



SEP 1 2005

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

Report Number: A-01-04-00011

Mr. Michael P. Starkowski
Acting Commissioner
Department of Social Services
State of Connecticut
25 Sigourney Street
Hartford, Connecticut 06106-5033

Dear Mr. Starkowski:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled "Review of Medicaid Home Health Payments Rendered During a Medicare Covered Stay for Dual Eligible Beneficiaries – State of Connecticut - October 1, 2001 Through September 30, 2003."

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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To facilitate identification, please refer to report number A-01-04-00011 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in black ink that reads "Michael J. Armstrong".

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Charlotte S. Yeh, M.D.
Regional Administrator
Centers for Medicare & Medicaid Services – Region I
Department of Health and Human Services
Room 2325, JFK Federal Building
Boston, Massachusetts 02203

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF
MEDICAID HOME HEALTH
PAYMENTS RENDERED DURING
A MEDICARE COVERED STAY FOR
DUAL ELIGIBLE BENEFICIARIES**

STATE OF CONNECTICUT

**OCTOBER 1, 2001 THROUGH
SEPTEMBER 30, 2003**



**Daniel R. Levinson
Inspector General**

**September 2005
A-01-04-00011**

Office of Inspector General

<http://oig.hhs.gov>

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OAS FINDINGS AND OPINIONS

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



EXECUTIVE SUMMARY

BACKGROUND

Home health care is provided as a benefit in both the Medicaid and Medicare programs. The Connecticut Medicaid program, administered by the Connecticut Department of Social Services (the State agency), reimburses providers for home health care services largely on a fee-for-service basis. The Medicare program, however, uses a home health prospective payment system that provides a lump sum payment for covered home health services rendered during a 60-day episode of care.

Section 1902(a)(25) of the Social Security Act states that Medicaid is the payer of last resort for health care services and requires that States take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state Medicaid plan. Our review focused on home health care payments made on behalf of individuals covered under both Medicare and Medicaid (dual eligible beneficiaries) in Federal fiscal years 2002 and 2003.

OBJECTIVE

Our objective was to determine whether Medicaid payments for home health services provided to dual eligible beneficiaries duplicated payments already reimbursed through a Medicare prospective payment system.

SUMMARY OF FINDINGS

For Federal fiscal years 2002 and 2003, we identified 3,453 Medicaid claims for home health care services provided to dual eligible beneficiaries that overlap and may have duplicated reimbursement already made under the Medicare program. The following factors that led us to conclude that the Medicaid claims may have duplicated a Medicare prospective payment:

- Beneficiaries were prematurely discharged from Medicare coverage, yet the providers continued to bill Medicaid for the same types of services; and
- Beneficiaries received fewer than the number of home health services authorized under the physician plan of care before being discharged from Medicare coverage, yet the deficit in services to beneficiaries was made up through Medicaid billings.

In all instances, providers retained the full Medicare payment and also received additional Medicaid reimbursements for the services provided during the episode of care. As a result, for the period reviewed, Medicaid could potentially have paid providers in Connecticut as much as \$1.8 million (\$900,000 Federal share) for home health care services already covered under the Medicare payment.

We found that providers of home health care services to dual eligible beneficiaries differed in their interpretations of Medicare coverage criteria. In addition, the State agency did not have

sufficient safeguards in place to identify potential duplicate Medicaid payments for home health claims associated with dual eligible beneficiaries. Finally, the difference in the Medicare and Medicaid payment systems does not allow for efficient coordination of benefits to prevent potential overpayments for the same services.

RECOMMENDATIONS

We recommend that the State agency:

- educate the provider community on the need for providers to ensure that Medicare coverage no longer applies to a beneficiary's condition before they bill Medicaid for home health care services provided during the Medicare episode of care;
- consider conducting prepayment edits of selected claims for home health services provided to dual eligible beneficiaries to ensure that Medicare coverage is no longer applicable before Medicare pays the claim;
- work with the Medicare regional home health intermediary to develop controls for identifying and recouping Medicaid payments that should have been covered under the Medicare home health prospective payment system; and
- initiate action to recover the potential overpayments identified in this audit and credit the Federal government for its proper share of the recoveries. We estimate such overpayments to be as much as \$1.8 million (\$900,000 Federal share).

