG), which typically includes the hospice's medical director or another hospice physician, a registered nurse, a social worker, and a pastor or counselor. According to 130 CMR 437.422(C), the IDG must review each plan of care and modify it as needed, based on the member's current needs, or at least every 15 days.

According to 42 CFR 418.56, the IDG also has other responsibilities. For example, hospice providers serving dual-eligible members must ensure that their IDGs direct, coordinate, and supervise all the goods and services (e.g., DME or ambulance rides) provided to these members:

- d. Standard: Review of the plan of care. The hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) must review, revise and document the individualized plan [of care] as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care.*
- e. Standard: Coordination of services. The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to—*
 - 1. Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided.*
 - 2. Ensure that the care and services are provided in accordance with the plan of care.*
 - 3. Ensure that the care and services provided are based on all assessments of the patient and family needs.*
 - 4. Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.*
 - 5. Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.*

AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor (OSA) has conducted a performance audit of MassHealth's administration of claims for hospice-related services provided to dual-eligible members for the period January 1, 2015 through July 31, 2019.

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.

Below is our audit objective, indicating the question we intended our audit to answer, the conclusion we reached regarding the objective, and where the objective is discussed in this report.

Objective	Conclusion
1. Does MassHealth administer payments to non-hospice providers for hospice-related services in compliance with Section 450.316 of Title 130 of the Code of Massachusetts Regulations?	No; see Findings <u>1</u> , <u>2</u> , <u>3a</u> , <u>3b</u> , and <u>4</u>

Methodology

To achieve our audit objective, we gained an understanding of the internal control environment related to the objective by reviewing applicable MassHealth and federal regulations and other authoritative guidance, as well as conducting inquiries with MassHealth officials and management at 59 hospice providers. To obtain sufficient, appropriate audit evidence to address our audit objective, we conducted further audit testing as follows.

Hospice Sampling Strategy

Staff members at the United States Department of Health and Human Services' Office of Inspector General (HHS OIG) gave us a data file of all claims paid by MassHealth for dual-eligible members who received hospice services between January 1, 2015 and July 31, 2019. We then worked with HHS OIG staff members to review the information in this data file and, using a risk-based approach, determined which Medicaid claim types should be tested. This risk-based approach included selecting claim types that had the highest dollar amounts and were typically paid by Medicare instead of MassHealth. We also

excluded any professional or inpatient claims that were less than \$500 and durable medical equipment (DME) or transportation claims that were less than \$50. The claim types selected included ones that were submitted to MassHealth by non-hospice providers and included professional services, inpatient services, DME, and transportation. Professional claims include such things as home health aide services, homemaker services,⁷ and companion care. Inpatient claims relate to hospital stays. DME includes medical equipment such as wheelchairs, incontinence products, and wound dressings. Transportation claims are incurred when a MassHealth member is transported to a hospital by an ambulance. The table below details the total population of the four claim types, as well as the total amounts paid for these claims during our audit period.

Total Population of Claims

Claim Type	Total Claims	Total Amount Paid
Professional	14,755	\$ 63,771,564
Inpatient	298	433,293
DME	6,015	793,391
Transportation	2,421	287,354
Total	<u>23,489</u>	<u>\$ 65,285,602</u>

OSA collaborated with HHS OIG to design the sampling method to select the statistical samples for each of the four claim types. HHS OIG and OSA selected four statistical random samples, totaling 400 of 23,489 paid claims for services provided to dual-eligible members during the audit period.

- HHS OIG and OSA selected a stratified random sample of 100 claims from the population of 14,755 professional claims. HHS OIG and OSA used an expected error rate of 50%, a desired precision of 18%, and a confidence level of 90%. The population was separated into four strata, based on the dollar value of the individual claims. HHS OIG and OSA randomly selected 25 claims from each stratum, for a total of 100 sampled claims.
- HHS OIG and OSA selected a stratified random sample of 100 claims from the population of 298 inpatient claims. HHS OIG and OSA used an expected error rate of 50%, a desired precision of 12%, and a confidence level of 90%. The population was separated into two strata, based on the dollar value of the individual claims. HHS OIG and OSA randomly selected 90 claims from the first stratum and 10 claims from the second, for a total of 100 sampled claims.

7. Homemaker services consist of help preparing meals, shopping for groceries, picking up medications, and performing housekeeping duties.

- HHS OIG and OSA selected a stratified random sample of 100 claims from the population of 6,015 DME. HHS OIG and OSA used an expected error rate of 50%, a desired precision of 20%, and a confidence level of 90%. The population was separated into three strata, based on the dollar value of the individual claims. HHS OIG and OSA randomly selected 34 claims from the first stratum and 33 claims each from the second and third, for a total of 100 sampled claims.
- HHS OIG and OSA selected a stratified random sample of 100 claims from the population of 2,421 transportation claims. HHS OIG and OSA used an expected error rate of 50%, a desired precision of 16%, and a confidence level of 90%. The population was separated into three strata, based on the dollar value of the individual claims. HHS OIG and OSA randomly selected 34 claims from the first stratum and 33 claims each from the second and third, for a total of 100 sampled claims.
- For this audit, HHS OIG and OSA designed our samples so that we would be 90% confident that the actual error rate in the population would be within a specific range of the error rate in our samples. For each claim type, the population was separated into two, three, or four strata based on the dollar value of the individual claims. The table below details each sampling stratum.

Sampling Strata

Claim Type	Stratum	Sample Size	Population Claim Count	Claim Total	Dollar Range of Claims in Stratum*
Professional	1	25	9,395	\$ 10,855,610	\$500–\$3,056.20
Professional	2	25	2,504	14,267,759	\$3,065.46–\$10,086.49
Professional	3	25	1,802	19,854,002	\$10,089.40–\$13,615.20
Professional	4	25	1,054	18,794,193	\$13,632.30–\$55,530.00
Total		<u>100</u>	<u>14,755</u>	<u>\$ 63,771,564</u>	
Inpatient	1	90	288	\$ 355,296	\$503.70–\$1,974.00
Inpatient	2	10	10	77,997	\$2,680–\$22,176.65
Total		<u>100</u>	<u>298</u>	<u>\$ 433,293</u>	
DME	1	34	3,746	\$ 315,945	\$50.00–\$133.00
DME	2	33	2,043	352,760	\$133.20–\$273.60
DME	3	33	226	124,686	\$274.20–\$4,964.28
Total		<u>100</u>	<u>6,015</u>	<u>\$ 793,391</u>	
Transportation	1	34	1,562	\$ 100,172	\$50.14–\$96.40
Transportation	2	33	567	88,925	\$97.36–\$245.58
Transportation	3	33	292	98,257	\$250.22–600.06
Total		<u>100</u>	<u>2,421</u>	<u>\$ 287,354</u>	
Grand Total		<u>400</u>	<u>23,489</u>	<u>\$ 65,285,602</u>	

* To show the specific strata we used in our sampling method, we did not round these dollar amounts.

Hospice Expenditure Testing

To review the documentation for the 400 claims in our sample, OSA conducted in-person or virtual site visits at 59 of the 81 hospice providers⁸ that served MassHealth members during our audit period (see [Appendix](#)). During our site visits, we reviewed the healthcare files of the members who received the services in the sampled claims and determined whether all required forms were properly completed in accordance with MassHealth and Medicare regulations. For each file, we also reviewed each member's plan of care to determine whether the service in the sampled claim was listed in the member's plan of care and therefore should have been paid for by the hospice provider and not MassHealth. We also sent examples of scenarios from our sample to the Centers for Medicare & Medicaid Services (CMS) and asked CMS for further clarification regarding who should have paid the claim. Based on the results of the testing of our sampled claims, we projected a statistically valid estimate of the dollar amounts that we found to be improper. We conducted interviews with hospice provider staff members to get a better understanding of the hospice benefit and to clarify any questions we had about the documentation provided.

Hospice Enrollment Testing

For the 400 claims in our sample population, we reviewed each member's Medicare or MassHealth Hospice Election Form to verify that it was accurately completed and submitted to Medicare and MassHealth. We compared the information in a data file provided to us by HHS OIG, which listed all members who had chosen to receive hospice care as reported by hospice providers to Medicaid, to the members who had chosen to receive hospice care as reported in MassHealth's Medicaid Management Information System (MMIS) to determine whether MMIS accurately reflected that the members associated with the 400 claims had chosen to participate in hospice.

In our testing, we found that for 223 of the 400 claims in our sample, although the members had chosen to receive hospice services, MassHealth was unaware of this fact (see [Finding 1](#)). We provided the results of our testing to MassHealth for its review.

Data Reliability

We obtained data from MMIS for testing purposes. To test the reliability of the data, we relied on the work performed by OSA in two separate projects completed in 2015 and 2019 that tested certain

8. There were 81 providers as of January 2021.

information system controls in MMIS. As part of that work, OSA reviewed existing information, tested selected system controls, and interviewed knowledgeable agency officials about the data. Additionally, we performed validity and integrity tests on all claim data, including (1) testing for missing data, (2) scanning for duplicate records, and (3) looking for dates outside specific periods. Based on these procedures, we determined that the data obtained were sufficiently reliable for the purposes of this report.

HHS OIG obtained data from the Transformed Medicaid Statistical Information System (TMSIS), a data system used by CMS for testing purposes. To test the reliability of the data, HHS OIG performed validity and integrity tests on all the claim data it provided to us, including (1) performing electronic testing, (2) reviewing existing information about the data and the system that produced them, and (3) tracing a random sample of claims from TMSIS to MMIS. OSA reviewed HHS OIG's reliability assessment of the TMSIS data and agreed with the methodology and with the evaluation of the Medicare datasets. Therefore, we agree with the HHS OIG conclusion that the data are reliable.

