Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

COLORADO IMPROPERLY CLAIMED SOME MEDICAID COSTS FOR HOSPICE SERVICES PROVIDED BY EVERCARE HOSPICE AND PALLIATIVE CARE

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Patrick J. Cogley
Regional Inspector General

October 2013
A-07-13-04204

Office of Inspector General

https://oig.hhs.gov/

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EXECUTIVE SUMMARY

Colorado claimed an estimated $75,151 in unallowable Federal reimbursement for Medicaid hospice services provided by Evercare Hospice during the period October 1, 2009, through September 30, 2011.

WHY WE DID THIS REVIEW

A hospice is a public agency, private organization, or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. When hospice care is furnished to a Medicaid recipient residing in a nursing facility, hospice and nursing facility providers enter into a written agreement under which the hospice provider takes full responsibility for the professional management of the recipient's hospice services while the nursing facility provider agrees to provide room and board. Under such an agreement, the hospice bills the State Medicaid agency for nursing facility room and board costs on behalf of a Medicaid recipient. When the State Medicaid agency reimburses the hospice for those costs, the hospice then passes those payments through to the recipient's nursing facility. Previous Office of Inspector General reviews found that State Medicaid agencies, when reimbursing hospice providers for nursing facility room and board claims, did not always use correct per diem rates, reimburse payments at the required 95-percent room and board per diem rate, or reduce payments by Medicaid recipients' financial contributions.

The objective of this review was to determine whether the Colorado Department of Health Care Policy and Financing's (State agency's) claimed costs for hospice services provided by Evercare Hospice & Palliative Care (Evercare) were in accordance with Federal and State requirements during the period October 1, 2009, through September 30, 2011.

BACKGROUND

In Colorado, the State agency is responsible for administering the Medicaid program. The Social Security Act (the Act) gives State Medicaid agencies the option of offering hospice care as a benefit to eligible Medicaid recipients. Federal regulations require the State agency to reduce Medicaid payments to hospice providers by using certain additional financial resources of recipients. In addition, the State agency must reimburse hospice providers at 95 percent of the room and board per diem rate that the State agency would have paid to nursing facility providers for recipients in nursing facilities who are not receiving hospice care. Additionally, the State agency reimburses hospice providers at defined care-level rates for the types of hospice care they provide to recipients and at a per diem rate for room and board provided by a nursing facility. Further, the Act requires that Medicaid payments to States be increased to the extent of any underpayment for which an adjustment has not already been made.

Evercare is a national hospice provider whose home office is in Eden Prairie, Minnesota, and that provides hospice care to Medicaid recipients and other individuals facing serious or terminal illness.

The State agency made hospice payments to Evercare totaling $10,686,175 ($6,417,820 Federal share) during the period October 1, 2009, through September 30, 2011.

WHAT WE FOUND

The State agency did not always claim costs for hospice services provided by Evercare in accordance with Federal and State requirements. Specifically, claimed costs associated with 55 of the 100 recipient months in our statistical sample were unallowable for the following reasons:

- the State agency did not reduce payments for hospice services by the amount of recipients' financial contributions (19 recipient months) resulting in overpayments totaling $20,437 ($12,503 Federal share);

- the State agency did not reduce its payments to 95 percent of the room and board per diem rate (2 recipient months) resulting in overpayments totaling $273 ($168 Federal share); and

- the State agency did not use correct rates when making room and board per diem rate adjustment payments for hospice claims (34 recipient months) resulting in underpayments totaling $4,602 ($2,834 Federal share).

(A recipient month could contain either single or multiple claims for hospice services within that month.)

Claimed costs associated with these 55 recipient months totaled $16,108 ($9,837 Federal share) in net overpayments.

For the remaining 45 recipient months in our sample, the State agency claimed costs in accordance with Federal and State requirements.