STATE AGENCY'S COMMENTS

In its August 8, 2005, response to our draft report, the State agency acknowledged a potential problem in ensuring that Medicaid does not pay for home health services that are covered by a 60-day Medicare prospective payment. The State agency agreed to work with CMS to address the findings and recommendations in our report. However, the State agency disagreed with our finding that it did not have sufficient safeguards in place to identify potential duplicate payments. The State agency cited a joint recovery project it has undertaken with CMS and its ongoing provider audit activities as evidence that it ensures that Medicaid is the payer of last resort.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

The State agency's recovery project with CMS and its audits of home health care providers both attempt to identify payment liability and seek financial recovery from Medicare for services provided to dual eligible beneficiaries that were paid entirely by the Medicaid program. However, these efforts do not specifically address situations where both Medicaid and Medicare paid for services provided during a beneficiary's Medicare episode of care period. As a result, we maintain the need for the State agency to implement our procedural recommendations. We will also submit to them our detailed listings of potential improperly paid Medicaid services for research and recovery as appropriate.

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INTRODUCTION

BACKGROUND

Medicaid Home Health Care Services

Title XIX of the Social Security Act (the Act) established the Medicaid program in 1965 to provide medical assistance to certain individuals and families with low incomes and limited resources. Medicaid is a jointly funded Federal and State entitlement program. The Centers for Medicare & Medicaid Services (CMS) administers Medicaid at the Federal level. In Connecticut, the Connecticut Department of Social Services (the State agency) is responsible for the overall administration of the program.

As part of its State Medicaid plan, Connecticut provides home health care services to eligible beneficiaries. The services include skilled nursing care, home health aides, physical therapy, occupational therapy, speech therapy, and medical social worker services. Medicaid reimburses providers on a fee-for-service basis. From October 2001 through September 2003, the State agency claimed about \$177 million in Federal funds for the home health care program.

Medicare Home Health Care Services

The Medicare program, created under Title XVIII of the Act, is a Federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease. Before October 1, 2000, Medicare had traditionally covered home health care services on a fee-for-service basis. However, the Balanced Budget Act of 1997, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999, called for Medicare to develop and implement a prospective payment system for home health care services. Effective October 1, 2000, all home health care agencies came under this system, through which they receive a lump sum predetermined prospective payment for all qualified home health services that they provide. The prospective payment amount is derived, in part, from information that the provider puts into the Outcome and Assessment Information Set database. The prospective payment covers a 60-day episode of care and includes the services of nurses, home health aides, and therapists as detailed on a physician-approved plan of care.

Medicare payments are processed through a CMS-contracted regional home health intermediary (RHHI). Associated Hospital Service of Portland, Maine, is the Medicare RHHI for the Connecticut providers in our review.

Dual Eligible Beneficiaries

Many elderly or disabled individuals with chronic health conditions are covered under both Medicare and Medicaid. Home health care services covered under Medicaid

generally help these beneficiaries maintain their place in the community and avoid costly institutionalization. Medicare coverage comes into play if the individual's chronic condition worsens. Under Medicare, the beneficiary receives skilled medical care on a part-time, intermittent basis in accordance with a physician-approved, 60-day plan of care. Patients generally resume Medicaid coverage when Medicare coverage ends.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicaid payments for home health services provided to dual eligible beneficiaries duplicated payments already reimbursed through a Medicare prospective payment system.

Scope

Our audit covered Medicare and Medicaid home health care payments made to Connecticut providers on behalf of dual eligible Medicare/Medicaid beneficiaries from October 2001 through September 2003. Our review of internal controls was limited to obtaining an overall understanding of the policies and procedures governing Medicare and Medicaid home health care payments to Connecticut providers.

We performed our fieldwork at the State agency in Hartford, Connecticut; at Associated Hospital Services in Portland, Maine; and at the offices of 11 Connecticut home health care providers.