For the claims in the data file provided to us by HHS OIG as stated above, we performed validity and integrity tests on the data provided, including (1) testing for missing data, (2) testing for duplicates, (3) looking for dates outside specific periods, and (4) tracing our test sample of data we received from HHS OIG to data we obtained from MMIS. Based on these procedures, we determined that the data obtained were sufficiently reliable for the purposes of this report.

For our hospice enrollment testing, MassHealth provided us with a data extract of all members whose MMIS records included the code HSPC, indicating that they had chosen to receive hospice care during the period January 1, 2015 through December 11, 2020 (the date the information was extracted from MMIS). We performed validity and integrity tests on the data provided, including (1) testing for missing data, (2) testing for duplicates, (3) testing for data validity errors (specifically character fields that contained invalid printable characters or date and time fields that contained invalid dates and times), and (4) tracing a sample of data back to MMIS. Based on these procedures, we determined that the data obtained were sufficiently reliable for the purposes of this report.

At the end of our audit fieldwork, we gave the Executive Office of Health and Human Services (EOHHS) a copy of our draft report for its review, comments, and concurrence. We then collaborated with HHS OIG in developing replies to EOHHS's comments, which are included in this report.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. MassHealth did not ensure that it had accurate information in its Medicaid Management Information System about dual-eligible members who chose to receive hospice services.

During our audit period, MassHealth did not ensure that it had accurate information in its Medicaid Management Information System (MMIS) about dual-eligible members who chose to receive hospice services. Specifically, for 223 (56%) of the 400 claims in our sample, although the member had chosen to receive hospice services (according to Medicare information provided to us by the United States Department of Health and Human Services' Office of Inspector General), either MassHealth did not receive the member's MassHealth Hospice Election Form and therefore could not update MMIS to reflect that the member had chosen to participate in hospice, or (in at least four instances) MassHealth received the member's MassHealth Hospice Election Form but did not update MMIS to show that the member had chosen to participate in hospice. Not ensuring that MMIS reflects accurate information for these services creates a higher-than-acceptable risk that the payments for them may be improper. Examples of improper payments that occurred during the audit period and may have been the result of this issue appear in [Finding 2](#), [Finding 3](#), and [Finding 4](#).

Once a member has chosen to receive hospice services, MassHealth enters the code HSPC in MMIS to indicate that the member has chosen hospice care. Subsequently, all claims for services provided to the member are subject to system edits related to hospice care, which are designed to ensure that MassHealth does not pay any claims that should be paid by either the hospice provider or Medicare. Based on our statistical sample of 400 reviewed claims, we estimate that during our audit period, approximately \$56,640,242 in non-hospice-provider claims⁹ of the four types tested were for members who had chosen to participate in hospice. However, this information was not reflected in MMIS, so the claims were not subject to the proper MMIS system edits.

9. This number represents the sum of all four sample types. The professional claim sample totaled \$55,766,857, the inpatient claim sample totaled \$182,461, the durable medical equipment claim sample totaled \$638,475, and the transportation claim sample totaled \$52,449. We are 90% confident that the lower limit for professional claims is \$51,674,262 and the upper limit is \$59,859,452; that the lower limit for inpatient claims is \$156,381 and the upper limit is \$208,541; that the lower limit for durable medical equipment claims is \$566,381 and the upper limit is \$710,568; and that the lower limit for transportation claims is \$35,729 and the upper limit is \$69,169.

Authoritative Guidance

Section 437.412(C) of Title 130 of the Code of Massachusetts Regulations (CMR) states that providers must send hospice election forms to MassHealth:

Each time a MassHealth member . . . seeks to elect hospice services . . . the hospice must complete the MassHealth agency's hospice form according to the instructions on the form and submit the form to the MassHealth agency.

MassHealth needs to monitor compliance with this requirement so it can ensure that the information in MMIS about dual-eligible members' choice to participate in hospice is complete and accurate and that MassHealth does not pay for improper bills submitted by non-hospice providers for these services.

Reasons for Issue

MassHealth does not have an effective monitoring process to ensure that hospice providers submit to it a MassHealth Hospice Election Form for every dual-eligible member who chooses to receive hospice services. Further, officials from 46 of the 59 hospice providers we visited told us that they were unaware that they were required to send MassHealth a MassHealth Hospice Election Form for all dual-eligible members who chose to receive hospice services; many stated that they thought they only had to send in this form when they were going to bill MassHealth for services provided to a member.

Recommendations

1. MassHealth should establish an effective monitoring process to ensure that hospice providers send it a MassHealth Hospice Election Form for every dual-eligible member who chooses to receive hospice services.
2. MassHealth should consider collaborating with the Centers for Medicare & Medicaid Services (CMS) to obtain CMS's hospice election information about dual-eligible members and determine whether all MassHealth's hospice providers have submitted the required MassHealth Hospice Election Forms.
3. MassHealth should review MMIS for all members who have elected the hospice benefit to ensure that their MassHealth Hospice Election Forms are accurately reflected in MMIS.

Auditee's Response

In its written response to our draft audit report, the Executive Office of Health and Human Services (EOHHS), in collaboration with MassHealth, provided some general comments, excerpted below.

When MassHealth receives a Member's MassHealth hospice election form it opens a hospice segment in MassHealth's Medicaid Management Information System (MMIS) enabling the

MassHealth hospice provider to bill MassHealth for the per diem hospice rate intended to cover hospice services provided to the member. In completing and signing the MassHealth hospice election form the member is affirmatively waiving their right to receive other MassHealth covered services related to or for the treatment of their terminal illness, the submission of the MassHealth hospice election form also triggers additional program integrity measures related to the member's receipt of other MassHealth covered services. Specifically, submission of the MassHealth hospice election form and the establishment of a hospice segment in MMIS activates an MMIS edit ("edit 2018"), that denies claims for other MassHealth covered services that may be related to the member's terminal illness, such as physician services and inpatient hospital services, during the period the MassHealth hospice segment is in place and active. Importantly, and by design, edit 2018 does not deny payments for MassHealth services categorically unrelated to the member's terminal illness, such as 1915(c) home and community-based waiver services that enable members with disabilities to live and remain in the community as an alternative to facility settings.

EOHHS and MassHealth (hereafter EOHHS) indicated that they had conducted an analysis of the claims in our sample and, based on all available information, determined that there were no inappropriately paid claims. EOHHS separated the claims in our sample into five categories and explained why they believe they would have paid the claims:

1. Medicare Crossover Claims [64 claims; \$74,845]

The claims in Category 1 are appropriately paid Medicare crossover claims. Here, Medicare determined that the claim was not precluded from payment by the dual eligible member's election of Medicare hospice and therefore Medicare paid the Medicare portion of the claim as primary payor, and the crossover claim was forwarded to MassHealth by Medicare for processing of the remaining patient responsibility (the cost-sharing amount) as secondary payor. . . . The MassHealth program is required to pay any patient responsibility amount for Medicare crossover claims in accordance with Sections 1902(a)(10)(E) and 1902(n)(1) & (2) of the Social Security Act and MassHealth regulations at 130 CMR 450.318.

2. Claims for 1915(c) Home and Community Based (HCBS) Waiver Services [85 claims; \$868,810]

The claims in Category 2 are appropriately paid claims for 1915(c) HCBS Waiver services. Claims identified by the auditors in this category include claims for residential habilitation waiver services (group home services) provided through MassHealth's [Intellectually Disabled / Developmentally Disabled, or ID/DD] Residential Supports Waiver, claims for home health aide, homemaker, and companion services provided through the Frail Elder Waiver, and a claim for acquired brain injury skills training services provided through one of MassHealth's Acquired Brain Injury waivers. . . .

MassHealth members enrolled in a 1915(c) HCBS Waiver are not required to disenroll from their waiver upon the election of hospice and may continue to receive HCBS waiver services while on hospice. . . .

For all 1915(c) HCBS waiver services the auditors identified as being inappropriately paid, EOHHS disagrees with the auditors' draft finding that the identified 1915(c) HCBS waiver services may have been duplicative or otherwise unallowable. EOHHS's review of the subject claims indicates that the claims were for waiver services that were either not related to the member's terminal illness, and/or were for waiver services not covered by hospice (e.g., residential habilitation services; companion services; homemaker services and home health aide services for the provision of in-home respite). . . .

3. Claims for State Plan Services Categorically Unrelated to Hospice [108 claims; \$35,219]

Claims in this category are appropriately paid claims for State Plan services that are categorically unrelated to hospice, as well as claims for Medicaid personal care services for which a hospice election does not apply. Claims for State Plan services in this category include claims for services such as non-emergency medical transportation as well as claims for Adult Foster Care ("AFC") services, which provide 24/7 personal care provided by a live-in caregiver. . . .

4. Claims Outside the Hospice Election Period [1 claim; \$17,215]

This category includes one claim for acute inpatient hospital services after the member had disenrolled from Hospice. EOHHS found that this claim was appropriately paid, where it was for services after the member had disenrolled from Medicare hospice, and therefore, the member was entitled to their full Medicare and MassHealth benefits.

5. Claims for State Plan Services Appropriately Payable If Unrelated to the Terminal Illness [60 claims; \$14,290]

Claims in this category are appropriately payable if the provided service was not related to the terminal illness for which the member elected hospice. This category consists of [durable medical equipment, or DME] claims and oxygen and respiratory equipment claims. The claims in this category would require further clinical review to validate whether they were related to the terminal illness; however, based on all information reviewed to date (including all information provided by the auditors), EOHHS has not identified any inappropriately paid claims in this category.