Based on the results of our statistical sample, we estimated that the State agency incorrectly reimbursed Evercare at least $123,853 ($75,151 Federal share) for the period October 1, 2009, through September 30, 2011, and incorrectly claimed these costs for Federal reimbursement. The net overpayments occurred because the State agency's claims processing system did not have adequate computer edits and other internal controls to always ensure that the State agency correctly claimed costs for hospice services provided under the Medicaid program.

WHAT WE RECOMMEND

We recommend that the State agency:

- recoup $75,151 from Evercare and refund this amount to the Federal Government and

- develop and implement enhanced internal controls, such as computer edits, to ensure that (1) payments for hospice claims are always reduced by recipient financial contributions, (2) room and board per diem is reimbursed at a 95-percent rate, and (3) correct room and board per diem rate adjustment payments are made.

EVERCARE COMMENTS AND OUR RESPONSE

In written comments on our draft report, Evercare said that it did not dispute our findings regarding the 100 recipient months in our statistical sample. Evercare added, however, that in its judgment our statistical estimation did not account for room and board positive offsets (i.e., underpayments) from the State agency. Evercare also asked that we add language to our report regarding the flow of information and payments—to include retroactive payments—between the State agency and hospice providers.

Contrary to Evercare's statement, our statistical estimation took State agency room and board underpayments and other positive offsets into account. We maintain that our statistical estimation was correct and that all of our findings and recommendations remain valid.

With respect to the added language that Evercare requested, we believe that these issues bear, not on our review, but rather on the relationship between Evercare and the State agency, and as such would be more appropriately directed to the State agency.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency partially concurred with our recommendations. For our first recommendation, the State agency said that it agreed with most of our audit findings. The State agency added, however, that it could not verify the overpayment amount that we had determined but said that it would work with CMS to determine the correct overpayment amount, perform the appropriate recovery, and refund the Federal Government the Federal share of any overpayment.

The State agency concurred with our second recommendation and described corrective actions that it had taken or would take.

Our draft report included another finding and associated recommendation that related to incorrect care-level rate amounts. The State agency disagreed with this finding, saying that it paid the claims correctly because it pays the lower of the amount calculated using predefined rates or the billed amount.

After reviewing the State agency's comments, we removed the finding and associated recommendation related to incorrect care-level rates, which totaled $23 (Federal share) in underpayments. As a result, our estimate of the incorrect reimbursement increased by $404 (Federal share), and we revised the associated recommendation accordingly.

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INTRODUCTION

WHY WE DID THIS REVIEW

A hospice is a public agency, private organization, or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. When hospice care is furnished to a Medicaid recipient residing in a nursing facility, hospice and nursing facility providers enter into a written agreement under which the hospice provider takes full responsibility for the professional management of the recipient's hospice services while the nursing facility provider agrees to provide room and board. Under such an agreement, the hospice bills the State Medicaid agency for nursing facility room and board costs on behalf of a Medicaid recipient. When the State Medicaid agency reimburses the hospice for those costs, the hospice then passes those payments through to the recipient's nursing facility. Previous Office of Inspector General reviews (Appendix A) found that State Medicaid agencies, when reimbursing hospice providers for nursing facility room and board claims, did not always use correct per diem rates, reimburse payments at the required 95-percent room and board per diem rate, or reduce payments by Medicaid recipients' financial contributions.

OBJECTIVE

Our objective was to determine whether the Colorado Department of Health Care Policy and Financing's (State agency's) claimed costs for hospice services provided by Evercare Hospice & Palliative Care (Evercare) were in accordance with Federal and State requirements during the period October 1, 2009, through September 30, 2011.

BACKGROUND

Medicaid Program

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

States use the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), to report actual Medicaid expenditures for each quarter and CMS uses it to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on the CMS-64 report and its attachments must be actual expenditures and be supported by documentation.

Medicaid Hospice Program

Federal statute gives State Medicaid agencies the option of offering hospice care as a benefit to eligible Medicaid beneficiaries.[1] Medicaid payments for hospice care are made at one of four care-level rates: routine home care, continuous routine home care, inpatient respite care, or general inpatient care.