Methodology

To gain an understanding of the home health care coverage and reimbursement requirements of the Medicare and Medicaid programs, we:

- interviewed personnel from both the State Medicaid agency and Associated Hospital Service of Maine, the Medicare RHHI;
- consulted with CMS regional staff involved in the Medicare and Medicaid home health care programs; and
- evaluated the home health care oversight activities provided by the State agency's quality assurance unit and the State of Connecticut Auditors of Public Accounts.

Through computer matching, we identified Connecticut Medicaid payments totaling approximately \$1.8 million (\$900,000 Federal share) for home health care services provided to dual eligible beneficiaries¹ during a concurrent 60-day Medicare episode of care. Medicare paid \$5.6 million in home health care prospective payments for these episodes. From the results of our computer matches, we judgmentally selected for review

¹ Elderly and/or disabled beneficiaries qualifying for both Medicaid and Medicare coverage. Approximately 25 percent of the beneficiaries identified in our review were under age 65.

747 patient episodes of care from a total of 11 home care providers with the highest dollar matches. Medicaid payments for services provided during these episodes totaled \$806,567, or 45 percent of the Medicaid payments identified in the computer match. In reviewing these episodes, we:

- discussed coverage policies and reimbursement procedures for the Medicare and Medicaid programs with provider personnel;
- examined billing and medical records to determine why Medicare coverage was discontinued during the episode of care; and
- selected cases for review by RHHI medical review personnel.

We conducted our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

For Federal fiscal years 2002 and 2003, we identified 3,453 Medicaid claims for home health care services provided to dual eligible beneficiaries that overlap and may have duplicated reimbursement already made under the Medicare program. The following findings led us to conclude that the Medicaid claims may have duplicated a Medicare prospective payment:

- Beneficiaries were prematurely discharged from Medicare coverage, yet the providers continued to bill Medicaid for the same types of services, and
- Beneficiaries received fewer than the number of home health care services authorized under the physician plan of care before being discharged from Medicare coverage, yet this deficit in services was made up through Medicaid billings.

In all instances, providers retained the full Medicare payment and also received additional Medicaid reimbursements for the services provided during the episode of care.

Under Federal law, Medicaid remains the payer of last resort for health care services. As a result, for the period reviewed, Medicaid could potentially have paid providers in Connecticut as much as \$1.8 million (\$900,000 Federal share) for home health services already covered under the Medicare payment.

FEDERAL REQUIREMENTS

Medicaid

The Medicaid program reimburses providers for home health care services to eligible beneficiaries on an individual fee-for-service basis. Covered under home health care are the services of nurses, home health aides, and therapists. Section 1902 (a)(25) of the Act requires Medicaid to be the payer of last resort and requires States to take all reasonable

measures to ascertain the legal liability of third parties to pay for care and services available under the State Medicaid plan.

Medicare

The Balanced Budget Act of 1997 changed the way that Medicare pays for home health care from a cost-based method to a prospective payment system of fixed, predetermined rates. The new prospective payment system, effective nationally on October 1, 2000, covers a 60-day episode of care and includes the services of nurses, home health aides and therapists. Services are provided based on a plan of care developed through the guidance of the patient's physician.

When a patient no longer meets Medicare coverage requirements for home health benefits, the provider is required to notify the patient via a home health advanced beneficiary notice (HHABN). The HHABN tells the patient that the provider believes the Medicare program will not cover further home health services. Reasons that the provider commonly gives on the HHABN for Medicare coverage being stopped are that the patient:

- is no longer homebound,
- has met treatment plan goals,
- is not receiving intermittent or part-time care,
- has returned to a chronic and stable condition,
- receives medication administration services, and/or
- requires no further skilled services.

The HHABN gives the patient the option of appealing the provider's coverage determination through a demand letter to the RHHI. Otherwise, the patient will assume liability for further services, or the provider will bill an alternate insurance source. For dual eligible patients, this alternate source is Medicaid.

MEDICAID PAYMENTS OVERLAPPING A MEDICARE EPISODE OF CARE

Our computer match of Medicare and Medicaid payments for the 2-year period ending September 30, 2003, identified 3,453 claims totaling \$1.8 million (\$900,000 Federal share) paid by Medicaid for home health care services provided to dual eligible beneficiaries that overlapped a concurrent 60-day Medicare episode of care. Medicare also paid a total of \$5.6 million for these episodes of care.