In response to Finding 1, EOHHS provided the following comments.

The audit pertains to dual eligible members receiving Medicare covered hospice services and sub-regulatory guidance from CMS in its Medicare Benefit Policy Manual at Chapter 9, Section 20.3 that Medicare hospice providers must require dual eligible members to waive their right to receive all other Medicare and Medicaid covered services related to their terminal illness for which they would otherwise be eligible to receive via simultaneous election of both the Medicare and

Medicaid hospice benefits. The audit identified that some Medicare hospice providers, when providing Medicare covered hospice services to dual eligible members, failed to require such members to simultaneously complete a MassHealth hospice election form with the election of their Medicare hospice benefit. In particular, the auditors found that for 223 out of the 400 MassHealth claims for non-hospice services associated with certain dual eligible members who had elected Medicare hospice and were receiving Medicare covered hospice services, that the Medicare hospice provider had not required the member's completion of a MassHealth hospice election form through which the member waived their right to receive certain MassHealth covered services related to their terminal illness.¹⁰

EOHHS agrees in part with the auditors' findings indicating that the audited Medicare hospice providers failed to require dual eligible members to complete a MassHealth hospice election form along with their Medicare hospice election in some of the 223 cases . . . in violation of the sub-regulatory Medicare guidance in the Medicare Benefit Policy Manual at Chapter 9, Section 20.3.¹¹ However as previously discussed and as provided below, EOHHS has not identified any inappropriately paid claims as a result of this deficiency on the part of the audited Medicare hospice providers.

In particular, all of the claims identified in Finding 1 fall into one of the MassHealth Categories of appropriately paid claims as follows:

- Category 1 (Medicare Crossover Claims): 45 Claims; \$59,622*
- Category 2 (1915[c] HCBS Waiver Claims): 77 Claims; \$813,099*
- Category 3 (State Plan Services Unrelated to Hospice): 48 Claims; \$23,628*
- Category 4 (Claims Outside Hospice Election Period): 1 Claim; \$17,215*
- Category 5 (Claims Payable if Unrelated to Terminal Illness): 52 Claims; \$12,029*

Accordingly, while EOHHS agrees that the audited Medicare hospice providers failed to require the dual eligible member to complete a MassHealth hospice election form in some cases, EOHHS strongly disagrees with the auditors' finding of any "improper payments" arising out of this issue. Notably, MassHealth's Third Party Liability (TPL) edits deny claims for services covered under Medicare to ensure that MassHealth is the payer of last resort. Via TPL edits, MassHealth is able to ensure that it only pays for services that are not covered under Medicare, which includes all of the claims identified by the auditors (i.e. Medicare cross-over claims, claims for Medicaid 1915(c)

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10. *A member's completion of the MassHealth hospice election form (through which the member waives their right to MassHealth coverage of certain medical services) is required in order for MassHealth to appropriately deny non-hospice provider claims that are for the treatment of or related to the member's terminal illness.*
11. *MassHealth's analysis revealed that MassHealth election forms were absent for 184 out of 223 cases alleged by the auditors where there should have been such a form present. For the remaining 39 cases (approximately 17%), MassHealth disagrees with the finding that MassHealth election forms were missing where they should have been present, based on discrepancies between the auditors' findings and the Medicare and MassHealth hospice election data in MMIS. For example, in some cases there was a MassHealth hospice election form present, and in other cases the claims were outside of the hospice election period and therefore no form was required for the dates of service on the underlying claim.*

HCBS waiver services, claims for AFC services, etc.). Any asserted "risk that the payments for these services may be improper" arising out of this issue (i.e. the absence of a MassHealth hospice election form in certain situations in which a dual eligible member was receiving Medicare covered hospice services) does not rise to the level of "approximately \$56,640,242" as asserted by the auditors, as EOHHS analysis of the claims at issue revealed that many of the services identified by the auditors are categorically unrelated to hospice and were appropriately payable regardless of whether there was a MassHealth hospice election on file. . . .

EOHHS agrees with [Recommendation 1] and in October 2020 took action. EOHHS issued MassHealth Hospice Provider Bulletin 15 as a reminder to MassHealth enrolled hospice providers of the federal sub-regulatory guidance that requires dual-eligible members to simultaneously elect their hospice benefit under both Medicare and Medicaid, and that hospice providers need to submit a MassHealth hospice election form for these members regardless of whether MassHealth is paying for the hospice services. MassHealth will continue to follow up and provide education and training for MassHealth hospice providers on their responsibility to comply with this requirement when providing Medicare covered hospice services to dual-eligible members.

In addition, EOHHS is developing additional measures to ensure it receives MassHealth hospice election forms from MassHealth enrolled hospice providers providing Medicare covered hospice services to dual-eligible members:

- additional program integrity processes to identify when a dual eligible member has elected Medicare covered hospice services via Medicare data and confirming there is an associated MassHealth hospice election on file for the member; and*
- administrative sanctions on MassHealth enrolled Medicare hospice providers will be imposed when they fail to submit a MassHealth hospice election form for a dual-eligible member simultaneous to the member's completion of a Medicare hospice election form, as required by federal sub-regulatory guidance and as set forth in MassHealth's Hospice Bulletin 15 issued in October of 2020. . . .*

EOHHS agrees with [Recommendation 2] and is developing program integrity processes to confirm there is a MassHealth hospice election on file in instances where the MassHealth member is receiving Non-MassHealth Medicare covered hospice services, and as described above under Recommendation 1. . . .

EOHHS agrees with [Recommendation 3] and is developing program integrity processes to ensure MassHealth enrolled providers of Medicare covered hospice services submit a MassHealth hospice election form for dual eligible members receiving Medicare covered hospice services, as described above in EOHHS's response to Recommendations 1 and 2. In addition, as described in the initial section of this audit response, EOHHS has an effective process for ensuring that there is a MassHealth Hospice election form in place for MassHealth members receiving MassHealth covered hospice services. Specifically, EOHHS requires submission of a MassHealth hospice election form as a prerequisite for a hospice provider to bill MassHealth for MassHealth covered hospice services. Through this process, MassHealth is able to deny the provider's claims for MassHealth covered hospice services until the provider submits the Member's MassHealth hospice election form, which ensures compliance with this requirement in situations in which MassHealth is the payor of the hospice services. . . .

EOHHS appreciates this audit of Medicare hospice providers' compliance with the federal sub-regulatory guidance on hospice election for dual eligible members and appreciates the opportunity to utilize these findings as a vehicle towards improving MassHealth's oversight of MassHealth enrolled hospice providers that provide Medicare covered hospice services to dual eligible members.

Auditor's Reply

As noted above, for the *majority* of the claims, 223 (56%) of the 400 claims in our sample, for which the members had elected the hospice benefit, either MassHealth did not receive the member's MassHealth Hospice Election Form and therefore could not update MMIS to reflect that the member had elected the benefit, or (in at least four instances) MassHealth received the member's MassHealth Hospice Election Form but did not update MMIS to show that the member had elected the benefit. Although EOHHS faults hospice providers for failing to require the MassHealth members in question to complete a Medicare Hospice Election Form, MassHealth, as the state purchasing agency, should have had an effective monitoring process in place that ensured that hospice providers submit to it a MassHealth Hospice Election Form for every dual-eligible member who chose to receive hospice services. EOHHS agrees that for 184 of the 223 claims, the information in MMIS did not accurately reflect that the member had elected the hospice benefit. For the remaining 39 claims, EOHHS asserts that there was evidence that the member had elected the benefit; however, EOHHS did not provide this evidence, so we cannot comment on the assertion.

In its response, EOHHS states that it agrees with our finding which it believes is: "Medicare hospice providers failed to require the dual eligible member to complete a MassHealth hospice election form in some cases." However, to be clear, our finding was not with the hospice providers we reviewed but with the fact that in the majority of the cases, MassHealth did not ensure that it had accurate information in MMIS about dual-eligible members who chose to receive hospice services. Since MassHealth regulations require the submission of the MassHealth Hospice Election Form, in the Office of the State Auditor's (OSA's) opinion, the agency is responsible for having monitoring and other controls in place to ensure compliance with this requirement, especially because this information is used in MMIS as a control to prevent improper payments. EOHHS further states that it had "not identified any inappropriately paid claims as a result of this deficiency on the part of the audited Medicare hospice providers." Since we were not provided with any documentation regarding EOHHS's analysis of the claims in our sample, we cannot comment on the accuracy of this assertion. However, our concern is not with the dollar value of the claims that may or may not be improper but with the fact that MassHealth failed to ensure that it

had the necessary information in MMIS to prevent improper payments from occurring regardless of the amounts.

In their response, EOHHS states that the third-party liability (TPL) edits deny claims for services covered under Medicare, such as those cited in our report, to ensure that MassHealth is the payer of last resort. Although this TPL edit process may be effective for some claim types, OSA questions how it can be effective for all hospice claim types if, as EOHHS states, MassHealth is not ensuring that it has accurate information in MMIS about all dual-eligible members who elect the hospice benefit.

Our projection of the amount of the claims that were not subject to MassHealth's system edits for members in hospice (\$56,640,242) was based on sound statistical analysis. This analysis was not designed to determine what amount, if any, of these paid claims was improper, but rather what amount was at risk of being improper because MassHealth had not identified all members who had elected the hospice benefit in MMIS. EOHHS asserts that it has determined that many of the claims in our sample may have been properly paid, but we do not believe this mitigates the fact that MassHealth did not properly ensure that it collected and maintained complete and accurate information on its members who had elected the hospice benefit so that it could effectively administer the claims. It should be noted that this \$56,640,242 is only a projection of the amount of the payments that were at risk of being improper from the four hospice claim types in our sample during our audit period. We separately analyzed claims paid for all hospice services during the audit period and found that hundreds of millions of dollars in hospice claims may have been paid for members who had elected the hospice benefit although this information was not accurately reflected in MMIS; this means these claims are at risk of being improper.