In addition, hospices will receive a 95-percent payment for the room and board per diem of hospice patients residing in nursing facilities. When the State Medicaid agency reimburses the hospice for those costs, the hospice will then pass those payments through to the recipient's nursing facility. Hospice and nursing facility providers enter into written agreements under which the hospice provider takes full responsibility for the professional management of a recipient's hospice services while the nursing facility provider agrees to provide room and board. Room and board include the provision of a room and meals as well as services such as administering medication, maintaining the cleanliness of the recipient's room, and supervising and assisting recipients in using durable medical equipment. The nursing facility provider bills the hospice provider for room and board provided to a recipient receiving hospice care.

Colorado Medicaid Hospice Program

In Colorado, the State agency is responsible for administering the Medicaid program. The amount that the Federal Government reimburses to the State agency, known as Federal financial participation (FFP) or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on a State's relative per capita income. The State agency's FMAP rates ranged from 50.00 to 61.59 percent during Federal fiscal years 2010 through 2011 (October 1, 2009, through September 30, 2011, our audit period).

Federal regulations require the State agency to reduce Medicaid payments to hospice providers by using certain additional financial resources of recipients. These resources include Social Security or pension income along with health and casualty insurance payments. The State agency must reimburse hospice providers at 95 percent of the room and board per diem rate that the State agency would have paid to nursing facility providers for recipients in a nursing facility who are not receiving hospice care. Additionally, the State agency reimburses hospice providers at defined care-level rates for the types of hospice care they provide to recipients, and at a per diem rate for room and board provided by a nursing facility.

Overpayments to hospice providers can occur if the State agency does not reduce the Medicaid payment by the amount of a recipient's financial contribution. Overpayments can also occur if the State agency reimburses hospice providers above 95 percent of the room and board per diem rate or reimburses them at an incorrect care-level rate. When hospice providers receive overpayments, they must refund all overpayments to the State agency, which in turn must refund the Federal share to CMS on its CMS-64 report.

[1] The Social Security Act (the Act), sections 1902(a)(10)(A), 1905(a), and 1905(a)(18).

Section 1903 of the Act addresses payments to States under the Medicaid program, to include general language about FMAP rates and enhanced rates for certain services. The Act requires that payments be increased to the extent of any underpayment for which an adjustment has not already been made (section 1903(d)(2)(A)).

HOW WE CONDUCTED THIS REVIEW

The State agency made hospice payments to Evercare totaling $10,686,175 ($6,417,820 Federal share) during the period October 1, 2009, through September 30, 2011. Many recipients had some form of income that should have been counted toward their financial contribution. From the total payments made to Evercare by the State agency, we identified 1,653 recipient months, with payments totaling $3,757,325 ($2,254,185 Federal share), as high-risk because these months were not reduced by any recipient financial contributions.[2] From those 1,653 recipient months, we reviewed a simple random sample of 100 recipient months paid for hospice services.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B contains details of our audit scope and methodology and Appendix C contains the details of our statistical sampling methodology.

FINDINGS

The State agency did not always claim costs for hospice services provided by Evercare in accordance with Federal and State requirements. Specifically, claimed costs associated with 55 of the 100 recipient months in our statistical sample were unallowable for the following reasons:

- the State agency did not reduce payments for hospice services by the amount of recipients' financial contributions (19 recipient months) resulting in overpayments totaling $20,437 ($12,503 Federal share);

- the State agency did not reduce its payments to 95 percent of the room and board per diem rate (2 recipient months) resulting in overpayments totaling $273 ($168 Federal share); and

- the State agency did not use correct rates when making room and board per diem rate adjustment payments for hospice claims (34 recipient months) resulting in underpayments totaling $4,602 ($2,834 Federal share).

Claimed costs associated with these 55 recipient months totaled $16,108 ($9,837 Federal share) in net overpayments.

[2] A recipient month could contain either single or multiple claims for hospice services within that month.

For the remaining 45 recipient months in our sample, the State agency claimed costs in accordance with Federal and State requirements.

