Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ILLINOIS DID NOT ALWAYS PROPERLY CLAIM MEDICAID REIMBURSEMENT FOR HOSPICE CLAIMS

Inquiries about this report may be addressed to the Office of Public Affairs at
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Regional Inspector General

September 2013
A-05-12-00029

Office of Inspector General
https://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

Illinois did not always properly claim Federal Medicaid reimbursement for hospice claims.

WHY WE DID THIS REVIEW

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

The objective of this review was to determine whether Illinois properly claimed Federal Medicaid reimbursement for hospice claims submitted by hospices in Illinois.

BACKGROUND

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

In Illinois, the Department of Healthcare and Family Services (the State agency) administers its Medicaid program in accordance with the Centers for Medicare & Medicaid Services (CMS) approved State plan. The State plan establishes what services the Medicaid program will cover including hospice care. To be eligible to elect hospice care under the Medicaid program, an individual must be certified by a physician as terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less. If an individual elects to receive hospice care, he or she must file an election statement with a particular hospice.

For hospice services to be covered under Medicaid, services must be provided in accordance with the *State Medicaid Manual* (the Manual) issued by CMS. The Manual specifies the requirements for: proper pricing procedures, physician certification, the use of licensed and qualified workers, provider reimbursement at the proper amount and level of care, and election statement content.

HOW WE CONDUCTED THIS REVIEW

We limited our review to Medicaid hospice claims of $100 or more paid to Illinois hospices during the 2-year period January 1, 2009, through December 31, 2010. From a total of 56,044 hospice claims totaling approximately $143 million ($88 million Federal share), we reviewed a random sample of 120 hospice claims totaling $258,803 ($159,112 Federal share) from 42 Illinois hospices. A claim represented the Medicaid costs for room and board, or hospice care services, or both, paid for one beneficiary during the month.

WHAT WE FOUND

The State agency did not always properly claim Federal Medicaid reimbursement for hospice claims. Of the 120 sampled claims, the State agency properly claimed Federal Medicaid reimbursement for 97 claims. The State agency did not properly claim Federal Medicaid reimbursement for the 23 remaining claims (1 claim contained 2 errors). However, the unallowable dollar amounts related to these 23 claims are immaterial.

For the 23 improper claims, the:

- State agency did not ensure patient credits applied to claims were correct or adjusted when necessary (11 claims),
- State agency did not ensure claims were priced correctly or adjusted when necessary (10 claims),
- hospice did not meet physician certification requirements (1 claim),
- hospice allowed a potentially unqualified worker to perform hospice services (1 claim), and
- hospice claimed the incorrect amount and level of service (1 claim).

In addition, hospices did not always meet election statement requirements. Of the 120 claims reviewed, hospices met the election statement requirements for 68 claims. Hospices did not meet the election statement requirements for the remaining 52 claims. For these claims, the:

- hospices did not ensure election statements contained required language (50 claims), and
- hospices did not retain the election statements (2 claims).

The improper claims and election statement deficiencies occurred because the State agency did not always ensure that claims were processed correctly and adjusted when necessary, and did not adequately monitor hospices for compliance with Federal and State requirements. In addition, the State agency did not have a uniform election statement for use state-wide by all hospices.

WHAT WE RECOMMEND

We recommend that the State agency:

- ensure that hospice claims are processed correctly, and adjusted when necessary, to meet Medicaid reimbursement requirements;
- monitor hospices to ensure that Federal and State requirements are met with regard to physician certification, the use of qualified workers, and election statement content and retention; and

- consider establishing a uniform election statement to be used state-wide by all hospices to ensure that all required language is included in the statement.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our findings and described actions that it has taken to address our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

Hospice care is a program of palliative care that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family. The goal of such care is to achieve the highest quality of life as defined by the patient and his or her family through the relief of suffering and control of symptoms. Previous Office of Inspector General reviews found that States did not always comply with Federal and State requirements for hospice claims.[1]

OBJECTIVE

Our objective was to determine whether Illinois properly claimed Federal Medicaid reimbursement for hospice claims submitted by hospices in Illinois.

