



Office of Audit Services, Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203

September 23, 2011

Report Number: A-01-10-00012

JudyAnn Bigby, MD
Secretary
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Dr. Bigby:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Hospice Payments to Evercare Hospice & Palliative Care for State Fiscal Years 2007 Through 2009*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Curtis Roy, Audit Manager, at (617) 565-9281 or through email at Curtis.Roy@oig.hhs.gov. Please refer to report number A-01-10-00012 in all correspondence.

Sincerely,

/Michael J. Armstrong/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
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233 North Michigan Avenue, Suite 600
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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICAID HOSPICE
PAYMENTS AT EVERCARE HOSPICE &
PALLIATIVE CARE FOR STATE FISCAL
YEARS 2007 THROUGH 2009**



Daniel R. Levinson
Inspector General

September 2011
A-01-10-00012

Office of Inspector General

<http://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

BACKGROUND

The Massachusetts Executive Office of Health and Human Services, Office of Medicaid (State agency), is responsible for administering MassHealth, the Massachusetts Medicaid program, in compliance with Federal and State statutes and administrative policies. State agencies have the option of offering hospice care as a benefit to eligible Medicaid beneficiaries.

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 beneficiary residing in a nursing facility, the hospice and nursing facility enter into a written agreement under which the hospice takes full responsibility for the professional management of the beneficiary's hospice services and the nursing facility agrees to provide room and board.

In Massachusetts, the State agency reimburses hospices at 95 percent of the room and board per diem rate that the State agency would have paid to nursing facilities for beneficiaries not receiving hospice care. Federal regulations require the State agency to use certain additional financial resources that beneficiaries have to reduce Medicaid payments to hospices.

The State agency made hospice payments to Evercare Hospice & Palliative Care (Evercare) totaling \$6,974,327 for 1,482 beneficiary months during State fiscal years 2007 through 2009 (July 2006 through June 2009). We limited our review to 100 randomly selected beneficiary months totaling \$482,173.

OBJECTIVE

Our objective was to determine whether the State agency made Medicaid payments to Evercare for hospice services in accordance with Federal and State requirements.

SUMMARY OF FINDING

The State agency did not always make Medicaid payments to Evercare in accordance with Federal and State requirements. Specifically, the State agency did not use the correct per diem rate, make the appropriate payment reduction, or reduce Medicaid payments to Evercare for some of the claims within 86 of the 100 beneficiary months in our random sample. These 86 beneficiary months contained claims with \$101,669 in overpayments. The State agency correctly reimbursed the claims in the remaining 14 beneficiary months.

Based on our sample results, we estimated that the State agency incorrectly reimbursed Evercare \$1,269,153 (\$669,119 Federal share) for the period July 1, 2006, through June 30, 2009.

The overpayments occurred because Evercare submitted claims that had incorrect information and the State agency's claims processing system was not designed to ensure that the appropriate per diem rate, payment reduction, and beneficiary financial contribution were used to calculate the correct claim payment amount.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$669,119 to the Federal Government,
- use our data to identify and collect potential overpayments from Evercare, and
- implement internal controls, such as a computer edit, to ensure that payments for hospice claims are based on the correct per diem rate, payment reduction, and beneficiary financial contribution.

EVERCARE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Evercare stated that it agreed with our finding that the State agency overpaid Evercare by approximately \$1,200,000 on hospice claims submitted during the audit period and has been cooperating with the State agency to correct and refund the payment errors. Evercare stated that the overpaid hospice claims contained the most accurate information at the time of billing and it expected the State agency's system edits to adjust claim amounts properly. In addition, Evercare stated that the State agency underpaid Evercare on hospice claims submitted during the audit period by approximately \$300,000 and it reserves the right to ask the State agency to offset recoupment for underpayments made during the audit period. Evercare's comments are included in their entirety as Appendix C.