Based on the results of our statistical sample, we estimated that the State agency incorrectly reimbursed Evercare at least $123,853 ($75,151 Federal share) for the period October 1, 2009, through September 30, 2011, and incorrectly claimed these costs for Federal reimbursement. The net overpayments occurred because the State agency's claims processing system did not have adequate computer edits and other internal controls to always ensure that the State agency correctly claimed costs for hospice services provided under the Medicaid program. Appendix D contains details on our sample results and estimates.

INCORRECT PAYMENT CALCULATION

For 55 of the 100 recipient months in our statistical sample, the State agency did not claim costs for hospice services provided by Evercare in accordance with Federal and State requirements. Claimed costs associated with these 55 recipient months totaled $16,108 ($9,837 Federal share) in net overpayments.

Payments Not Reduced by Recipient Contributions

Federal regulations state that State Medicaid agencies must reduce payments to institutions for services provided to Medicaid-eligible individuals by the amount that remains after adjusting an individual's total income by deductions for clothing and other needs for the individual, by deductions for spousal and family maintenance needs, and by deductions for other considerations (42 CFR § 435.733).

For 19 of the 100 recipient months that we sampled, the State agency did not reduce payments for hospice services by the amount of recipients' financial contributions. The payments not reduced by recipient contributions resulted in overpayments for the 19 recipient months totaling $20,437 ($12,503 Federal share). For example, one claim reimbursement for a recipient's nursing facility room and board was $4,546. The State agency did not reduce the payment by the recipient's monthly $432 financial contribution. The reimbursement for this claim should therefore have been $4,114, which meant that there was a $432 overpayment.

Payment Reductions Not Made

Section 1902(a)(13)(B) of the Act requires hospice per diem rates to equal 95 percent of the rate that would have been paid by a State agency to a nursing facility provider if the recipient had not been receiving hospice care.

For 2 of the 100 recipient months that we sampled, the State agency did not reduce the payment to 95 percent of the per diem rate for hospice room and board claims. Because the correct payment reductions were not made, the provider received overpayments for the 2 recipient months totaling $273 ($168 Federal share). For example, the State agency reimbursed one claim at $2,480.52. However, at the 95-percent rate the claim reimbursement should have been $2,356.49. This claim thus had an overpayment of $124.03.

Incorrect Per Diem Rates

Section 1903 of the Act addresses payments to States under the Medicaid program, to include general language about FMAP rates and enhanced rates for certain services. The Act requires that payments be increased to the extent of any underpayment for which an adjustment has not already been made (section 1903(d)(2)(A)). Therefore, we have included underpayments that were identified during our review.

These underpayments were identified as claims for which the State agency's reimbursements did not use correct nursing facility rates. For 34 of the 100 recipient months that we sampled, the State agency did not use correct rates when making room and board per diem rate adjustment payments for hospice claims. The incorrect per diem rates resulted in underpayments for the 34 recipient months totaling $4,602 ($2,834 Federal share). For example, the State agency reimbursed one nursing facility room and board claim for 30 days at a per diem rate of $210.36 instead of using the rate of $214.73, resulting in an underpayment of $131.10.

INADEQUATE CONTROLS

The net overpayments occurred because the State agency's claims processing system did not have adequate computer edits and other internal controls to ensure that the State agency correctly claimed costs for hospice services provided under the Medicaid program. The State agency's Medicaid Management Information System (MMIS) did not have adequate computer edits to ensure that payments for hospice claims were always reduced by recipient financial contributions, that room and board per diem was reimbursed at a 95-percent rate, and that correct room and board per diem rate adjustment payments were made.

UNALLOWABLE OVERPAYMENTS

Based on the results of our statistical sample, we estimated that the State agency incorrectly reimbursed Evercare at least $123,853 ($75,151 Federal share) for the period October 1, 2009, through September 30, 2011.