BACKGROUND

The Medicaid Program: How It Is Administered and What Hospice Services It Covers

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. In Illinois, the Department of Healthcare and Family Services (the State agency) administers its Medicaid program in accordance with the CMS-approved State plan. The State plan establishes what services the Medicaid program will cover including hospice care when it is provided by a licensed hospice.

Hospices Provide Care to Terminally Ill Patients and Patient Eligibility

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

A Medicaid participating hospice meets the Medicare conditions of participation for hospices and has a valid provider agreement. To be eligible to elect hospice care under the Medicaid program, an individual must be certified by a physician as terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course. If an individual elects to receive hospice care, he or she must file an election statement with a particular hospice.

[1] U.S Department of Health and Human Services, Office of Inspector General, report number A-01-10-00004 entitled *Review of Medicaid Hospice Payments Made by Massachusetts for State Fiscal Years 2007 and 2008,* issued February 18, 2011; A-01-10-00012 entitled *Review of Medicaid Hospice Payments to Evercare Hospice & Palliative Care for State Fiscal Years 2007 Through 2009,* issued September 23, 2011; A-01-11-00005 entitled *Rhode Island Did Not Always Comply With State Requirements on Medicaid Payments for Hospice Services,* issued March 26, 2012; and A-01-12-00002 entitled *Rhode Island Hospice General Inpatient Claims and Payments Did Not Always Meet Federal and State Requirements,* issued August 13, 2012.

How Hospice Care Services Are Reimbursed Under the Medicaid Program

A hospice is reimbursed for each day that an individual is under its care based on the type and intensity of the services, or level of care furnished to the individual for that day. The different levels of care include, but are not limited to, continuous home care and routine home care.

For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the individual for that day. A minimum of 8 hours per day must be provided. Routine home care is paid without regard to the volume and intensity of services provided on any given day. A hospice is paid at the routine home care rate for each day that an individual is under its care and does not qualify at another rate.

When hospice care is furnished to an individual residing in a nursing facility, the hospice is paid an additional amount to take into account the expense of the room and board furnished by the facility. The amount that the hospice is paid is equal to ninety-five percent (95%) of the State agency's calculated per diem rate for basic care at that nursing facility, minus any applicable patient income. States are required to reduce payments to a hospice for services provided to certain Medicaid-eligible individuals by amounts deducted from an individual's income to pay for medical expenses.[2] In Illinois, this amount is referred to as the patient credit.

For hospice services to be covered under Medicaid, services must be provided in accordance with the *State Medicaid Manual* (the Manual) issued by CMS. The Manual specifies the requirements for: proper pricing procedures, physician certification, the use of licensed and qualified workers, provider reimbursement at the proper amount and level of care, and election statement content.

HOW WE CONDUCTED THIS REVIEW

We limited our review to Medicaid hospice claims of $100 or more paid to Illinois hospices during the 2-year period January 1, 2009, through December 31, 2010. From a total of 56,044 hospice claims totaling approximately $143 million ($88 million Federal share), we reviewed a random sample of 120 hospice claims totaling $258,803 ($159,112 Federal share) from 42 Illinois hospices. A claim represented the Medicaid costs for room and board, or hospice care services, or both, paid for one beneficiary during the month.

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.

[2] The amount deducted from each individual's income is based on the individual's total income, a personal needs allowance, and other considerations specified in regulation 42 CFR § 435.832.

Appendix A contains the details of our audit scope and methodology. Appendix B contains excerpts from the Manual detailing, among other things, the content requirements for the election statement.

FINDINGS

The State agency did not always properly claim Federal Medicaid reimbursement for hospice claims. Of the 120 sampled claims, the State agency properly claimed Federal Medicaid reimbursement for 97 claims. The State agency did not properly claim Federal Medicaid reimbursement for the 23 remaining claims.[3] However, the unallowable dollar amounts related to these 23 claims are immaterial.