Based on its response, EOHHS is taking measures to address our concerns on this matter.

2. MassHealth paid for professional services that were not coordinated by hospice providers.

During our audit period, MassHealth paid an estimated \$45,110,697 in claims¹² for professional services such as home health aide services, homemaker services, and companion care that were not coordinated by members' hospice providers. Instead, they were arranged by members, their relatives, or others without the hospice providers' knowledge. Subsequently, the non-hospice providers billed MassHealth

12. We are 90% confident that the lower limit for professional services is \$39,530,086 and the upper limit is \$50,691,309.

directly for these services. Because the services were not coordinated by the hospice providers, they may have been duplicative of services that the hospices were already providing and that were therefore unallowable.

Based on our review of these services, we estimate that claims totaling \$5,952,842,¹³ of the total \$45,110,697 in claims submitted to MassHealth by non-hospice providers, were already included in members' plans of care and would have been paid for by the hospice providers. Although the services associated with the remaining \$39,157,855 in claims were not included in the members' plans of care, the services were not coordinated by the hospice providers. Without coordinating these services, hospices do not have the opportunity to review the claims to determine whether they should pay them. MassHealth could have used this money to provide additional services to other MassHealth members.

Authoritative Guidance

According to Section 418.56(e) of Title 42 of the Code of Federal Regulations (CFR), hospice providers must effectively direct, coordinate, and supervise all services provided to dual-eligible members who have chosen to receive hospice services:

Standard: Coordination of services. The hospice must . . .

- 1. Ensure that the [hospice] interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided. . . .*
- 4. Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.*
- 5. Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.*

Effective coordination of services would include ensuring proper billing.

According to 130 CMR 437.421(C)(2), hospice providers must provide all the services members need, as documented in their plans of care, and coordinate all in-home support services that are provided by non-hospice providers.

Role of Team. The hospice interdisciplinary team . . . must supervise care and services, including . . .

13. We are 90% confident that the lower limit for professional services that were included in the members' plans of care is \$2,509,218 and the upper limit is \$9,396,466.

- b. ensuring that the plan of care is coordinated with any services the member may be authorized to receive from . . . a home- and community-based service network.*

In addition, according to 130 CMR 437.412(B)(3)(a), MassHealth does not pay for “any MassHealth services that are equivalent to or duplicative of hospice services.”

Reasons for Issue

Hospice providers did not coordinate these services with non-hospice providers to ensure proper service coordination and billing. In addition, the information in MMIS that identifies dual-eligible members who have chosen to receive hospice services may not be accurate (see [Finding 1](#)), which would result in some of these claims not being appropriately screened before payment. For the members who were correctly identified in MMIS as having chosen to receive hospice services, the system edits in MMIS appear not to have been effective in detecting and denying all claims for hospice services that may have been duplicative of services that the hospices were already providing that were therefore unallowable.

Recommendations

1. MassHealth should ensure that its hospice providers coordinate professional services with non-hospice providers for dual-eligible members to ensure proper service coordination and billing.
2. MassHealth should update its system edits in MMIS to detect and deny claims for dual-eligible members in hospice care that might be duplicative of services that should be paid for by hospice providers.

Auditee's Response

EOHHS and MassHealth responded,

EOHHS disagrees with the conclusion indicated by the auditors' draft findings that if a member with disabilities enrolled in an HCBS waiver elects to receive hospice services, the member should cease to receive HCBS waiver services such as residential habilitation, companion services, or services that provide in-home respite. For purposes of residential habilitation, this would likely mean requiring the member to be placed in a nursing facility. Similarly, as hospice does not cover in-home respite (only inpatient respite services), this would likely result in unnecessary and inappropriate hospital admissions for members whose caregivers had previously utilized in-home respite through the member's HCBS waiver prior to the member's election of hospice. EOHHS disagrees with an outcome in which members with disabilities enrolled in an HCBS waiver must choose between, on the one hand, their continued receipt of HCBS waiver services that help them to remain in the community, and on the other hand, receipt of hospice services for the palliation and management of their terminal illness. . . .

Pursuant to CMS guidance on the scope of the Medicare hospice benefit, Medicare hospice services are meant to supplement rather than replace personal care services provided under Medicaid. Specifically, CMS clarified at page 32905 of Federal Register Vol. 73, No. 109 (2008) (announcing changes to Medicare hospice regulations) that:

Hospice care is meant to supplement the care provided by the patient's caregiver. If the individual(s) furnishing Medicaid personal care services is functioning as the patient's caregiver, then the hospice would not be expected to replace the Medicaid personal care providers with its own homemaker services on a round the-clock basis. The Medicare hospice benefit is not meant to be a caregiver benefit and should not be expected to function as such.

As part of the auditors' basis for their finding that these services should have been paid by the Medicare hospice provider, the auditors cite federal Medicare guidance addressing the scope of the rates for Medicare covered hospice services. Specifically, the auditors cite . . . Federal Register Vol. 83, No. 89 (2018) (announcing Medicare rates for hospice services) and CMS's statement that the Medicare rates for hospice are:

comprehensive, and we have reiterated since 1983 that "virtually all" care needed by the terminally ill individual would be provided by hospice. We believe that that it would be unusual and exceptional to see services provided outside of hospice for those individuals who are approaching the end of life.

Notably, however, Medicare and Medicaid are separate health programs and Medicare is a much narrower benefit than Medicaid, covering a substantially smaller scope of services. As a result, while the CMS guidance cited by the auditors is that the Medicare hospice rates are intended to cover "virtually all" Medicare services, EOHHS disagrees with the auditors' overly broad interpretation that this guidance also means the Medicare hospice rates are intended to cover (or could cover) "virtually all" Medicaid services, such as the array of long term services and supports available under MassHealth that are not covered under Medicare, like Adult Foster Care. . . .

EOHHS disagrees with Finding 2. The audit team identified 70 MassHealth claims for non-hospice services totaling \$628,298 that fall under Audit Finding 2, in which the auditors assert that the services "were not coordinated by the hospice providers" and "may have been duplicative of services that the hospice agencies were already providing and that were therefore unallowable." EOHHS's review of these claims indicates that all 70 claims were appropriately paid claims for either MassHealth Category 2—1915(c) HCBS waiver services (57 claims) or MassHealth Category 3—state plan services unrelated to hospice (13 claims). Accordingly, EOHHS strongly disagrees with the auditors' finding that MassHealth paid an estimated \$45,110,697, based on extrapolation as detailed in the draft audit report, for services that may have been unallowable due to a lack of coordination, where these claims were for either payable 1915(c) HCBS waiver claims or payable claims for state plan services unrelated to hospice.

With regard to the 57 HCBS waiver claims, as discussed in EOHHS' introduction, HCBS waiver services provide long term services and supports that enable members with disabilities to remain in the community as an alternative to a facility and are services which are neither covered under Medicare nor included in the scope of the Medicare hospice benefit. MassHealth members

enrolled in an HCBS Waiver are not required to disenroll from their waiver upon the election of hospice and may continue to receive HCBS waiver services while on hospice. Additionally, to avoid duplication of services, members enrolled in an HCBS Waiver receive case management and care coordination of their HCBS waiver services, which includes coordination of their HCBS waiver services with other non-waiver services the member may be receiving, such as hospice.

Contrary to the auditors' assertions that there was an absence of care coordination, EOHHS's review of Frail Elder Waiver care plans for the members associated with the identified claims for home health aide, homemaker, and companion waiver services indicates that the member's waiver case manager was aware of the member's receipt of hospice services and was coordinating these waiver services with the hospice provider's provision of hospice services. In many instances, the HCBS waiver services were for the purpose of in-home respite, which is not covered under the Medicare hospice services the member was receiving.¹⁴ In other instances, these waiver services were for long standing [activity of daily living and instrumental activity of daily living] support in place prior to the member's election of hospice and which were not related to the member's terminal illness and thus also not covered under the Medicare hospice services the member was receiving.