RECOMMENDATIONS

We recommend that the State agency:

- recoup $75,151 from Evercare and refund this amount to the Federal Government and

- develop and implement enhanced internal controls, such as computer edits, to ensure that (1) payments for hospice claims are always reduced by recipient financial contributions, (2) room and board per diem is reimbursed at a 95-percent rate, and (3) correct room and board per diem rate adjustment payments are made.

EVERCARE COMMENTS

In written comments on our draft report, Evercare said that it did not dispute our findings regarding the 100 recipient months in our statistical sample. Evercare added, however, that in its judgment our statistical estimation did not account for room and board positive offsets (i.e., underpayments) from the State agency. Evercare also asked that we add language to our report regarding the flow of information and payments—to include retroactive payments—between the State agency and hospice providers.

Evercare's comments are included in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE TO EVERCARE COMMENTS

Our statistical estimation took State agency room and board underpayments and other positive offsets into account. We maintain that our statistical estimation was correct and that all of our findings and recommendations remain valid.

With respect to the added language that Evercare requested, we believe that these issues bear, not on our review, but rather on the relationship between Evercare and the State agency, and as such would be more appropriately directed to the State agency.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency partially concurred with our recommendations. For our first recommendation, the State agency said that it agreed with most of our audit findings. The State agency added, however, that it could not verify the overpayment amount that we had determined but said that it would work with CMS to determine the correct overpayment amount, perform the appropriate recovery, and refund the Federal Government the Federal share of any overpayment.

The State agency concurred with our second recommendation and described corrective actions that it had taken or would take.

Our draft report included another finding and associated recommendation that related to incorrect care-level rate amounts. The State agency disagreed with this finding, saying that it paid the claims correctly because it pays the lower of the amount calculated using predefined rates or the billed amount.

The State agency's comments are included in their entirety as Appendix F.

OFFICE OF INSPECTOR GENERAL RESPONSE TO STATE AGENCY COMMENTS

After reviewing the State agency's comments, we removed the finding and associated recommendation related to incorrect care-level rates, which totaled $23 (Federal share) in

underpayments. As a result, our estimate of the incorrect reimbursement increased by $404 (Federal share), and we revised the associated recommendation accordingly.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

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

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed $10,686,175 ($6,417,820 Federal share) that the State agency claimed for Evercare hospice services in Colorado during the period October 1, 2009, through September 30, 2011. We did not include a focused medical review to determine whether the services were medically necessary.

We did not review the overall internal control structure of the State agency or the Medicaid program. We reviewed only the internal controls that pertained directly to our objective.

We performed fieldwork at Evercare in Denver, Colorado, in August 2012.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal and State hospice and nursing home requirements;
- interviewed officials from CMS, the State agency, and Evercare to gain an understanding of the Colorado hospice program;
- reconciled hospice claims reported on the State agency's CMS-64 reports for Federal fiscal years 2010 through 2011 to the State agency's supporting documentation;
- defined high-risk recipient months as those not containing any recipient financial contributions;
- identified, from the State agency's MMIS file, 1,653 high-risk recipient months totaling $3,757,325 ($2,254,185 Federal share);
- selected a simple random sample (Appendix C) of 100 of the 1,653 recipient months totaling $189,006 ($114,623 Federal share);
- reviewed nursing home billing invoices, remittance advices,[3] and State agency claims data to validate payment information and determine whether the 100 sampled recipient months were correctly reimbursed by the State agency;
- estimated the total overpayments and the Federal share of these overpayments based on our sample results (Appendix D), and

[3] A remittance advice is a notice of payments and adjustments to providers, billers, and suppliers, which may serve as a companion to a claim payment(s) or as an explanation when there is no payment. The remittance advice explains the reimbursement decisions, including the reasons for payments and adjustments of processed claims.

- provided the results of our review to Evercare officials on March 18, 2013.

We assessed the reliability of the hospice claims data provided by the State agency by reconciling it to the applicable CMS-64 report and the State agency's supporting documentation. We determined that the data were sufficiently reliable for the purposes of this review.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of 4,692 recipient months totaling $10,686,175 in hospice services claims submitted for reimbursement by Evercare for the period October 1, 2009, through September 30, 2011 (audit period).