We appreciate Evercare's efforts to correct and refund the approximately \$1,200,000 in payment errors that we identified. In regards to Evercare's statement that the overpaid hospice claims contained the most accurate information at the time of billing, our audit report showed that the overpaid hospice claims contained inaccurate information at the time of billing. In regards to Evercare's statement that it expected the State agency's system edits to adjust claim amounts properly, the State agency has been aware that its system did not adjust claim amounts during our audit period and has been working to implement new computer edits since May 2009 to adjust claims that contain inaccurate billing information. Regarding the potential underpayments, we suggest that Evercare work with the State agency to resolve this issue.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings and recommendations. The State agency's comments are included in their entirety as Appendix D.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Hospice Care.....	1
Nursing Facilities’ Role in Hospice.....	1
Hospice Billing	2
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective.....	2
Scope.....	2
Methodology.....	3
FINDINGS AND RECOMMENDATIONS	3
PROGRAM REQUIREMENTS	4
Per Diem Rates	4
Payment Reduction	4
Beneficiary Contributions.....	4
INCORRECT PAYMENT CALCULATION	4
Incorrect Per Diem Used.....	4
Payment Reduction Not Made	4
Payments Not Reduced by Beneficiary Contributions	5
AMOUNT OWED TO FEDERAL GOVERNMENT	5
CAUSE OF UNREPORTED OVERPAYMENTS	5
RECOMMENDATIONS	5
EVERCARE COMMENTS	5
OFFICE OF INSPECTOR GENERAL RESPONSE	6
STATE AGENCY COMMENTS	6
APPENDIXES	
A: SAMPLE DESIGN AND METHODOLOGY	
B: SAMPLE RESULTS AND ESTIMATES	
C: EVERCARE COMMENTS	
D: STATE AGENCY COMMENTS	

INTRODUCTION

BACKGROUND

Pursuant to Title XIX of the Social Security Act, 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 the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Federal Government pays its share of Medicaid expenditures, including claims for hospice services, according to a formula established in section 1905(b) of the Act. That share is known as the Federal medical assistance percentage (FMAP). The FMAP in Massachusetts ranged from 50 percent to approximately 60 percent during our audit period.

The Massachusetts Executive Office of Health and Human Services, Office of Medicaid (State agency), is responsible for administering MassHealth, the Massachusetts Medicaid program.

Hospice Care

State agencies have the option of offering hospice care as a benefit to eligible Medicaid beneficiaries. A hospice is a public agency, private organization, or a subdivision of either that is primarily engaged in providing palliation and management of terminal illnesses and related conditions. Medicaid payments for hospice care are made at one of four prospective rates for routine home care, continuous routine home care, inpatient respite care, or general inpatient care. In addition, hospices may also receive a partial payment for the room and board of hospice patients residing in nursing facilities. Evercare Hospice & Palliative Care (Evercare) is part of the UnitedHealth Group and offers hospice services in 11 states, including Massachusetts.

Nursing Facilities' Role in Hospice

Hospices and nursing facilities enter into written agreements under which the hospice takes full responsibility for the professional management of a beneficiary's hospice services and the nursing facility agrees to provide room and board. Room and board includes the provision of a room and meals as well as activities such as the administration of medication, maintaining the cleanliness of the beneficiary's room, and supervision and assistance in the use of durable medical equipment. The nursing facility subsequently bills the hospice for the room and board provided to a beneficiary receiving hospice care.

Title 114.3 Code of Massachusetts Regulations (CMR), Chapter 43, provides hospices payments equal to 95 percent of the room and board per diem rate that it would have paid to nursing facilities for beneficiaries not receiving hospice care. Furthermore, the *Commonwealth of Massachusetts Division of Medical Assistance Nursing Facility Manual* (the Manual) §456.420

provides that the State agency will pay for nursing facility services based on per diem rates. The State agency reviews and assigns per diem rates based on beneficiary questionnaires completed by nursing homes. In completing the questionnaires, nursing homes use information from beneficiaries' medical records including physicians' orders, nursing progress notes, and other pertinent documentation. The State agency assigns scores for the amount of nursing care needed for factors such as dispensing medications, dressing, and assisting with mobility and eating. The questionnaires are completed for each beneficiary quarterly, and the per diem rates are adjusted as necessary.

Hospice Billing

The State agency, pursuant to Federal requirements, must use certain additional financial resources that beneficiaries have to reduce Medicaid payments to hospices. These resources include Social Security and health and casualty insurance payments. When the State agency uses an incorrect room and board per diem rate or does not reduce the Medicaid payment to a hospice by the amount of the beneficiary's contribution, the hospice could receive overpayments. The hospice must return the overpayments to the State Medicaid program, which in turn must refund the Federal share to CMS on its Quarterly Statement of Expenditures for the Medical Assistance Program (Form CMS-64).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency made Medicaid payments to Evercare for hospice services in accordance with Federal and State requirements.