HCBS waiver claims in Audit Finding 2 also included claims for residential habilitation services (group home services) provided under MassHealth's ID/DD Residential Supports waiver. Residential Habilitation is paid at a per diem rate and is provided in group homes that are provider owned-and-operated and include 24/7 staffing and supervision provided by employees of the provider. Where members receiving residential habilitation reside in the provider's group home, it is unrealistic to envision a scenario in which the provider of Medicare covered hospice services was not coordinating its delivery of care with the member's residential habilitation services. Additionally, where residential habilitation services are paid at a per diem rate, absent a denial of residential habilitation services in potential violation of the [Americans with Disabilities Act], it is unclear to EOHHS how "MassHealth could have used this money to provide additional services to other MassHealth members" as the auditors assert. . . .¹⁵

Audit Finding 2 also included 13 claims for MassHealth state plan services unrelated to hospice, which were primarily claims for AFC services (10 claims). As noted above, AFC services provide 24/7 personal care that is provided by a live-in caregiver and which, like hospice, are paid at a per diem rate. Pursuant to federal Medicaid guidance, Members may continue to receive personal care services, such as AFC, while on hospice.¹⁶ Contrary to the auditors' assertion that the AFC services were not coordinated with hospice, MassHealth AFC bulletin 13 specifies that "if the member elects hospice, the AFC provider must coordinate its delivery of AFC services with the services provided through hospice. . . ." Notably, the auditors have provided no evidence that the

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14. *See Medicare Benefit Policy Manual at Chapter 9, Section 40.2.2, which specifies that hospice "[r]espice care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home."*
 15. *To the extent Medicare hospice providers inappropriately billed Medicare for services unrelated to the Member's terminal illness and that should have been provided by the Member's residential habilitation provider, arguably that is a finding to be directed to the Medicare program, where MassHealth was not the payer of the hospice services.*
 16. *See Federal Register Vol. 73, No. 109 (2008) (clarifying that Medicare hospice is meant to supplement not replace Medicaid personal care services) at page 32905.*

AFC's live-in caregiver failed to coordinate their delivery of care with the Medicare hospice provider and due to the live-in nature of this care, it is difficult to envision a scenario in which the AFC's caregiver and the Medicare hospice provider were not coordinating the delivery of their care. Finally, where AFC services are paid at a per diem rate, absent a denial of AFC services in potential violation of the ADA, it is unclear to EOHHS how "MassHealth could have used this money to provide additional services to other MassHealth members" as the auditors assert. . . .¹⁷

[Regarding Recommendation 1,] as mentioned above, EOHHS's review of the professional services identified in Finding 2 indicates that the services were coordinated and the claims were appropriately paid by MassHealth. EOHHS will continue to provide education to MassHealth enrolled hospice providers on their obligation to coordinate the delivery of hospice services with other non-hospice services a member may be receiving.

[Regarding Recommendation 2,] as noted above, EOHHS is implementing processes to proactively identify dual-eligible members receiving Medicare covered hospice services who have not simultaneously executed a MassHealth hospice election form. This process may result in additional MMIS system edits.

Auditor's Reply

Contrary to what EOHHS states in its response, our audit does not conclude that if a member with disabilities who is enrolled in a home and community-based services (HCBS) program with a waiver elects to receive hospice services, the member should stop receiving their HCBS waiver services. Rather, our report concludes that members who have elected the hospice benefit should receive all of their required services. However, our concern is that all of these services are not being properly coordinated with members' hospice providers and, therefore, may not always be paid for by the appropriate parties. Further, we do not question the provision of the professional services under HCBS waivers included in our sample and do not suggest that members with disabilities enrolled in an HCBS program with a waiver must choose between their continued receipt of HCBS waiver services and the receipt of hospice services for the palliation and management of their terminal illness.

Although EOHHS states that its review of the Frail Elder Waiver care plans for the members in question indicated that these services were coordinated with the members' hospice providers, it did not provide us with any documentation to substantiate this assertion. Further, during our audit, OSA reviewed the plans of care for each member and conducted interviews with management at each of the 59 hospices we visited. Based on this audit work, we found no evidence that many of the services included in our

17. *To the extent Medicare hospice providers inappropriately billed Medicare for services unrelated to the Member's terminal illness and that should have been provided by the Member's AFC caregiver, arguably that is a finding to be directed to the Medicare program, where MassHealth was not the payer of the hospice services.*

sample had been coordinated with the hospice providers. In fact, as noted above, for 70 of the 100 claims in our sample population, hospice management for the members stated that they were unaware that these services had been performed.

In its response, EOHHS states that it determined that it would have paid for most of the claims in our sample. We cannot comment on this because, as previously mentioned, we were not provided with the records EOHHS used to make this determination. However, even if EOHHS's assertion is accurate, our concern is that MassHealth did not ensure that certain claim processing controls, designed to prevent improper payments for hospice services, functioned as intended. As mentioned in [Finding 1](#), for the majority of the claims in our sample, MassHealth was not aware that the members had elected the hospice benefit. Therefore, none of the claims processed for these members during the audit period had been subjected to the system edit ("edit 2018") that would have detected and prevented improper payments. Even if EOHHS would have paid for the majority of the claims in our sample as they assert, we estimate that during our audit period, MassHealth processed approximately \$56,640,242 in non-hospice-provider claims in the four claim types we reviewed that were not subject to these system edits. As we stated previously in this report, CMS identified an improper payment rate of approximately 21% regarding all Medicaid claims. Therefore, we believe there is a higher-than-acceptable risk that some of these paid claims may have been improper.

In their response, EOHHS asserts that the services in our sample were coordinated with hospice providers, including services provided under a 1915(c) waiver for HCBS, which were coordinated by a waiver case manager. However, there was no documentation (e.g., notations in a member's plan of care) at the hospices we visited that indicated that the hospices were aware of the services and were coordinating them. On the contrary, hospice providers told us they were unaware that the services were being provided. Moreover, after reviewing the claims in question, a number of hospice officials stated that they would have paid for some of them. Federal regulations require hospice providers to coordinate all hospice services, including those provided under Medicaid waivers. This is because hospice personnel who have evaluated members' physical condition and determined their service needs are in the best position to ensure that the types and levels of services provided are appropriate, necessary, and not duplicative. Further, in terms of billing, the hospice is the only entity that can determine whether the services provided are related to a member's terminal illness and/or are contained in a member's plan of care and therefore represent expenses that should be paid for by the

hospice, not MassHealth. State regulation 130 CMR 437.422(B) also makes it clear that hospice providers must coordinate all care for members in hospice and must document all the services the members receive in their plans of care:

The plan of care must reflect member and family goals and interventions based on problems identified in the comprehensive assessment. The plan must include all services necessary for the palliation and management of the terminal illness and related conditions, including the coordination of all in-home supports. The plan of care must be coordinated with any services the member may be authorized to receive from the MassHealth Personal Care Attendant Program and such services may be used only to the extent that the hospice would routinely use the services of a hospice member's family in implementing the plan of care.

EOHHS and MassHealth state,

It is unrealistic to envision a scenario in which the provider of Medicare covered hospice services was not coordinating its delivery of care with the member's residential habilitation services.

However, CMS is aware that there is a lack of coordination between hospices and non-hospice providers. In *Federal Register* 84, No. 151 (2019), CMS states,

We have also received anecdotal reports from hospices who state they were unaware that patients had received care from non-hospice providers. In these reports, the hospice would first learn of this outside care when non-hospice providers would contact the hospice seeking reimbursement. If this care was related to the terminal illness and related conditions and the hospice did not make arrangements for such care, the beneficiary would be liable for the costs of receiving that care.

Additionally, if non-hospice providers bill Medicare for services that potentially should have been the coverage responsibility of hospice, Medicare could be making duplicative payments for care related to the terminal illness and related conditions.

In addition to the anecdotal reports, management at many of the hospices we visited stated, as mentioned above, that they were unaware that services outside their plans of care had been performed, since they never received any requests from the non-hospice providers for reimbursement for them. This indicates a lack of coordination of services.

EOHHS points that Medicare hospice services are meant to supplement personal care services, not replace them. OSA does not dispute this, but again, all services are required to be coordinated by a member's hospice.

Additionally, the system edits described above reduce improper payments and help ensure that MassHealth is the payer of last resort. Although this can be done by reviewing claims after they have been paid to determine whether payments were proper, the most effective way to minimize unnecessary payments for hospice services is to prevent them from occurring by ensuring that proper controls over claim processing have been established and are functioning as intended. This is particularly important for dual-eligible members who have elected the hospice benefit, since billing for the services they receive can be more complicated (e.g., some services are both Medicaid and Medicare reimbursable).

Regardless of the amount of the questionable claims we identified during this audit, during our audit period there were significant claim processing issues for hospice that put millions of dollars of hospice claims at risk of being improper. EOHHS needs to address this issue.

Based on its response, EOHHS is taking measures to address our concerns on this matter.

3. MassHealth unnecessarily paid for durable medical equipment for dual-eligible members.

During our audit period, MassHealth paid for dual-eligible members for durable medical equipment (DME) that was, or should have been, included in the members' plans of care and therefore paid for by their hospice providers.

a. MassHealth paid for DME that was included in members' plans of care.

During our audit period, MassHealth paid an estimated \$65,727 in claims¹⁸ for DME that were unnecessary because the DME was included in the members' plans of care and therefore should have been paid for by their hospice providers. In 10 of 100 sampled claims, MassHealth paid for DME, such as wheelchairs, incontinence products, and wound dressings, that was also included in the members' plans of care. Since the DME was included in plans of care, it was already paid for by monthly Medicare reimbursements the hospice providers received and therefore should have been paid for by the hospice providers, not MassHealth. MassHealth could have used this money to provide additional services to MassHealth members.

18. We are 90% confident that the lower limit for DME is \$27,639 and the upper limit is \$103,815.

Authoritative Guidance

The services covered by hospice programs are described in 42 CFR 418.202(f):

Medical appliances and supplies, including drugs and biologicals. . . . Appliances may include covered durable medical equipment . . . as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care and that are for palliation and management of the terminal or related conditions.

According to Chapter 1395x(1861)(dd)(1) of Title 42 of the United States Code (USC), hospice providers are required to provide the following:

- E. Medical supplies (including drugs and biologicals) and the use of medical appliances, while under [a plan of care]. . . .*
- I. any other item or service which is specified in the plan [of care] and for which payment may otherwise be made under this title.*

Covered services under hospice are described in 130 CMR 437.423(G):

The hospice must provide and be responsible for all . . . durable medical equipment and medical supplies needed for the palliation and management of the terminal illness and related conditions, according to the member's plan of care. . . . Durable medical equipment providers may bill MassHealth separately only for those services not related to the member's terminal illness.