SAMPLING FRAME

The State agency provided us with a Microsoft Access database from its MMIS that contained claims information for the audit period. The State agency's claims data contained eight quarterly tables, which we consolidated into a single table. The total reimbursement to Colorado hospice providers was $82,720,151. The total amount claimed by the State agency for the audit period as hospice benefit expenditures on the CMS-64 report, line 26 (Hospice Benefits), was $82,492,717. There was a difference of $227,434 between total reimbursement to Colorado hospice providers by the State agency and the amount the State agency claimed as expenditures on the CMS-64 report, line 26.[4]

We determined that claims containing zero dollars for patient payments in a recipient month were a higher risk for payment errors, as many recipients had some form of income that should have been counted toward the patient payment. We limited our scope to recipient months in which at least 1 day of hospice service was provided and which had claim reimbursements greater than $140. We developed a sampling frame of 1,653 recipient months, totaling $3,757,325 of reimbursement, which had zero dollars of patient payments and claims reimbursements that were greater than $140. We selected $140 as this threshold because that amount was higher (by $4) than the lowest routine home care rate[5] that the State agency paid during the period October 1, 2009, through September 30, 2011.

SAMPLE UNIT

The sample unit is one recipient month.

SAMPLE DESIGN

Our sample design is a simple random sample.

SAMPLE SIZE

Our sample size is 100 recipient months.

[4] Due to the immateriality of this difference ($227,434 / $82,492,717 = 0.28 percent) and the State agency's inability to further reconcile the data, we decided to use the State agency-provided MMIS data for our review.

[5] The routine home care rate is reimbursed each day that the recipient is at home and not receiving continuous home care.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services, statistical software (RAT-STATS).

ESTIMATION METHODOLOGY

We used RAT-STATS to estimate the unallowable payments for hospice services. Because the FMAP rate varied from quarter to quarter, we made separate estimations for the total unallowable costs and for the Federal share of those unallowable costs.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS AT TOTAL COMPENSATION

Frame Size	Frame Value	Sample Size	Value of Sample	Number of Claims With Unallowable Reimbursement	Amount of Unallowable Reimbursement
1,653	$3,757,325	100	$189,006	55	$16,108

ESTIMATES OF UNALLOWABLE PAYMENTS AT TOTAL COMPENSATION
(Limits Calculated for a 90-Percent Confidence Interval)

	Total Estimated Unallowable Reimbursement
Point estimate	$266,253
Lower limit	$123,853
Upper limit	$408,653

SAMPLE RESULTS AT FEDERAL FINANCIAL PARTICIPATION

Frame Size	Frame Value	Sample Size	Value of Sample	Number of Claims With Unallowable Federal Reimbursement	Amount of Unallowable Federal Reimbursement
1,653	$2,254,185	100	$114,623	55	$9,837

ESTIMATES OF UNALLOWABLE PAYMENTS AT FEDERAL FINANCIAL PARTICIPATION
(Limits Calculated for a 90-Percent Confidence Interval)

	Total Estimated Unallowable Federal Reimbursement
Point estimate	$162,605
Lower limit	$75,151
Upper limit	$250,058

APPENDIX E: EVERCARE COMMENTS

Evercare™
Hospice & Palliative Care

June 27, 2013

Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Audit Services
Office of the Inspector General, Region VII
301 East 12th Street, Room 0429
Kansas City, MO 64106

Report Number: A-07-13-04204

Dear Mr. Cogley:

The following is Evercare Hospice, Inc.'s ("Evercare") response to the Office of Inspector General's ("OIG") draft report entitled *Colorado Improperly Claimed Some Medicaid Costs for Hospice Services Provided by Evercare Hospice and Palliative Care* dated June 2013 ("Draft Audit Report").