As a result, the providers received the full Medicare prospective payment as well as additional Medicaid payments. Our review of a sample of these claims indicates that the Medicaid payments may represent duplicate reimbursements for these services.

Dual Eligible Beneficiaries Were Prematurely Discharged From Medicare Coverage

From our computer match results, we analyzed the dates of service for all episodes of care in our sample of 11 providers. About 59 percent of provider-initiated Medicare discharges were made within 30 days or fewer of the start of the 60-day episode. We requested that the RHHI review 19 selected episodes of home health care to determine whether the provider correctly billed the responsible insurer. The RHHI determined that, for 15 of these episodes, the provider discharged Medicare coverage prematurely and received Medicaid payment for services that were covered in the Medicare prospective payment.² For example, in one episode, a 39-year-old disabled dual eligible beneficiary with a fractured femur and leg wound was admitted to home health care with a 60-day plan of care prescribing skilled nursing care and physical therapy. The provider discharged the patient from Medicare coverage on day 11 of the episode with no written explanation and switched to billing Medicaid for the remainder of the episode. As a result, the provider received a full Medicare prospective payment of \$2,900 and overlapping Medicaid payments totaling \$1,395.

While we understand that not all Medicare episodes will run the full 60 days, the above analysis leads us to question whether the additional Medicaid payments were reasonable for many of the situations identified in our review.

Dual Eligible Beneficiaries Received Fewer Than the Number of Services Authorized

From the records of the 11 providers, we further analyzed the services prescribed in the plans of care for 295 beneficiaries and compared those services with the actual Medicare and Medicaid services provided. About 89 percent of the beneficiaries we reviewed received fewer Medicare services than were proposed in the provider-generated plans of care. However, in all of these cases, the deficit in services to the beneficiaries was made up through Medicaid billings. For example, a 73-year-old patient with multiple medical conditions was admitted to home health care with a 60-day plan of care prescribing nursing care 1-3 times per week and home health aide visits 3-5 times per week. Based on this frequency, the total combined services would average approximately 53 visits over the 60-day episode. However, the provider billed Medicare for only 34 services before discharging the patient from Medicare coverage. Thus, the services proposed by the provider in the plan of care, from which the Medicare prospective payment is ultimately derived, were considerably more than those actually billed to Medicare during the abbreviated Medicare coverage period. The patient remained under the care of the provider through the end of the episode, and Medicaid was billed for the remaining 22 services in the episode of care. As a rule, we found little or no changes in the level or frequency of services provided after the change in payer.

We believe that this condition provides additional support for our conclusion that Medicaid may have been inappropriately charged for these home health services.

² For the remaining four cases reviewed by the RHHI, two were in error but for unrelated conditions and two were appropriately billed.

LACK OF COORDINATION OF BENEFITS FOR HOME HEALTH CARE

Provider Interpretation of Medicare Coverage Criteria

Many of the providers we reviewed have told us that their interpretations of the applicable Medicare and Medicaid criteria permit them to bill Medicaid for services during an established Medicare episode of care when the patients' condition makes them no longer eligible for Medicare coverage. However, discrepancies between the providers' interpretations of the extent of Medicare coverage allowed and the RHHI's determinations show that providers may not clearly understand Medicare coverage requirements.

Contrary to the other providers we audited, one provider's office told us that it had initiated payment adjustments to return Medicaid payments of \$33,464, or 44 percent of this office's overpayments for services that our computer match identified. Many of these overpayments resulted from beneficiary appeals of the provider's decision that their home health care episode would no longer qualify for Medicare coverage. Upon appeal, the RHHI medical review overturned the provider's decision and Medicare continued to cover the episode. As a result, the provider received Medicaid overpayments and was in the process of returning such overpayments to the Medicaid program.

Insufficient Safeguards to Ensure Proper Medicaid Payments

Ensuring proper Medicaid payments for home health care services requires safeguards to prevent or deter improper payments. The Connecticut State Medicaid program has no specific prepayment edit systems to detect potential Medicare coverage for home health care services provided to dual eligible beneficiaries. In addition, the scope of its postpayment reviews is too limited to ensure that Medicaid is the payer of last resort for home health care services.