Scope

We limited our review to Medicaid hospice paid claims that were subject to the State agency's payment requirements. The State agency made payments for hospice services provided by Evercare totaling \$6,974,327 for 1,482 beneficiary months during State fiscal years (FY) 2007 through 2009 (July 2006 through June 2009). A beneficiary month could contain either single or multiple claims for hospice services within that month.

In performing our review, we established reasonable assurance that the claims data was accurate. We did not, however, assess the completeness of Evercare's paid claims file from which we obtained the data. We limited our review of internal controls to obtain an understanding of both the State agency and Evercare's procedures for billing and refunding overpayments of nursing home room and board services provided to hospice beneficiaries.

We performed fieldwork from June 2010 through April 2011 at Evercare's office in Waltham, Massachusetts; the State agency in Boston, Massachusetts; and the CMS Regional Office in Boston, Massachusetts.

Methodology

To accomplish our objective, we:

- reviewed Federal and State hospice and nursing home requirements;
- interviewed officials from CMS, the State agency, and Evercare;
- obtained a computer-generated payment file from Evercare identifying all beneficiary months that contained claims for hospice services provided by Evercare in Massachusetts during State FYs 2007 through 2009;
- identified 1,482 beneficiary months from Evercare's payment file, totaling \$6,974,327 (\$3,738,265 Federal share);
- selected a simple random sample of 100 of the 1,482 beneficiary months (Appendix A);
- reviewed nursing home billing invoices, remittance advices, and State agency claims data to validate payment information and determine whether the 100 sampled beneficiary months were correctly reimbursed by the State agency; and
- estimated the total overpayments and the Federal share of these overpayments based on our sample results (Appendix B).

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 objective.

FINDINGS AND RECOMMENDATIONS

The State agency did not always make Medicaid payments to Evercare in accordance with Federal and State requirements. Specifically, the State agency did not use the correct per diem rate, make the appropriate payment reduction, or reduce Medicaid payments to Evercare for some of the claims within 86 of the 100 beneficiary months in our random sample. These 86 beneficiary months contained claims with \$101,669 in overpayments. The State agency correctly reimbursed claims in the remaining 14 beneficiary months.

Based on the results of our statistical sample, we estimated that the State agency incorrectly reimbursed Evercare \$1,269,153 (\$669,119 Federal share) for the period July 1, 2006, through June 30, 2009.

The overpayments occurred because Evercare submitted claims that had incorrect information and the State agency's claims processing system was not designed to ensure that the appropriate

per diem rate, payment reduction, and beneficiary financial contribution were used to calculate the correct claim payment amount.

PROGRAM REQUIREMENTS

Per Diem Rates

The Manual establishes the requirements for nursing facility services under MassHealth. Section 456.420 of the Manual provides that the State agency will pay for nursing facility services based on per diem rates that correspond to the nursing care needs of the beneficiaries in the facility. To determine the per diem for each member's nursing care needs, a nursing facility must complete a questionnaire when the beneficiary elects hospice care and quarterly thereafter.

Payment Reduction

Title 114.3 CMR 43.04(3)(b) states that the hospice per diem rate shall equal 95 percent of the rate that would have been paid by the State agency to a nursing facility if the beneficiary had not been receiving hospice care.

Beneficiary Contributions

Pursuant to 42 CFR § 435, the State agency must reduce its payment to an institution for services provided to a Medicaid-eligible individual by the amount that remains after adjusting the individual's total income for a personal needs allowance and other considerations that the regulation specifies.

INCORRECT PAYMENT CALCULATION

The State agency correctly reimbursed the claims in 14 of the 100 beneficiary months we reviewed. However, the State agency did not use the correct per diem rate, make the appropriate payment reduction, or reduce Medicaid payments to Evercare for some of the claims in the remaining 86 beneficiary months.¹ Specifically:

- **Incorrect Per Diem Used:** The State agency did not always use the correct per diem rate when making payments for hospice claims. Instead, the State agency made payments to Evercare based on a higher per diem rate submitted by the provider rather than the current rate established by the State agency.
- **Payment Reduction Not Made:** The State agency did not always reduce the payment for hospice room and board claims to 95 percent of the per diem rate. Instead, the State agency paid 100 percent of the per diem rate to Evercare.

¹ Some of the claims in the 86 beneficiary months contained more than 1 type of error.

- **Payments Not Reduced by Beneficiary Contributions:** The State agency did not always reduce payments for hospice services by the amount of beneficiaries' financial contributions. Instead, the State agency made payments to Evercare without deducting the beneficiary contribution.