Overview of Draft Findings and Recommendations

OIG conducted a review to determine whether the Colorado Department of Health Care Policy and Financing's (State agency) claimed costs for hospice services provided by Evercare Hospice & Palliative Care (Evercare) were in accordance with Federal and State requirements during the period October 1, 2009 through September 30, 2011 (the "Audit Period"). During the Audit Period, the State agency made hospice payments to Evercare totaling $10,686,175 ($6,417,820 Federal share). From the total payments made to Evercare by the State agency, OIG identified 1,653 recipient months, with payments totaling $3,757,325 ($2,254,185 Federal share), as high-risk because these months were not reduced by any recipient financial contributions. From these 1,653 recipient months, OIG reviewed a random sample of 100 recipient months paid for hospice services (the "Audit Sample") with a value of $189,006.

On June 7, 2013, OIG provided Evercare with the Draft Audit Report identifying potential billing and payment discrepancies during the Audit Period. OIG stated that:

> The net overpayments occurred because the State agency's claims processing system did not have adequate computer edits and other internal controls to ensure that the State agency correctly claimed costs for hospice services provided under the Medicaid program. The State agency's Medicaid Management Information System (MMIS) did not have adequate computer edits to ensure that payments for hospice claims were always reduced by recipient financial

contributions, that room and board per diem was reimbursed at a 95 percent rate, that correct Medicaid care-level rates were used, and that correct room and board per diem rate adjustment payments were made.

Based on the foregoing draft findings, OIG recommends that State agency:

- Recoup $74,474 from Evercare and refund this amount to the Federal Government and;

- Develop and implement enhanced internal controls, such as computer edits, to ensure that (1) payments for hospice claims are always reduced by recipient financial contributions, (2) room and board per diem is reimbursed at a 95 percent rate, (3) correct care-level rates are used, and (4) correct room and board per diem rate adjustment payments are made.

Evercare's Response to Draft Findings and Recommendations

Based on an analysis of the Draft Audit Report and Evercare's own internal review, Evercare does not dispute the financial summary regarding the one hundred patients. However, Evercare believes that the offset fails to take into account the positive offsets for Evercare where it was underpaid for room and board services. Additionally, Evercare would encourage OIG to include several other pertinent facts in the final report.

Evercare asks that OIG please consider adding language addressing the following issues:

1. The state agency changes room and board rates retroactively on a regular basis, requiring mass retroactive adjustments;
2. The hospice organizations in Colorado do not have direct access to the most accurate patient responsibility information. They must rely on the state, county and SNFs to maintain accurate records; and
3. Hospice organizations perform the billing function on behalf of Medicaid at a loss. Room and Board charges are a pass through from the state to the facilities and result in unreimbursed administrative costs to the hospice agency.

An example of the retroactive adjustments can be evidenced by a recent communication on May 10, 2013, whereby Evercare received an email communication from a Provider Fee Analyst with the Colorado Department of Health Care Policy and Financing. This email stated that the final fiscal year (FY) 2012-13 rates for room and board claims (Revenue Code 659) had been loaded into the MMIS. These rates are effective back to July 1, 2012. Evercare was instructed to begin billing these claims at the final rates. Additionally, Evercare was instructed to make adjustments to the charges on all room and board claims back to July 1, 2012. The State agency included a list of all Colorado Medicaid Nursing Facilities and their final rates for FY 2012-13 for our reference.

The State agency stated that while they understand the administrative burden associated with adjusting room and board claims when they finalize rates during the fiscal year and need to do a mass adjustment of prior claims, they acknowledge that "Our system is not capable of performing this adjustment automatically, due to lower-of billing." The other options that were available posed great accounting and audit risk to the Department and were not supported by the State agency Controller.

Thus, they requested that hospice providers adjust all of their claims for NF room and board Revenue Code 659 between July 1, 2012 and April 15, 2013.

Based on Evercare's internal review, Evercare's claims contained the most accurate information available to it at the time of billing. Evercare did not intend to obtain payment from the State agency to which it was not entitled and reasonably expected State agency system edits to properly adjust claim payment amounts based on the information available to the state agency.

