DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

October 7, 2010

Report Number: A-07-09-01077

Ms. Vivianne M. Chaumont
Director
Division of Medicaid & Long-Term Care
Department of Health & Human Services
301 Centennial Mall South
Lincoln, NE 68509

Dear Ms. Chaumont:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Nebraska Medicaid Payments for Home Health Agency Claims*. 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 at (816) 426-3591, or contact Chris Bresette, Audit Manager, at (816) 426-3591 or through email at Chris.Bresette@oig.hhs.gov. Please refer to report number A-07-09-01077 in all correspondence.

Sincerely,

/Patrick J. Cogley/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF NEBRASKA MEDICAID PAYMENTS FOR HOME HEALTH AGENCY CLAIMS

Daniel R. Levinson
Inspector General

October 2010
A-07-09-01077

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

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. In Nebraska, the Department of Health & Human Services (State agency) administers the State's Medicaid program in accordance with its CMS-approved State plan.

A home health agency (HHA) provides skilled nursing services, home health aide services, and medical supplies and equipment to Medicaid recipients. Nebraska Administrative Code 471, section 9-002.02, states that all home health services must be necessary to a continuing medical treatment plan, prescribed by a licensed physician, and recertified by the licensed physician every 60 days. In addition, Nebraska Administrative Code 471, section 2-001.03, requires that HHAs submit claims which are true, accurate, and complete, and maintain records on all services provided for which a claim has been made. HHAs submit claims to the State agency in order to receive compensation for the services they provide to Medicaid recipients.

The responsibilities of the State agency include processing and monitoring HHA claims. As part of its monitoring responsibilities, the State agency has controls in place to ensure that payment limitations, such as a daily payment cap on nursing services and limits on therapy services, are not exceeded. If a problem or concern is identified, the State agency reviews a provider's supporting documentation to ensure that the payment is appropriate. The State agency then submits to CMS its Medicaid expenditures for the Federal share of its claimed costs.

For the period July 1, 2008, through June 30, 2009, the State agency claimed a total of approximately $23.1 million (approximately $14.9 million Federal share) for all HHA services. For this review we focused on 84 HHA providers throughout the State of Nebraska that claimed approximately $20.3 million (approximately $13.1 million Federal share) for HHA services.

OBJECTIVE

Our objective was to determine whether the State agency claimed costs for HHA services in accordance with Federal and State requirements.

SUMMARY OF FINDINGS

The State agency claimed some costs for HHA services that were not in accordance with Federal or State requirements. Our review of the 100 claims in our sample showed that 9 claims had errors totaling $764 ($489 Federal share) of improper Medicaid reimbursement. The errors

included 4 claims with unauthorized services, 4 claims for which a billed service was not rendered, and 1 claim with unsupported services.

Based on the results of our sample, we estimated that the State agency improperly claimed $56,049 ($36,761 Federal share) for HHA services that did not comply with Federal and State requirements. Although the State agency had controls in place to ensure that payments were appropriate for HHA claims, these controls did not always prevent the overpayments.

RECOMMENDATIONS

We recommend that the State agency:

- refund $36,761 to the Federal Government for unallowable HHA services claims and
- continue to strengthen internal controls to detect and recover improper payments for HHA services.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described corrective actions that it planned to take. The State agency's comments appear in their entirety as Appendix C.

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INTRODUCTION

BACKGROUND

Medicaid Program and Home Health Agency Services

Pursuant to Title XIX of the Social Security Act (the 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.

Section 1905 of the Act authorizes State Medicaid agencies to provide home health agency (HHA) services to Medicaid recipients. Pursuant to 42 CFR § 440.70, these services include skilled nursing services, home health aide services, and medical supplies and equipment. In addition, the HHA services may also include physical therapy, occupational therapy, or speech pathology and audiology services.

Nebraska Department of Health & Human Services

In Nebraska, the Department of Health & Human Services (State agency) administers the State's Medicaid program. During the period July 1, 2008, through June 30, 2009 (our audit period), the State agency paid approximately 21,000 Medicaid claims for HHA services.

The responsibilities of the State agency include processing and monitoring HHA claims. As part of its monitoring responsibilities, the State agency has controls in place to ensure that payment limitations, such as a daily payment cap on nursing services and limits on therapy services, are not exceeded. If a problem or concern is identified, the State agency reviews a provider's supporting documentation to ensure that the payment is appropriate.

On a quarterly basis, the State agency submits to CMS its standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), to summarize, by category of service, Medicaid expenditures for Federal reimbursement. CMS reimburses the State agency the Federal share of the State agency's claimed costs, based on the Federal medical assistance percentage (FMAP). The State of Nebraska's FMAP for the period July 1, 2008, through September 30, 2008, was 58.02 percent. The American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009, authorized the States to receive a higher FMAP. For the period October 1, 2008, through March 31, 2009, the State of Nebraska's FMAP was increased to 65.74 percent under the provisions of the Recovery Act. For the period April 1, 2009, through June 30, 2009, the State of Nebraska's FMAP was increased to 67.79 percent under these same provisions.

Nebraska Home Health Agency Services

Nebraska Administrative Code 471, section 9-002.02, states that all home health services must be necessary to a continuing medical treatment plan, prescribed by a licensed physician, and recertified by the licensed physician every 60 days. In addition, Nebraska Administrative Code 471, section 9-002.04, requires HHAs to maintain clinical records that include a plan of care for each client, signed by the physician responsible for that client's care.