For the 23 improper claims, the:

- State agency did not ensure patient credits applied to claims were correct or adjusted when necessary (11 claims),
- State agency did not ensure claims were priced correctly or adjusted when necessary (10 claims),[4]
- hospice did not meet the physician certification requirements (1 claim),
- hospice allowed a potentially unqualified worker to perform hospice services (1 claim), and
- hospice claimed the incorrect amount and level of service (1 claim).

In addition, hospices did not always meet election statement requirements. Of the 120 claims reviewed, hospices met the election statement requirements for 68 claims. Hospices did not meet the election statement requirements for the remaining 52 claims. For these claims, the:

- hospices did not ensure election statements contained required language (50 claims), and
- hospices did not retain the election statements (2 claims).

The improper claims and election statement deficiencies occurred because the State agency did not always ensure that claims were processed correctly and adjusted when necessary, and did not adequately monitor hospices for compliance with Federal and State requirements. In addition, the State agency did not have a uniform election statement for use state-wide by all hospices.

[3] One claim contained two errors; the State agency did not ensure the claim was priced correctly and the hospice allowed a potentially unqualified worker to perform hospice services.

[4] The State agency corrected 8 of these 10 errors during the course of our review.

STATE AGENCY DID NOT ENSURE PATIENT CREDITS APPLIED TO CLAIMS WERE CORRECT OR ADJUSTED WHEN NECESSARY

For 11 claims, patient credits applied to the room and board portion of the claims were either not correct, or not adjusted when there was a retroactive change in the patient credit amount. The State agency provided us with the patient credits for these 11 claims. We limited our review to determining whether the credits were properly applied. We did not verify whether patient credit amounts were computed correctly. These errors occurred due to weaknesses in the State agency's claims processing system and the State agency's policies. Specifically, the claims processing system did not always correctly identify the amount of patient credit that had already been applied. In addition, the State agency's policies did not ensure that claims were adjusted after a retroactive change in the patient credit amount.

STATE AGENCY DID NOT ENSURE CLAIMS WERE PRICED CORRECTLY OR ADJUSTED WHEN NECESSARY

For 8 claims, the State agency used the wage index initially published for Federal fiscal year (FFY) 2009 when pricing hospice claims, rather than using the revised wage index for FFY 2009. The wage index was recomputed to comply with provisions of the American Reinvestment and Recovery Tax Act. The Manual specifies that hospice claims must be priced using the appropriate wage index, adjusted for urban or rural wage differences.[5] Prior to our review, the State identified these errors and subsequently corrected these errors in June 2012 while we were performing our fieldwork.

For 2 claims, the State agency did not ensure adjustments were made when nursing facility per diem rates changed retroactively. The State agency sets the nursing facility rates based in part on data provided by the facility. When the new rates are established, the State agency may set an earlier effective date. For both of the claims, a retroactive rate was established after the claim was processed; however, these claims were not adjusted to reflect that change.

HOSPICE DID NOT MEET PHYSICIAN CERTIFICATION REQUIREMENTS

For 1 claim, the initial physician's certification that the individual was terminally ill was obtained verbally within the required 2 calendar days of the initiation of hospice care. However, the physician's corresponding written certification of the individual's terminal illness was not obtained until 12 calendar days after the initiation of hospice care, which is 4 days after the required certification timeline of 8 calendar days[6] when a verbal order is first obtained.

[5] State Medicaid Manual §§ 4306.3, 4306.4

[6] State Medicaid Manual § 4305.1, see Appendix B

HOSPICE ALLOWED A POTENTIALLY UNQUALIFIED WORKER TO PERFORM HOSPICE SERVICES

For 1 claim, hospice services were provided by a home health aide (HHA) who was potentially unqualified. The individual was an employee of a hospice that was subsequently sold. We attempted to locate the employee's personnel file to determine the HHA's qualifications, from both the former and current hospice as well as with the help of the State agency, but were unable to do so. We were also unable to locate the individual on the State's Healthcare Worker Registry of qualified individuals. All hospice services must be performed by appropriately qualified hospice personnel.[7]

HOSPICE CLAIMED INCORRECT AMOUNT AND LEVEL OF SERVICE

For 1 claim, an incorrect amount and level of service was claimed. The hospice claimed 24 hours of continuous home care for what our review determined was 21 hours of service at the routine home care level.