Please feel free to contact me directly if you have any questions regarding Evercare's response to the Draft Audit Report.

Respectfully Submitted,

Beverly J. Duffy, CHC
Compliance Officer
Evercare Hospice & Palliative Care
612-632-5259

cc: Chris Stidman, SVP, Optum Complex Population Management
Cyndi Seiwert, Chief Operating Officer, Evercare Hospice & Palliative Care
Lin Howland, Executive Director, Evercare Hospice & Palliative Care, Colorado Springs, CO
Soto Flouris, Executive Director, Evercare Hospice & Palliative Care, Denver, CO
Randy Drager, Chief Financial Officer

APPENDIX F: STATE AGENCY COMMENTS

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-3883 TTY

John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

September 18, 2013

Patrick J. Cogley, Regional Inspector General for Audit Services
Office of the Inspector General
Office of Audit Services, Region VII
601 E. 12th St., Room 0429
Kansas City, MO 64106

Dear Mr. Cogley:

Attached pleased find the Department of Health Care Policy and Financing's submission of responses to the draft report entitled *Colorado Improperly Claimed Some Medicaid Costs for Hospice Services Provided by Evercare Hospice & Palliative Care* (Report Number A-07-13-04204).

If you have any questions or comments, please contact me at 303-866-3538 or meri.delyser@state.co.us.

Sincerely:

Meri DeLyser
Audits Section Manager

cc: Steven Woodruff, Office of Inspector General

Enclosure

Department of Health Care Policy and Financing's
Response to the
Department of Health & Human Services
Office of Inspector General
Colorado Improperly Claimed Some Medicaid Costs for Hospice Services Provided by Evercare Hospice & Palliative Care
Control Number A-07-13-04204
July 2013

RECOMMENDATION

We recommend that the State Agency:

- **recoup $74,747 from Evercare and refund this amount to the Federal Government.**

Response:

The Department does agree with most of the Office of the Inspector General's (OIG) audit. However, at this time, the Department cannot verify the overpayment amount. The Department will work with the Centers for Medicare and Medicaid Services and determine the correct amount. Once that is accomplished, the Department will perform the appropriate recovery and refund the federal government the federal share of any overpayment.

RECOMMENDATION

We recommend that the State Agency:

- **develop and implement enhanced internal controls, such as computer edits to ensure that:**
  - **(1) Payments for hospice claims are always reduced by recipient financial contributions**

Response: *Concur.*

The Department agrees with this finding and will document a procedure for post-payment review of nursing facility (NF) hospice claims. To the extent feasible, if the Department is able at a future date to automate the procedure within Medicaid Management Information System (MMIS) to ensure pre-payment reduction of funds by the amount of recipient financial contributions, it will.

Department of Health Care Policy and Financing
Response to Control Number A-07-13-04204

RECOMMENDATION

We recommend that the State Agency:

- **develop and implement enhanced internal controls, such as computer edits to ensure that:**
  (2) Room and board per diem is reimbursed at a 95-percent rate

Response: *Concur.*

The Department has determined that the reason for overpayment reflected a switch of NF ownership, of which the hospice was not informed. As a result, the hospice rate was based on the original provider rate not on the new provider rate resulting from the transfer of ownership.

RECOMMENDATION

We recommend that the State Agency:

- **develop and implement enhanced internal controls, such as computer edits to ensure that:**
  (3) Correct care-level rates are used

Response: *Disagree.*

The claims which were the subject of this finding were correctly paid. The department pays the lower of the amount calculated using predefined rates or the billed amount. For these claims, the billed amount was lower.

RECOMMENDATION

We recommend that the State Agency:

- **develop and implement enhanced internal controls, such as computer edits to ensure that:**
  (4) Correct room and board per diem rate adjustment payments are made

Response: *Concur.*

The claims that were the subject of this finding were all the result of an adjustment process which does not correctly update NF hospice claims following a retroactive NF rate increase. The sequence of steps for correcting the adjustment process in the MMIS has been initiated.