AMOUNT OWED TO FEDERAL GOVERNMENT

Of the sampled beneficiary months, the State agency correctly reimbursed Evercare for claims in 14 months totaling \$50,656. However, the State agency incorrectly reimbursed Evercare \$101,669 for some of the claims in 86 beneficiary months.

Based on the results of our sample, we estimated that the State agency incorrectly reimbursed Evercare \$1,269,153 (\$669,119 Federal share) for the period July 1, 2006, through June 30, 2009 (Appendix B).

CAUSE OF UNREPORTED OVERPAYMENTS

The overpayments occurred because Evercare submitted claims that had incorrect information and the State agency's claims processing system was not designed to ensure that the appropriate per diem rate, payment reduction, and beneficiary financial contribution were used to calculate the correct claim payment amount.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$669,119 to the Federal Government,
- use our data to identify and collect potential overpayments from Evercare, and
- implement internal controls, such as a computer edit, to ensure that payments for hospice claims are based on the correct per diem rate, payment reduction, and beneficiary financial contribution.

EVERCARE COMMENTS

In written comments on our draft report, Evercare stated that it agreed with the finding that the State agency overpaid Evercare by approximately \$1,200,000 on hospice claims submitted during the audit period and has been cooperating with the State agency to correct and refund the payment errors. Evercare stated that the overpaid hospice claims contained the most accurate information at the time of billing and it expected the State agency's system edits to adjust claim amounts properly. In addition, Evercare stated that the State underpaid Evercare on hospice claims submitted during the audit period by approximately \$300,000 and it reserves the right to ask the State agency to offset recoupment for underpayments made during the audit period. Evercare's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

We appreciate Evercare's efforts to correct and refund the approximately \$1,200,000 in payment errors. In regards to Evercare's statement that the overpaid hospice claims contained the most accurate information at the time of billing, our audit report showed that the overpaid hospice claims contained inaccurate information at the time of billing. In regards to Evercare's statement that it expected the State agency's system edits to adjust claim amounts properly, the State agency has been aware that its system did not adjust claim amounts during our audit period and has been working to implement new computer edits since May 2009 to adjust claims that contain inaccurate billing information. Regarding the potential underpayments, we suggest that Evercare work with the State agency to resolve this issue.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings and recommendations. The State agency's comments are included in their entirety as Appendix D.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of 1,482 beneficiary months containing claims submitted by Evercare Hospice & Palliative Care (Evercare) for hospice services for the period July 1, 2006, through June 30, 2009.

SAMPLE FRAME

Evercare provided us with an Excel spreadsheet that aggregated its claims data by beneficiary by month. We subsequently compared this data to the Massachusetts Executive Office of Health and Human Services, Office of Medicaid's claims data and determined it to be complete. As listed on Evercare's spreadsheet, the sampling frame contains 1,482 beneficiary months valued at \$6,974,327 for the period July 1, 2006, through June 30, 2009.

SAMPLE UNIT

The sampling unit was one beneficiary month. A beneficiary month could contain either single or multiple claims within a month.

SAMPLE DESIGN

Our sample design was a simple random sample.

SAMPLE SIZE

We selected a sample of 100 beneficiary months.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OIG/OAS) statistical software.

METHOD OF SELECTING SAMPLED ITEMS

We consecutively numbered the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used OIG/OAS statistical software to estimate the dollar value of overpayments.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS AT TOTAL COMPENSATION

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Beneficiary Months Containing Overpayments	Value of the 86 Beneficiary Months' Overpayments
1,482	\$6,974,327	100	\$482,173	86	\$101,669

ESTIMATES OF UNALLOWABLE PAYMENTS AT TOTAL COMPENSATION

(Limits calculated for a 90-Percent Confidence Interval)

Point Estimate	\$1,506,740
Lower Limit	\$1,269,153
Upper Limit	\$1,744,327

SAMPLE RESULTS AT FEDERAL FINANCIAL PARTICIPATION

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Beneficiary Months Containing Overpayments	Value of the 86 Beneficiary Months' Overpayments
1,482	\$3,738,265	100	\$257,375	86	\$53,760

ESTIMATES OF UNALLOWABLE PAYMENTS AT FEDERAL FINANCIAL PARTICIPATION

(Limits calculated for a 90-Percent Confidence Interval)

Point Estimate	\$796,716
Lower Limit	\$669,119
Upper Limit	\$924,314

APPENDIX C: EVERCARE COMMENTS



August 2, 2011

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

Report Number: A-01-10-00012

Dear Mr. Armstrong:

The following is Evercare Hospice, Inc.'s ("Evercare") response to the Office of Inspector General's ("OIG") draft report entitled *Review of Medicaid Hospice Payments to Evercare Hospice for State Fiscal Years 2007 through 2009* dated July 6, 2011 ("Draft Audit Report").