Further, 130 CMR 450.316 states that MassHealth must be the payer of last resort:

All providers must make diligent efforts to obtain payment first from other resources . . . so that the MassHealth agency will be the payer of last resort. The MassHealth agency will not pay a provider and will recover any payments to a provider if it determines that, among other things, the provider has not made such diligent efforts.

b. MassHealth paid for DME that should have been included in members' plans of care.

For 87 of our 100 sampled claims, MassHealth paid an estimated total of \$723,640 for DME¹⁹ that should have been, but was not, included in the members' plans of care and paid for by their hospice providers. MassHealth could have used this money to provide additional services to other MassHealth members.

19. We are 90% confident that the lower limit for DME is \$665,146 and the upper limit is \$782,134.

Authoritative Guidance

In *Federal Register* 83, No. 89 (2018), CMS states,

Hospice services are comprehensive and we have reiterated since 1983 that "virtually all" care needed by the terminally ill individual would be provided by hospice. We believe that it would be unusual and exceptional to see services provided outside of hospice for those individuals who are approaching the end of life.

In *Federal Register* 84, No. 151 (2019), CMS reiterated this point:

Our long-standing position [is] that services unrelated to the terminal illness and related conditions should be exceptional, unusual and rare given the comprehensive nature of the services covered under the Medicare hospice benefit.

The services covered under hospice programs are described in 42 CFR 418.202(f):

Medical appliances and supplies, including drugs and biologicals. . . . Appliances may include covered durable medical equipment . . . as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care and that are for palliation and management of the terminal or related conditions.

According to 42 USC 1395x(1861)(dd)(1), hospice providers are required to provide the following:

- E. Medical supplies (including drugs and biologicals) and the use of medical appliances, while under [a plan of care]. . . .*
- I. any other item or service which is specified in the plan [of care] and for which payment may otherwise be made under this title.*

Covered services under hospice are described in 130 CMR 437.423(G):

The hospice must provide and be responsible for all drugs and durable medical equipment and medical supplies needed for the palliation and management of the terminal illness and related conditions, according to the member's plan of care. . . . Pharmacy and durable medical equipment providers may bill MassHealth separately only for those services not related to the member's terminal illness.

Further, 130 CMR 450.316 states that MassHealth must be the payer of last resort:

All providers must make diligent efforts to obtain payment first from other resources . . . so that the MassHealth agency will be the payer of last resort. The MassHealth agency will not pay a provider and will recover any payments to a provider if it determines that, among other things, the provider has not made such diligent efforts.

Reasons for Issues

Some hospice providers told us in interviews that regulations and guidance on what DME should be included in plans of care are unclear in some areas (see [Other Matters](#)). In addition, the information in MMIS that identifies dual-eligible members who have chosen to receive hospice services may not be accurate (see [Finding 1](#)), which would result in some of these claims not being appropriately screened before payment. For the members who were correctly identified in MMIS as having chosen to receive hospice services, the system edits in MMIS appear not to have been effective in detecting and rejecting all claims for hospice services that were, or should have been, included in members' plans of care.

Recommendations

1. MassHealth should ensure that information in MMIS about hospice election by dual-eligible members is accurate.
2. MassHealth should ensure that the system edits in MMIS for claims for hospice services for dual-eligible members are effective in detecting and rejecting improper claims.

Auditee's Response

EOHHS and MassHealth responded,

EOHHS disagrees with Finding 3a. The audit team provided 10 claims totaling \$2,387 that fall under Audit Finding 3a, in which the auditors' draft findings state that MassHealth paid an estimated \$65,727 for DME that was included in members' plans of care and therefore unnecessary. EOHHS's review of these claims revealed that 3 of the 10 were appropriately paid Medicare Crossover Claims (MassHealth Category 1). The remaining 7 claims fall into MassHealth Category 5 (Claims Payable if Unrelated to Terminal Illness), which would require additional information to determine whether the service was not related to the terminal illness; however, based on all information reviewed to date EOHHS has not identified any inappropriately paid claims. . . .

EOHHS disagrees with Finding 3b. The audit team identified 86 MassHealth non-hospice claims totaling \$21,457 that fall under Audit Finding 3b, in which the auditors assert that MassHealth paid an estimated \$723,640 for DME that should have been included in the members' Medicare hospice plan of care. EOHHS's review of these claims revealed that all 86 claims were appropriately paid as further described above and as categorized as follows:

- *Category 1 (Medicare Crossover Claims): 11 Claims*
- *Category 2 (HCBS Waiver Claims): 2 Claims*
- *Category 3 (State Plan Services Unrelated to Hospice): 22 Claims*

- *Category 5 (Claims Payable if Unrelated to Terminal Illness): 51*

EOHHS further notes that the auditors cite as the basis for Finding 3b that "some hospice providers told us in interviews that regulations and guidance on what DME should be included in plans of care [are] unclear" and the auditors then refer to the "Other Matters" section of the audit in which they cite Medicare guidance on what is covered in the monthly rate Medicare pays to a hospice provider and what is to be included in the Medicare hospice plan of care. As discussed in further detail below in EOHHS's response to the "Other Matters" section of the audit report, to the extent that providers of Medicare covered hospice services have confusion about what is within the scope of the monthly rate Medicare pays to Medicare providers of hospice services, that is a matter more appropriately addressed by Medicare, not EOHHS where EOHHS does not oversee the Medicare program nor establish the rates for Medicare covered hospice services.²⁰

As previously stated in the introduction and EOHHS' response to Audit finding 1, Audit Finding 2 and Audit Finding 3A, Medicare crossover claims, HCBS waiver claims, and claims for state plan services unrelated to hospice are appropriately payable claims. EOHHS therefore disagrees with the auditors' finding that MassHealth paid \$723,640 inappropriately. . . .

EOHHS agrees with [Recommendation 1]. As noted above in the Responses to Audit Recommendations for Finding 1, EOHHS is implementing processes to proactively identify dual-eligible members receiving Medicare covered hospice services who have not simultaneously executed a MassHealth hospice election form. . . .

EOHHS agrees with [Recommendation 2]. As noted above in the Responses to Audit Recommendations for Finding 1, EOHHS is implementing processes to proactively identify dual-eligible members receiving Medicare covered hospice services who have not simultaneously executed a MassHealth hospice election form. This process may result in additional MMIS system edits.

EOHHS further notes that MassHealth currently utilizes an MMIS edit (edit 2018) that effectively detects and rejects claims for MassHealth services related to hospice for all members receiving MassHealth covered Hospice services. Additionally, MassHealth requires a Member's completion of a MassHealth hospice election form as a prerequisite for payment of MassHealth covered hospice services, which effectively ensures that hospice providers providing MassHealth covered hospice services submit the member's MassHealth hospice election form.

Auditor's Reply

Regarding Finding 3a, as noted above, we found that MassHealth paid an estimated \$65,727 in claims for DME that were unnecessary because DME was included in the members' plans of care and therefore should have been paid for by their hospice providers. Although they dispute this finding, EOHHS's own

20. *Additionally, where MassHealth was not paying for the Medicare covered hospice services, to the extent providers of Medicare covered hospice services failed to maintain appropriate plans of care, this is a finding that may be more appropriately directed to Medicare.*

analysis shows that the vast majority of these claims (at least 7 of the 10) should have been paid for by the hospices if the DME was related to the members' terminal illnesses. Since the DME was included in the members' plans of care based on a medical examination performed by the hospices' interdisciplinary groups, it seemed clear to OSA that the DME was related to the members' terminal illnesses and therefore should have been paid for by the hospices, not MassHealth. Further, MassHealth is not required to pay crossover claims for DME that is already included in a member's plan of care; they should be paid for by the hospice provider.

Regarding Finding 3b, MassHealth also paid an estimated \$723,640 for DME²¹ that should have been, but was not, included in the members' plans of care. As noted in our report, CMS's position, as stated in *Federal Register* 83, No. 89 (2018), is that "virtually all" care needed by a member should be provided by the hospice. Further, CMS states in *Federal Register* 84, No. 151 (2019), that services that are unrelated to a terminal illness should be "exceptional, unusual and rare" given the breadth of services that the Medicare hospice benefit allows. The DME claims in question were for items that were necessary for members' wellbeing while they were receiving the hospice benefit, so we believe that according to CMS guidance, the items should have been included in the members' plans of care and paid for by the hospices. In their response, EOHHS suggests that it should pay for claims that Medicare has expressly stated should be paid for by hospices or by Medicare. This statement directly conflicts with 130 CMR 450.316 which states that MassHealth must be the payer of last resort.

Based on its response, EOHHS is taking measures to address our concerns on this matter.

4. MassHealth unnecessarily paid for ambulance and inpatient services for dual-eligible members.

During our audit period, MassHealth unnecessarily paid as much as \$203,135 for ambulance and inpatient services for dual-eligible members without the members' hospice providers' knowledge that these services had been provided.²² The non-hospice providers billed MassHealth directly instead of billing the members' hospice providers. Consequently, the hospice providers did not have the chance to review the claims and determine who was responsible for paying them. In 63 of 100 sampled claims for ambulance transportation for dual-eligible hospice members, MassHealth paid for the transportation

21. We are 90% confident that the lower limit for DME is \$665,146 and the upper limit is \$782,134.

22. The dollar amount represents the sum from two of our sample types: inpatient and transportation. The inpatient sample totaled \$28,497, and the transportation sample totaled \$174,638. We are 90% confident that the lower limit for inpatient services is \$15,123 and the upper limit is \$41,871, and we are 90% confident that the lower limit for transportation services is \$152,258 and the upper limit is \$197,019.

without the hospice provider reviewing the claim and determining who should have paid for the service: the hospice provider, MassHealth, or Medicare.²³ Similarly, in 7 of 100 sampled claims for inpatient services for dual-eligible hospice members, MassHealth paid for the services without the hospice providers reviewing the claim. During our audit, we reviewed some of the claims with the applicable hospice providers, and hospice provider personnel indicated that the providers would probably have paid them. MassHealth could have used this money to provide additional services to other MassHealth members.