For each day an individual is under the care of a hospice, payment is based on the type and intensity of the services furnished to the individual for that day. For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the beneficiary on that day. Continuous home care is to be provided only during a period of crises, in which the patient primarily requires nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and one or both of them must provide care for more than half of the period of care.[8]

Service documentation for the day showed that care was provided by 4 individuals including 3 licensed practical nurses and 1 certified nursing assistant. The combined hours of care by the licensed practical nurses was less than half of the 21 hours of care provided. The services, therefore, do not qualify as continuous home care and should have been claimed instead at the routine home care level.

HOSPICES DID NOT ENSURE ELECTION STATEMENTS CONTAINED REQUIRED LANGUAGE

For 50 claims, hospices did not meet the election statement requirements of the Manual,[9] as follows:

[7] State Medicaid Manual § 4305.5

[8] State Medicaid Manual § 4305.6

[9] Of the 50 claims that did not meet election statement requirements, 11 contained more than one deficiency.

- For 50 claims, the hospice election statements did not include a waiver of all rights to Medicaid payments for hospice care provided by a hospice other than the hospice designated by the individual.[10]

- For 10 claims, the hospice election statements did not include a waiver of all rights to Medicaid payments for services related to the treatment of the terminal condition or a related condition for which hospice care was elected or services equivalent to hospice care.[11]

- For 2 claims, the hospice election statements did not include the individual's acknowledgement that he or she had been given a full understanding of hospice care as an alternative to traditional covered Medicaid services.[12]

Election statement content varied from one hospice to another. The State agency does not have a uniform election statement used state-wide, which, if adopted, would ensure the required language is included in the election statements.[13]

HOSPICES DID NOT RETAIN ELECTION STATEMENTS

For 2 claims, the hospices could not provide an election statement for the beneficiary. If an individual elects to receive hospice care, he or she must file an election statement with a particular hospice.[14]

RECOMMENDATIONS

We recommend that the State agency:

- ensure that hospice claims are processed correctly, and adjusted when necessary, to meet Medicaid reimbursement requirements;

- monitor hospices to ensure that Federal and State requirements are met with regard to physician certification, the use of qualified workers, and election statement content and retention; and

- consider establishing a uniform election statement to be used state-wide by all hospices to ensure that all required language is included in the statement.

[10] State Medicaid Manual § 4305.2, see Appendix B

[11] State Medicaid Manual § 4305.2, see Appendix B

[12] State Medicaid Manual § 4305.3, see Appendix B

[13] States with uniform election statements include, but are not limited to, Connecticut, Florida, Mississippi, Missouri, and New Jersey.

[14] State Medicaid Manual § 4305.2, see Appendix B

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our findings and described actions that it has taken to address our recommendations. The State agency's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We limited our review to Medicaid payments made by the State agency to hospice providers for hospice care provided to Medicaid beneficiaries as authorized under the State plan for the audit period. We excluded claims in which the paid amount was less than $100.[15]

After taking into account the exclusions above, we determined that the State processed and paid 56,044 Medicaid hospice claims totaling $142,972,076 ($87,817,445 Federal share) for hospice care provided from January 1, 2009, through December 31, 2010. We reviewed a random sample of 120 claims.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we limited our internal control review to the objective of our audit.

We conducted fieldwork at 42 individual hospices around the State of Illinois.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- held discussions with State agency officials to gain an understanding of the State agency's hospice care program;
- obtained Medicaid paid claims for service dates from January 1, 2009, through December 31, 2010, from the State agency;
- identified a sampling frame of 56,044 hospice claims, totaling $142,972,076 ($87,817,445 Federal share); and
- selected a random sample of 120 hospice claims from our sampling frame, and for each claim, obtained and reviewed the related hospice documentation to determine whether hospice care was provided in accordance with Federal and State requirements.