Overview of Draft Findings and Recommendations

OIG conducted an audit of hospice payments made to Evercare by the Massachusetts Medicaid program ("MassHealth") during state fiscal years 2007 through 2009 (which ran from July 2006 through June 2009) (the "Audit Period"). During the Audit Period, MassHealth made hospice payments to Evercare totaling \$6,974,327 for 1,482 beneficiary months. For purposes of the audit, OIG reviewed 100 randomly selected beneficiary months for which MassHealth paid Evercare \$482,173 (the "Audit Sample").

On July 6, 2011, OIG provided Evercare with the Draft Audit Report identifying potential billing and payment discrepancies during the Audit Period. OIG stated that:

The overpayments occurred because Evercare submitted claims that had incorrect information and the State agency's claims processing system was not designed to ensure that the appropriate per diem rate, payment reduction, and beneficiary financial contribution were used to calculate the correct claim payment amount.

OIG stated that "the State agency did not use the correct per diem rate, make the appropriate payment reduction, or reduce Medicaid payments to Evercare for some of the claims within 86 of the beneficiary months" in the Audit Sample. OIG estimates that MassHealth incorrectly

reimbursed Evercare \$1,269,153 (\$669,119 Federal share) in hospice claims during the Audit Period.

Based on the foregoing draft findings, OIG recommends that MassHealth:

- refund \$669,119 to the Federal Government;
- use OIG data to identify and collect potential overpayments from Evercare; and
- implement internal controls, such as a computer edit, to ensure that payments for hospice claims are based on the correct per diem rate, payment reduction, and beneficiary financial contribution.

Evercare's Response to Draft Findings and Recommendations

Based on an analysis of the Draft Audit Report and our own internal review¹, we agree with the finding that MassHealth overpaid Evercare by approximately \$1,200,000 on hospice claims submitted during the Audit Period. Evercare has been working cooperatively with MassHealth to correct and refund these payment errors, and will continue to do so. Please note that, based on the information available to us, we estimate that MassHealth underpaid Evercare on hospice claims submitted during the audit period by approximately \$300,000. To the extent the extrapolated adjustments calculated by OIG did not include underpayments made by MassHealth to Evercare for hospice claims submitted during the Audit Period, Evercare reserves its right to ask MassHealth to offset recoupment to account for underpayments made during the Audit Period.

In preparing the final audit report, please consider removing the statement that "Evercare submitted claims that had incorrect information." Based on our internal review, we believe that Evercare's claims contained the most accurate information available to it at the time of billing. Evercare did not intend to obtain payment from MassHealth to which it was not entitled, and reasonably expected MassHealth system edits to properly adjust claim payment amounts based on the information available to the state agency. Nevertheless, Evercare has modified its claim system and procedures to reduce the likelihood of similar billing and payment errors going forward. These modifications include revisions to the claims submission software and enhanced retrospective monthly reviews to detect and correct hospice claim payment errors.

Lastly, Evercare respectfully requests that OIG recommend to MassHealth that it accept the final audit report and not conduct an investigation of its own. OIG and Evercare have conducted an in depth investigation and it is in the best interests of all parties to accept the

¹ Evercare conducted an internal review of these claims in January 2010. Evercare reported the potential overpayments to MassHealth and OIG on May 7, 2010. At the time of Evercare's report, MassHealth had already recouped approximately \$93,000 in overpayments.

OIG's findings and move forward without spending additional resources on duplicative investigations.

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/

Beverly J. Duffy, CHC
Compliance Officer
Evercare Hospice & Palliative Care
301-260-1014

cc: Anita Messal, President Evercare Hospice & Palliative Care
Tricia Ford, Vice President of Operations, Evercare Hospice & Palliative Care
Sue Mullaney, Executive Director, Evercare Hospice & Palliative Care, Waltham, MA
Randy Drager, Director of Finance



DEVAL L. PATRICK
Governor

TIMOTHY P. MURRAY
Lieutenant Governor

JUDYANN BIGBY, M.D.
Secretary

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place
Boston, MA 02108

MassHealth

September 13 , 2011

Michael J. Armstrong
Regional Inspector General, Audit Services
HHS/OIG/OAS
Region I
JFK Federal Building
Boston, MA 02203

RE: Audit Report No: A-01-10-00012

Dear Mr. Armstrong,

Thank you for the opportunity to review and comment on Draft Audit Report No.: A-01-10- 00012 Review of Medicaid Hospice Payments to Evercare Hospice & Palliative Care for State Fiscal Years 2007 through 2009.