Dissimilar Medicare/Medicaid Reimbursement Systems

The dissimilar payment systems for home health care claims under Medicare and Medicaid have contributed to the overpayments noted in this report. Moreover, neither insurer is aware of the home health care payments made by the other. These conditions may offer providers an incentive to prematurely discharge patients from Medicare prospective payment coverage and bill for fee-for-service Medicaid payments. Furthermore, dual eligible patients have no incentive to challenge the providers' coverage determinations because they incur no additional expense or interruption in their care. As a result, providers have received Medicaid reimbursements for services that were already reimbursed through the full Medicare prospective payment system.

We acknowledge that, under certain situations, Medicaid payment may be justified during a Medicare episode of care. However, a significant amount of Medicaid payments could be avoided through better coordination of payments between the Medicare and

Medicaid programs. Because conditions unique to each patient may affect Medicare coverage, each episode of care for dual eligible beneficiaries would need to be medically reviewed to quantify the extent of Medicaid overpayments.

POTENTIAL EXCESSIVE MEDICAID PAYMENTS

For Federal fiscal years 2002 and 2003, we identified 3,453 Medicaid home health care claims made on behalf of beneficiaries for dates of service that fell within the Medicare 60-day episode of care. Payments for these claims totaled about \$1.8 million (\$900,000 Federal share). Conditions identified in this audit present a significant potential for the Medicaid program to overspend for home health care services already covered under Medicare.

RECOMMENDATIONS

We recommend that the State agency:

- educate the provider community on the need for providers to ensure that Medicare coverage no longer applies to a beneficiary's condition before they discharge the beneficiary from Medicare coverage and bill Medicaid for home health care services provided during the Medicare episode of care;
- consider conducting prepayment edits of selected claims for home health services provided to dual eligible beneficiaries to ensure that Medicare coverage is no longer applicable before Medicaid pays the claim;
- work with the Medicare RHHI to develop controls for identifying and recouping Medicaid payments that should have been covered under the Medicare home health care prospective payment system; and
- initiate action to recover the potential overpayments identified in this audit and credit the Federal government for its proper share of the recoveries. We estimate such overpayments to be as much as \$1.8 million (\$900,000 Federal share).

STATE AGENCY'S COMMENTS

In its August 8, 2005, comments to our draft report (see Appendix), the State agency acknowledged a potential problem in ensuring that Medicaid does not pay for home health care services that are covered by a 60-day Medicare prospective payment. The State agency agreed to work with CMS to address the findings and recommendations in our report.

However, the State agency disagreed with our finding that the State agency did not have sufficient safeguards in place to identify potential duplicate payments. The State agency identified two approaches it takes to ensure that Medicaid is the payer of last resort. First, the State agency indicated that it had an extensive system for appealing Medicare

coverage. It noted that, for fiscal years 1990 through 2000, it had contracted with a private organization to pursue appeals for home health care services previously paid by Medicaid on behalf of dual eligible beneficiaries. The State agency indicated that it had recovered more than \$70 million from Medicare as a result of the project. For fiscal years 2001 and 2002, the State agency and CMS agreed to a demonstration project to simplify the process of determining Medicare liability for home health care claims paid by Medicaid. To date, the demonstration project has identified an additional \$36 million in recoveries from the Medicare program.

The second approach that the State agency noted in its comments is its efforts to identify Medicare and other liable insurers through ongoing audits of providers. The response states that the auditors review providers' records for third party liability to ensure that Medicaid is the payer of last resort.

The State agency also noted that efforts are underway for the State to obtain real-time access to Medicare paid claims files. The State agency believes such access is critical in addressing our findings and recommendations. Finally, through State legislative action, the State agency is working to lower the threshold for prior authorization for home health care services.

Because of these measures that the State agency has taken, the State agency believes that it should not be subject to a financial penalty.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

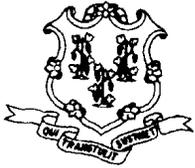
At the start of our audit, we discussed the home health demonstration project noted in the State agency's response with both the State agency and the RHHI. The project's goal is to identify, through a series of computer matches, dual eligible beneficiaries whose home health care providers received Medicaid payments for services for which Medicare should have been the primary payer but did not pay. As the State agency noted, this project has resulted in considerable Medicaid recoveries for the State agency. We commend the State agency's efforts to recover these funds for the benefit of both the State and Federal governments. However, the recoveries identified in the demonstration project were not part of the scope of our current review.