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.

[15] A claim represented the Medicaid costs for room and board or hospice care services, or both, paid for one beneficiary during the month.

APPENDIX B: FEDERAL AND STATE REQUIREMENTS FOR HOSPICE CARE

PHYSICIAN CERTIFICATION REQUIREMENTS

Pursuant to the Manual Part 4305, in order to be eligible to elect hospice care under Medicaid, an individual must be certified by a physician as terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less.

Pursuant to the Manual section 4305.1, the hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures:

> For the first period of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician (if the individual has an attending physician).
>
> If the hospice does not obtain a written certification within two days after the initiation of hospice care, a verbal certification may be obtained within these 2 days, and a written certification obtained no later than 8 days after care is initiated. If these requirements are not met, no payment can be made for days prior to the certification. The attending physician is a physician who is a doctor of medicine or osteopathy and is identified by the individual at the time he or she elects to receive hospice care as having the most significant role in the determination and delivery of the individual's medical care.
>
> For any subsequent period, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six months or less if the terminal illness runs its normal course and the signature(s) of the physician(s). The hospice must retain the certification statements.

ELECTION STATEMENT CONTENT REQUIREMENTS

Pursuant to section 4305.4 of the Manual, to be covered, a certification that the individual is terminally ill must have been completed as set forth in § 4305.1 and hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care in accordance with § 4305.2….

Pursuant to section 4305.2 of the Manual, if an individual elects to receive hospice care, he or she must file an election statement with a particular hospice. An election may also be filed by a representative acting pursuant to State law. With respect to an individual granted the power of

attorney for the patient, State law determines the extent to which the individual may act on the patient's behalf.

Pursuant to section 4305.3 of the Manual, the election statement must include the following items of information: identification of the particular hospice that will provide care to the individual; the individual's or representative's acknowledgement that he or she has been given a full understanding of hospice care; the individual's or representative's acknowledgement that he or she understands that the Medicaid services listed in § 4305.2 are waived by the election; the effective date of the election; and, the signature of the individual or representative.

The services that must be waived pursuant to section 4305.2 are:

- Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice); and

- Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services—

    - Provided (either directly or under arrangement) by the designated hospice;

    - Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services; or

    - Provided as room and board by a nursing facility if the individual is a resident.

APPENDIX C: STATE AGENCY COMMENTS

ILLINOIS DEPARTMENT OF Healthcare and Family Services

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August 30, 2013

Department of Health and Human Services
Office of Audit Services, Region V
Attn: Sheri L. Fulcher, Regional Inspector General for Audit Services
233 North Michigan Avenue, Suite 1360
Chicago, Illinois 60601

Re: Draft Audit Report A-05-12-00029

Dear Ms. Fulcher:

Thank you for providing the opportunity to comment on your draft audit report entitled *"Illinois Did Not Always Properly Claim Medical Reimbursement for Hospice Claims"*.

The Department concurs with the recommendation. The Department has corrected the claims noted during the course of the audit and has requested a revision to its system to consider alternate and exceptional care rates for hospice pricing. A new Integrated Eligibility System will allow eligibility changes to be made automatically; implementation is anticipated in 2016. The Department has also revised our Hospice election form to include appropriate language. HFS is developing a Hospice Handbook which will state hospices must ensure employment files contain appropriate credentials, active employees be listed on the Department of Public Health's Health Care Worker Registry and employee files must be retained. Hospice inspections and investigations are performed by the Department of Public Health, as established by Administrative Rule, to ensure compliance with the Hospice Program Licensing Act.

We appreciate the work completed by your audit team. If you have any questions or comments about our response to the audit, please contact Amy Lyons, External Audit Liaison, at (217) 557-0576 or through email at amy.lyons@illinois.gov.

Sincerely,

Julie Hamos
Director

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