The Office of the Inspector General (OIG), Executive Office of Health and Human Services (EHS) and the MassHealth Provider Compliance Unit (PCU) have worked cooperatively for the last four years advancing our mutual goals and efforts to identify and prevent fraud, waste and abuse as well as recover overpayments. This hospice engagement is a good example of the concept and benefits of partnership audits.

MassHealth's Provider Compliance Unit ("PCU") conducts post-payment reviews of hospice room and board paid claims to ensure that the correct per diem amount is billed and the correct PPA is deducted. In October 2009, the PCU sent initial notices of overpayments to 63 hospices for selected room and board claims with dates of service from July 1, 2004 through April 30, 2009. Subsequently, in October 2010, audit notices were sent to 82 hospices for all room and board claims, excluding only those claims reviewed by the Office of Inspector General and by PCU in the October 2009 recovery project. This audit covered dates of service January 1, 2005 through December 31, 2009. To date, \$4,622,892 has been recovered from both PCU projects with an additional \$547,348 in outstanding accounts receivables, and an additional \$815,948 in accounts receivables to be set up. In total, the PCU's hospice recovery projects will yield \$5,986,188. With regard to Evercare, there was \$94,477 recovered from this hospice provider during the first project. All Evercare claims were excluded from PCU's second project as requested by the OIG. For identified overpayments, MassHealth recovers the overpayments from the hospice providers and refunds the Federal share to the federal government.

The Evercare audit benefits from previous corrective action taken by MassHealth during prior OIG hospice audits.

Our responses to the report's specific recommendations are as follows:

Recommendation 1): Refund \$669,119 Federal share to the federal government.

Response:

Upon receipt and review of the claims detail from OIG, MassHealth will pursue recovery of overpayments from Evercare hospice consistent with MassHealth regulations at 130 CMR

450.437, and will refund the federal share in accordance with Section 6506 of the Affordable Care Act and as described in State Medicaid Director letter #10-014, dated July 13, 2010.

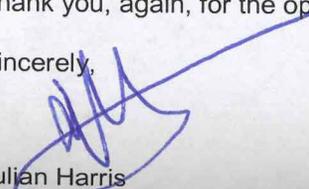
Recommendation 2): Implement internal controls, such as a computer edit, to ensure that payments for hospice claims are based on the correct per diem, payment reduction and beneficiary final contribution amounts.

Response:

- In May 2009, MassHealth implemented a computer edit for the beneficiary's contribution amount for hospice claims. MassHealth refers to the beneficiary contribution amount as the patient-paid amount (PPA). See, 130 CMR 456.423. When a hospice claim is processed for payment, MMIS searches its records for a Patient Paid Amount (PPA), and, if a PPA is found, MMIS deducts that amount from the hospice paid claim. If a hospice provider enters an incorrect PPA on the claim or does not include a PPA on the claim, MMIS will search for a PPA on every hospice claim and make the appropriate adjustment to the paid claim.
- MassHealth is working on a claims processing computer edit that will ensure all hospice claims are paid at the correct per diem amount and calculate 95% of the per diem amount. A change order has been submitted that will allow MMIS to calculate and pay hospice room and board claims at 95% of the nursing facility case mix rate. We expect this function to be operational as soon as MassHealth has implemented 5010 (early spring of 2012). Until such time as this edit is operational, MassHealth will continue to work with the provider compliance unit (PCU) to identify, and recover, any overpayments made to Evercare hospice.
- MassHealth conducted training on MassHealth billing procedures for hospice providers in 2009; this training reinforced the provider's responsibility to bill the correct per diem rate, the 95% calculation, and the PPA. Along with the trainings, MassHealth revised the billing guidelines for hospice providers. MassHealth created hospice billing tips and job aids which contained detailed billing instructions to further address these hospice billing procedures. The billing guidelines, hospice tips and job aids are all posted on the MassHealth website.

Thank you, again, for the opportunity to respond to the draft report.

Sincerely,


Julian Harris
Medicaid Director