Our review centered on an offshoot of the demonstration project. As we noted in our report, the RHHI identified a number of cases for which both Medicare and Medicaid had paid for the same services provided to the same beneficiaries during a Medicare episode of care. We found that the RHHI and the State agency had taken no action to determine which agency was liable for these payments. Our computer match of Medicaid and Medicare payment files identified about \$1.8 million in Medicaid payments that overlapped Medicare episodes of care. This finding was the basis of our conclusion that the State agency does not have controls in place to identify this type of potential overpayment situation. This lack of controls continues to increase the potential for overpayments by the Medicaid program.

We also reviewed the State agency's audits of home health care providers. While we found that the State agency had made comprehensive efforts to ensure that Medicaid home health services were properly documented and in compliance with the plan of care, we found no reviews to determine whether Medicaid-paid services should have been included in the existing Medicare prospective payment.

In summary, we maintain the need for the State agency to implement our procedural recommendations. In addition, contrary to the State agency's contention, we are not recommending a financial penalty against the State. We are only asking that the State refund the proper Federal share of Medicaid overpayments recovered through the process of identifying and recouping Medicaid payments that should have been covered under the Medicare home health care prospective payment system. Recovering these additional potential duplicate Medicaid payments will benefit both the State and Federal governments. Therefore, as the State agency requested, we will submit to them our detailed listings of potential improperly paid Medicaid services for research and recovery as appropriate.

APPENDIX

**STATE OF CONNECTICUT**

DEPARTMENT OF SOCIAL SERVICES

MICHAEL P. STARKOWSKI
ACTING COMMISSIONER

August 8, 2005

TELEPHONE
(860) 424-5053TDD/TTY
1-800-842-4524FAX
(860) 424-5057

Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Audit Services, Region 1
John F. Kennedy Federal Building
Boston, MA 02203

RE: QA Response to OIG HHA Dual Eligible Review

Dear Mr. Armstrong:

The Connecticut Department of Social Services ("DSS") has reviewed the "Review of Medicaid Home Health Payments Rendered During a Medicare Covered Day for Dual Eligible Beneficiaries, State of Connecticut, October 1, 2002 through September 30, 2003" [hereinafter the "OIG Review"], and offers the following comments.

DSS recognizes that there is a potential problem in ensuring that Medicaid does not pay for services that fall within the type and quantity of services covered by a 60-day Medicare prospective payment. Because the OIG Review is based on statistics derived from cases that were "judgmentally selected," it is unclear to what extent the problem exists. Nevertheless, DSS looks forward to working with CMS to address the findings and recommendations in the OIG Review.

However, DSS disagrees with various statements throughout the OIG Review that reflect that DSS did not have sufficient safeguards in place to identify potential duplicate payments. To the contrary, Connecticut established and implemented a two-pronged approach to better ensure that Medicaid is the payer of last resort.

First Prong – Medicare Maximization Project

Prior to the review years of FFY02 and FFY03, Connecticut had developed, and for some time operated, an extensive system for appealing Medicare coverage. Connecticut believes that no other state in the nation has had such an aggressive program to pursue Medicare TPL for its dual eligibles for home health services. From 1990 through FFY00, DSS contracted with the Center for Medicare Advocacy, Inc. (the Center) to pursue Medicare appeals for home health care services previously paid for by Medicaid on behalf of individuals who were eligible for both Medicare and Medicaid. More than \$70 million was recovered for the State from the federal Medicare program as a result of this project. Based on these recoveries, Medicaid expenditures were reversed and \$35 million in FFP returned to the Federal Government.