Authoritative Guidance

According to 42 CFR 418.56(e), hospice providers must “[maintain] responsibility for directing, coordinating, and supervising the care and services provided.” Effective coordination of services would include ensuring proper billing.

Further, 130 CMR 437.421(D)(3) requires hospice providers to pay providers for services that are included in members’ plans of care:

The hospice is responsible for paying contract personnel who have provided hospice-approved services according to the member’s plan of care.

To comply with this regulation, hospice providers must be able to review each claim and determine whether they should pay for the services provided.

Section 40.1.9 of CMS’s *Medicare Benefit Policy Manual* states,

Ambulance transports of a hospice patient, which are related to the terminal illness and which occur after the effective date of election, are the responsibility of the hospice.

In addition, the CMS document *Medicare Learning Network: Official CMS Information for Medicare Fee-for-Service Providers* states that Medicare may pay for the following type of ambulance transportation:

Covered care in an emergency room, hospital, or other inpatient facility; outpatient services; or ambulance transportation, unless these services are either arranged by the Hospice or are unrelated to the terminal illness.

23. In some instances, Medicare directly pays for ambulance transportation that is not paid for by the hospice provider if the transportation was not arranged by the hospice (e.g., if it was requested by a family member).

Reasons for Issue

MassHealth did not ensure that its hospice providers explained to the members and their families that the members and families were required to inform any non-hospice providers that the members had elected the hospice benefit to ensure service coordination and billing. Some hospice providers told us that, in many instances, members' relatives requested the services without the hospice providers' knowledge and consent. As a result, the non-hospice providers submitted their claims directly to MassHealth instead of to the hospice providers. In addition, MassHealth's claim processing system, MMIS, does not have system edits in place to ensure that these claims are properly denied and that non-hospice providers bill hospice providers directly.

Recommendations

1. MassHealth should ensure that its hospice providers explain to its members and their families that the members and families are required to inform any non-hospice providers that the members have elected the hospice benefit to ensure service coordination and billing.
2. MassHealth should ensure that the system edits in MMIS for claims for hospice services for dual-eligible members are effective in detecting and denying improper claims.

Auditee's Response

EOHHS and MassHealth responded,

EOHHS disagrees with Finding 4. The audit team provided 73 claims totaling \$26,037 that fall under Audit Finding 4. EOHHS's review of these claims revealed that 12 of the 73 claims were appropriately paid Medicare Crossover Claims for transportation and acute inpatient hospital services (MassHealth Category 1), and the remaining 61 claims were appropriately paid claims for non-emergency medical transportation provided under an HCBS waiver service (MassHealth Category 2) or as a State Plan service unrelated to hospice (MassHealth Category 3). Accordingly, EOHHS disagrees with the auditors' finding that MassHealth made \$203,135 in unnecessary payments, as MassHealth's analysis of the 73 claims at issue revealed \$0 in improper payments. . . .

EOHHS agrees with [Recommendation 1]. EOHHS will continue to provide education to MassHealth enrolled hospice providers on their responsibilities to provide education to members and their families when providing services to dual-eligible members. In particular, EOHHS will continue to provide clarification that even when such providers are providing Medicare covered hospice services, they still have a responsibility to require the dual-eligible member to complete a MassHealth hospice election form waiving their right to receive other MassHealth covered services for the related to their terminal illness. . . .

EOHHS agrees with [Recommendation 2]. See also EOHHS response to Recommendation 2 to Audits Findings 3a and 3b, above.

Auditor's Reply

Federal regulations require hospices to pay for ambulance transportation that is related to members' terminal illnesses regardless of whether it is emergency transportation. Hospice providers told us that they were unaware that these services had been provided because the non-hospice providers who provided them billed MassHealth directly. Had MassHealth denied these claims, the non-hospice providers would have been required to submit their claims directly to the hospice providers for reimbursement. The hospice providers could then have determined whether the transportation was related to the members' terminal illnesses. EOHHS's analysis indicated that none of the claims was improper, but they did not provide OSA with evidence of how they determined this. As noted above, management at some of the hospices we visited indicated that they would have paid the claims had they been aware that the services had been performed.

Based on its response, EOHHS is taking measures to address our concerns on this matter.

OTHER MATTERS

1. MassHealth should consider requiring its hospice providers to send it plans of care for dual-eligible members.

As previously noted, a dual-eligible member's plan of care describes the types and levels of services that the hospice provider has determined the member needs and that the hospice provider has agreed to provide while the member is in hospice care. Further, under Section 418.24(c) of Title 42 of the Code of Federal Regulations (CFR), effective October 1, 2020, hospice providers are required to develop an addendum to each member's Medicare Hospice Election Form, titled "Patient Notification of Hospice Non-Covered Items, Services, and Drugs," that details what services the hospice has determined are not related to the member's terminal illness and therefore the hospice will not pay for. According to 42 CFR 418.24(c), a hospice must provide this addendum on request to members, non-hospice providers, and/or the Centers for Medicare & Medicaid Services (CMS) within a specific number of days.

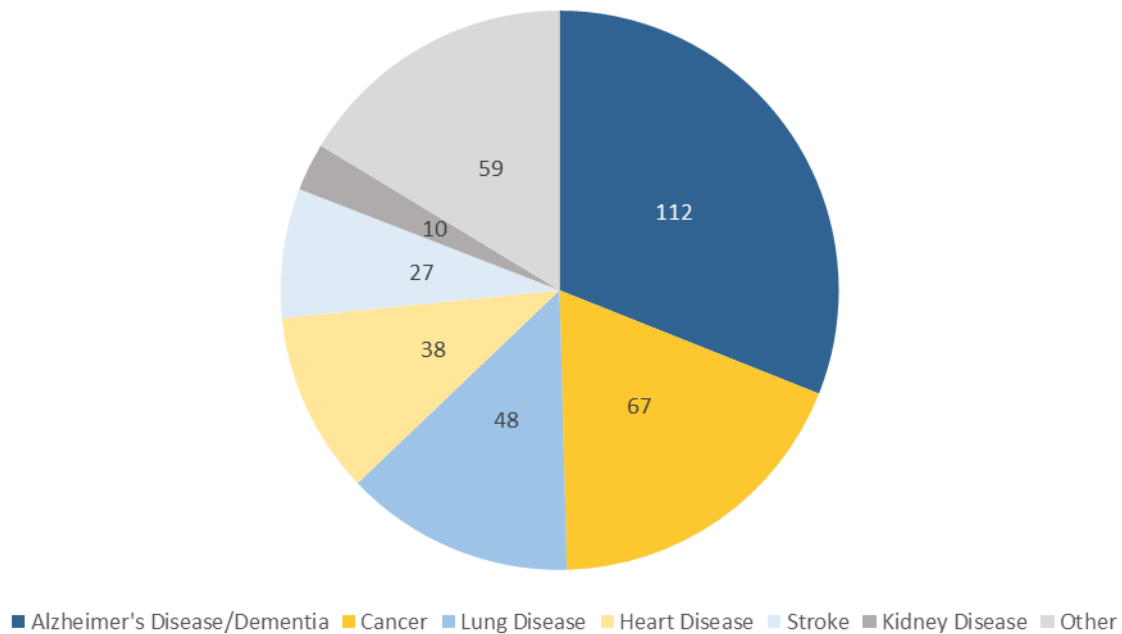
For example, the addendum must contain the following:

5. *A list of the individual's conditions present on hospice admission (or upon plan of care update) and the associated items, services, and drugs not covered by the hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions.*
6. *A written clinical explanation, in language the individual (or representative) can understand, as to why the identified conditions, items, services, and drugs are considered unrelated to the individual's terminal illness and related conditions and not needed for pain or symptom management. This clinical explanation must be accompanied by a general statement that the decision as to whether or not conditions, items, services, and drugs are related is made for each patient and that the individual should share this clinical explanation with other health care providers from which they seek items, services, or drugs unrelated to their terminal illness and related conditions.*

Currently, MassHealth does not require hospice providers to submit to it any plans of care. At least three other state Medicaid departments—those of Nebraska, Nevada, and West Virginia—do require hospice providers to submit their plans of care when members first choose to participate in hospice.

The Office of the State Auditor (OSA) believes that requiring hospice providers to submit plans of care, as well as the information on the addendum required by 42 CFR 418.24(c), would provide MassHealth with information it could use to establish more effective system edits in the Medicaid Management Information System and reduce its risk of improper payments to non-hospice providers. MassHealth could also use this information to monitor services provided to its dual-eligible members who have

chosen to receive hospice services to ensure that they receive all the services included in their plans of care. The chart below details the most common types of primary terminal diagnoses for the total 361 members represented in our sample population of 400 claims. The six most common types of primary terminal diagnosis are shown below; they account for 84% of all primary terminal diagnoses in our sample.



In addition, this information would allow MassHealth to ensure regulatory compliance. For example, as previously noted, 42 CFR 418.200 states,

A plan of care must be established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary group of the hospice program. . . . That plan of care must be established before hospice care is provided.

Further, Section 437.422(B) of Title 130 of the Code of Massachusetts Regulations identifies specific requirements for plans of care:

The plan [of care] must include all services necessary for the palliation and management of the terminal illness and related conditions, including the coordination of all in-home supports. The plan of care must be coordinated with any services the member may be authorized to receive from the MassHealth Personal Care Attendant Program and such services may be used only to the extent that the hospice would routinely use the services of a hospice member's family in implementing the plan of care.