RE: QA Response to OIG HHA Dual Eligible Review
Page 2

During this process DSS felt strongly that CMS administrative decisions interfered with Connecticut's ability to appeal Medicare coverage decisions and; DSS sued CMS. As a result of that lawsuit, a settlement agreement was reached with CMS in December 2002 for Medicare claims filed by the Center on behalf of Connecticut home health patients and DSS. Connecticut's share was over \$33 million. In addition, the Agreement resulted in a new Demonstration Project between DSS and CMS (and two other states) intended to simplify and make more cost-effective the Medicare determination process by using a sampling method instead of a case-by-case review system while demonstrating an equal return in Medicare dollars to Connecticut when compared to the individual review process. DSS's litigation and eventual settlement reflects our aggressive stance to ensure that Medicaid is the payer of last resort. The change from an individual case-by-case review method to a sampling method in the Demonstration Project was the direct result of the settlement of the lawsuit and agreement with CMS to demonstrate a new recovery system.

Since the commencement of the Demonstration Project, almost \$36 million (\$18 million state share, \$18 million FFP returned) has been recovered from Medicare for Medicaid paid benefits for FFY01 and FFY02. Additional dollars for those fiscal years are anticipated.

Second Prong – Provider Audits

In addition to the above Project with the Center, DSS also performs provider audits. When a provider is subject to an audit, DSS will review the TPL and will address failures to properly seek TPL and ensure that DSS is the payer of last resort. This is achieved by identifying the individual case TPL issue and extrapolating the impact over the provider's universe of relevant services/beneficiaries. Because of the nature of the extrapolation, DSS receives the TPL dollars (with an appropriate federal Medicaid claim adjustment) although a subsequent individual case review will not reflect the TPL reimbursement. Such may be the situation with cases in the OIG Review sample.

Next Steps

DSS is concerned about the specific cases discussed in the OIG review and formally asks for specific documentation so we may review these individual cases as recommended by the OIG.

DSS also agrees that the ongoing education of providers is essential to ensuring that Medicaid is the payer of last resort for HHA services for dual eligibles. Part of the Demonstration Project is the education of providers regarding Medicare coverage decisions. The Demonstration Project provides a timely opportunity to address the findings in the OIG Review. Connecticut would support a discussion with CMS as to whether the OIG may present its findings and recommendations at the Demonstration

RE: QA Response to OIG HHA Dual Eligible Review
Page 3

Project training for home health providers in Connecticut, New York and Massachusetts, anticipated for the fall of 2005.

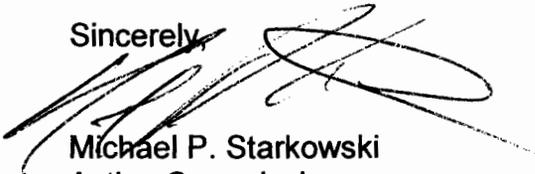
The OIG Review also supports the critical need for state agencies and their representative to have real time access to the Medicare paid claims file. Although efforts are underway in this regard, ensuring access to this information would better position the state to address the findings and recommendations in the OIG Review.

During the 2005 session of the Connecticut General Assembly, the Department sought and obtained legislative concurrence with an initiative to lower the prior authorization threshold for skilled nursing services in an attempt to contain the type of over-billing that you cite in the audit. All skilled nursing visits will now require prior authorization, as opposed to those in excess of 12 per month as was the case previously. The Department also sought authorization to reduce the prior authorization threshold for home health aide visits from 20 hours per week to 14 hours per week. However, this initiative failed to gain legislative support. We will continue to aggressively pursue this issue with the additional technical capacity provided by the new Decision Support system, which is scheduled to be operational at the end of FFY 2005. With all of these corrective measures in motion, DSS feels it is inappropriate for the OIG or the Centers for Medicare and Medicaid Services (CMS) to impose a financial penalty on the State of Connecticut.

Finally, all states would benefit from a clear statement from CMS regarding whether a state may make a Medicaid payment for hours of services beyond the maximum allowed under the Medicare home health coverage rules.

Again, DSS is prepared to work with the OIG, CMS and others to address the findings and recommendation in the OIG Review.

Sincerely,



Michael P. Starkowski
Acting Commissioner

MPS:scs

Cc: Patricia A. Wilson-Coker, Commissioner
David Parrella, Director - Medical Care Administration
James R. Wietrak, Director - Quality Assurance
Kristine D. Ragaglia, Manager - Fraud & Recovery
Michele Parsons, Manager - Alternate Care Unit