Auditee's Response

EOHHS will consider this suggestion.

2. MassHealth should consider providing additional guidance to hospice providers on expenses that can be billed to MassHealth.

During our audit, personnel at many hospice providers we visited told us that the regulatory guidance and other guidance issued by MassHealth and CMS are unclear as to who is responsible for paying for certain goods and services for dual-eligible members in hospice. For instance, hospice providers told us they found the following regulations unclear:

- According to 42 CFR 418.202, professional services, including home health aides and homemaker services, are covered in the monthly rate Medicare pays to a hospice if they are included in a member's plan of care. However, some hospice providers we visited stated that this regulation could be clearer regarding how much of a service should be provided to a member. Specifically, some hospice providers told us they believed they were responsible for providing as many hours of professional services as were specified in the members' plans of care. In contrast, other hospice providers stated that they believed the hospice benefit should only cover a specific number of hours per week as determined by the hospice and that that was what they included in plans of care. One hospice provider stated that one of its members revoked the hospice benefit with that provider and went to a different one that offered more home health aide services.
- According to 42 CFR 418.202(f), durable medical equipment (DME) is covered in the monthly rate Medicare pays to a hospice if it is included in a member's plan of care. During our interviews of staff members at the 59 hospice providers we visited, many staff members indicated that in their opinion, both federal and state regulations were unclear as to who should pay for some DME. One example of this was whether products used to treat incontinence should be considered related to members' terminal illnesses and therefore paid for by the hospice, not MassHealth. Some hospice personnel told us they paid for incontinence products for dual-eligible members and always included these items in the plans of care. Others indicated that they did not pay for incontinence products because they believed they were a "custodial product" and not included in the per diem rate the providers received from Medicare, so they did not include the products in plans of care. Others stated that they only included incontinence products in a member's plan of care if the member lived at home, since nursing facilities and group homes pay for such products. Finally, some stated that they only included some incontinence products in plans of care, such as those that were reusable, not disposable.

Hospice providers can contact MassHealth and CMS with questions about what services should be included in dual-eligible members' plans of care. In our interviews, many hospice providers stated that the regulations were unclear and they did not contact MassHealth or CMS for guidance. Therefore, OSA believes MassHealth should consider collaborating with CMS and providing additional guidance to

address the issues detailed above. We believe this would better ensure consistency in the provision of the goods and services in question and minimize the possibility of improper billing for them.

Auditee's Response

The auditors in providing this suggestion, cite to Federal Medicare regulations for Hospice at 42 CFR 418.202 that state that home health aide and homemaker services are included in the monthly rate that Medicare pays to a hospice provider and note that "some hospice providers we visited stated that this regulation could be clearer regarding how much of a service should be provided to a member." Elsewhere in the audit report, the auditors cite CMS guidance on the scope of Medicare covered hospice services and state that CMS intends Medicare covered hospice services to cover "virtually all" Medicare services. . . . EOHHS notes that Medicare and Medicaid are separate benefit programs with a different scope of covered services (e.g. Medicare does not cover Medicaid 1915[c] HCBS waiver services nor many of the Medicaid services that provide long term supports, such as Adult Foster Care services). To the extent hospice providers of Medicare covered hospice services find that CMS regulations on the scope of Medicare hospice need clarification, it is unclear how EOHHS could appropriately provide such clarification, where EOHHS does not oversee the Medicare hospice program nor pay for Medicare covered hospice services.

Auditor's Reply

OSA recognizes that Medicare and Medicaid are separate benefit programs, but hospice program services are related: dual-eligible members are entitled to receive benefits under both programs, and all services, including those paid for by Medicaid and Medicare (MassHealth), must be coordinated by members' hospice providers. Therefore, OSA believes it is important that hospice providers fully understand the types and levels of benefits that need to be included in members' plans of care so that MassHealth is not improperly billed for them. As noted above, management at a number of the hospices we visited stated that they would appreciate more clarity about certain hospice benefits. OSA recognizes that many of the benefits that appear to be unclear to hospice providers are ones that would typically be funded by Medicaid. However, OSA believes that MassHealth would benefit from collaborating with CMS and providing additional guidance, as needed, on federal and state regulations related to hospice benefits. We believe this would better ensure consistency in the provision of the benefits and minimize the possibility of improper billing for them.

APPENDIX

During the audit period, the 59 hospices in our sample provided services to approximately 24,458 MassHealth members and received reimbursement of \$449,259,367, as shown below.

Hospice Provider*	Location	Type	Amount Received	Members Served
Beacon Hospice, an Amedisys Company	Charlestown	For Profit	\$ 47,747,415	2,222
Compassionate Care Hospice, an Amedisys Company	Woburn	For Profit	34,978,504	1,706
CareDimensions	Danvers	Nonprofit	32,968,509	1,799
Hospice Services of Massachusetts	Lakeville	For Profit	29,120,449	1,079
Compassus	North Andover	For Profit	27,020,863	1,159
Seasons Hospice & Palliative Care of MA LLC	Norwood	For Profit	25,737,699	1,082
Fidelis Hospice	Haverhill	For Profit	21,127,620	1,041
Ascend Hospice	Marlborough	For Profit	15,220,580	707
Hospice of Western & Central Massachusetts	Feeding Hills	For Profit	14,757,193	787
Compassionate Care Hospice, an Amedisys Company	Arlington	For Profit	14,682,699	773
Brookhaven Hospice	Westborough	For Profit	13,561,051	596
HospiceCare in the Berkshires	Pittsfield	Nonprofit	11,180,661	755
New England Hospice	Hingham	For Profit	9,271,031	583
Beacon Hospice, an Amedisys Company	Leominster	For Profit	9,018,132	509
Kindred Hospice	Auburndale	For Profit	8,832,411	421
Old Colony Hospice and Palliative Care	West Bridgewater	Nonprofit	8,539,823	623
Compassus	Taunton	For Profit	8,456,797	323
HopeHealth	Brockton	Nonprofit	8,281,330	406
Kindred Hospice	Fall River	For Profit	7,077,413	331
Cranberry Hospice	Plymouth	Nonprofit	6,788,518	382
Good Shepherd Community Care	Newton	Nonprofit	6,421,314	426
Merrimack Valley Hospice House	Lawrence	Nonprofit	6,179,303	601

Hospice Provider*	Location	Type	Amount Received	Members Served
Beacon Hospice, an Amedisys Company	Springfield	For Profit	6,147,579	496
All Care	Lynn	Nonprofit	6,016,643	314
Salmon VNA and Hospice	Leominster	For Profit	4,896,640	405
Broad Reach Hospice Care	North Chatham	For Profit	4,152,826	189
Constellation	Newburyport	For Profit	4,151,848	156
Trinity Hospice	Worcester	For Profit	3,933,388	215
Notre Dame Hospice	Worcester	Nonprofit	3,476,117	295
VNA Care	Worcester	Nonprofit	3,409,083	301
Compassus	Northampton	For Profit	3,407,313	197
AseraCare Hospice, an Amedisys Company	Wellesley Hills	For Profit	3,006,647	190
AccentCare	Auburn	For Profit	2,997,974	329
Hospice of Franklin County	Greenfield	For Profit	2,973,565	329
Hospice of the South Shore	Rockland	Nonprofit	2,962,273	195
Gentiva Hospice	Marlborough	For Profit	2,736,939	146
Chelsea Jewish Lifecare	Chelsea	Nonprofit	2,679,046	135
Chelsea Jewish Hospice and Palliative Care	Chelsea	Nonprofit	2,576,658	135
Baystate Hospice	Milford	Nonprofit	2,455,815	266
Caregroup Parmenter Home Care & Hospice	Watertown	Nonprofit	2,340,232	178
Community Nurse Home Care	Fairhaven	Nonprofit	1,678,502	105
Overlook VNA and Hospice	Charlton	Nonprofit	1,642,812	117
Southcoast Visiting Nurse Association	Fairhaven	Nonprofit	1,540,332	143
VNA of Cape Cod	Hyannis	Nonprofit	1,534,075	135
Hallmark Health VNA and Hospice	Malden	Nonprofit	1,474,362	193
Clifton Hospice Services, LLC	Fall River	For Profit	1,445,192	72
Metrowest Hospice Care, an Amedisys Company	Marlborough	For Profit	1,406,005	128
Cooley Dickinson VNA and Hospice	North Hampton	Nonprofit	1,239,692	179
Holyoke VNA Hospice Life Care	Holyoke	Nonprofit	1,178,470	144
Community VNA	Attleboro	Nonprofit	997,289	71
Mercy Hospice	West Springfield	Nonprofit	949,597	98

Hospice Provider*	Location	Type	Amount Received	Members Served
NVNA and Hospice	Norwell	Nonprofit	777,081	62
HealthAlliance Home Health and Hospice	West Springfield	Nonprofit	567,631	72
GVNA Healthcare, Inc.	Gardner	Nonprofit	426,952	48
Nashoba Nursing Service and Hospice	Shirley	Municipal	367,787	39
Baystate Wing VNA and Hospice	Springfield	Nonprofit	220,480	26
Visiting Nurse and Community Health	Westwood	Nonprofit	202,714	3
First Choice Healthcare	Brookline	For Profit	192,180	18
Middlesex-East Visiting Nurse Hospice	Woburn	Nonprofit	128,313	23
Total			<u>\$ 449,259,367</u>	<u>24,458</u>

* This column shows the name of each hospice during the audit period. Some hospice names could have changed as of the issuance date of this report.