HHAs submit claims to the State agency in order to receive compensation for the services they provide to Medicaid recipients. Payments for HHA claims are made on a per-visit basis, whereby a visit is defined as consisting of 1 to 8 units and each unit is 15 minutes long. (Services which require more than 8 units of service are paid for on an hourly basis.) Nebraska Administrative Code 471, section 2-001.03, requires that HHAs submit claims which are true, accurate, and complete, and maintain records on all services provided for which a claim has been made. HHAs submit claims covering a period of time to the State agency; each claim may contain multiple types of services.

For the period July 1, 2008, through June 30, 2009, the State agency claimed services totaling approximately $23.1 million (approximately $14.9 million Federal share) for 85 HHA providers. We are reviewing the amounts claimed for one of these HHA providers (First Care Home Health Agency (approximately $2.8 million; approximately $1.8 million Federal share)) in a separate audit (report number A-07-10-01086).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed costs for HHA services in accordance with Federal and State requirements.

Scope

We reviewed claims for 84 HHA providers throughout the State of Nebraska totaling $20,310,628 ($13,070,329 Federal share) received from the State agency as reimbursement for the period July 1, 2008, though June 30, 2009.

We did not review the State agency's overall internal control structure because our objective did not require us to do so. We limited our internal control review to those controls related directly to processing and monitoring HHA claims.

We conducted our fieldwork from April through June 2010 at the State agency and at the 37 provider locations in our simple random sample. We did not review the sampled claims to determine medical necessity.

Methodology

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and other requirements regarding Medicaid reimbursement for HHA services, as well as the Nebraska State plan;

- interviewed officials at the State agency to gain an understanding of how they administer and monitor the Medicaid HHA program;

- reconciled the State agency's electronic claims data to the CMS-64 reports for the period July 1, 2008, through June 30, 2009;

- selected a simple random sample of 100 HHA claims from 84 HHA providers in the State of Nebraska, totaling $113,043 ($71,401 Federal share);

- obtained and reviewed the supporting documentation for each sampled claim to determine the allowability of the services claimed; and

- provided the results of our review and discussed those results with State agency officials on June 3, 2010.

Appendixes A and B contains details of our sampling and projection methodologies.

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 claimed some costs for HHA services that were not in accordance with Federal or State requirements. Our review of the 100 claims in our sample showed that 9 claims had errors totaling $764 ($489 Federal share) of improper Medicaid reimbursement. The errors included 4 claims with unauthorized services, 4 claims for which a billed service was not rendered, and 1 claim with unsupported services.

Based on the results of our sample, we estimated that the State agency improperly claimed $56,049 ($36,761 Federal share) for HHA services that did not comply with Federal and State requirements.

UNALLOWABLE HOME HEALTH AGENCY SERVICES

Unauthorized Services

Pursuant to 42 CFR § 440.70, HHA services are provided to a recipient under a physician's orders as a part of a written plan of care.

According to Nebraska Administrative Code 471, section 9-002.02, all home health services must be necessary to a continuing medical treatment plan, prescribed by a licensed physician, and recertified by the licensed physician every 60 days. Further, Nebraska Administrative Code 471, section 9-002.04, requires that HHAs' clinical records include a plan of care for each client, signed by the physician responsible for that client's care.

For 4 of the 100 sampled claims, the State agency did not claim some costs pursuant to these Federal and State requirements. Specifically, the State agency paid for HHA services for which the frequency of the services provided exceeded the limits prescribed on the recipient's written plan of care.

For each of these four claims, the HHA billed either a skilled nursing visit or a period of home health aide hours that was in excess of the limit prescribed on the written plan of care.

Billed Services Not Rendered

Nebraska Administrative Code 471, section 2-001.03, states that by signing a provider agreement with the State agency, the provider agrees to "[s]ubmit claims which are true, accurate, and complete."

For 4 of the 100 sampled claims, the State agency improperly claimed costs for HHA services.

For these four claims, the provider billed for at least 1 hour of service in excess of what was supported in the visit notes; thus the claims were not accurate. For example, one of the claims billed 11 hours of service when only 10 hours were documented and supported in the visit notes.

Unsupported Services

Nebraska Administrative Code 471, section 2-001.03, states that by signing a provider agreement with the State agency, the provider agrees to "[m]aintain records on all services provided for which a claim has been made, and furnish on request, the records to the Department [the State agency], the federal Department of Health and Human Services, and the federal or state fraud and abuse units."

Further. the CMS *State Medicaid Manual*, section 2500.2(A), requires that the State agency "[r]eport only expenditures for which <u>all</u> supporting documentation, in readily reviewable form, has been compiled and which is immediately available when the claim is filed." (Emphasis in original.)

For 1 of the 100 sampled claims, the State agency claimed costs for HHA services for which it did not maintain supporting documentation pursuant to Federal and State requirements. For this claim, a provider billed for a 2-hour skilled nursing visit, but was unable to provide us with any documentation to support the services billed.

UNALLOWABLE CLAIMS FOR FEDERAL REIMBURSEMENT

Of the 100 HHA claims in our sample, 9 had errors totaling $764 ($489 Federal share) of improper Medicaid reimbursement. Based on the results of our sample, we estimated that the State agency improperly claimed $56,049 ($36,761 Federal share) for HHA services that did not comply with Federal and State requirements. Although the State agency had controls in place to ensure that payments were appropriate for HHA claims, these controls did not always prevent the overpayments.

RECOMMENDATIONS

We recommend that the State agency:

- refund $36,761 to the Federal Government for unallowable HHA services claims and
- continue to strengthen internal controls to detect and recover improper payments for HHA services.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described corrective actions that it planned to take. The State agency's comments appear in their entirety as Appendix C.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of claims representing home health agency (HHA) services paid for the period July 1, 2008, through June 30, 2009. The population includes only those claims paid to all providers that were not sampled as part of review A-07-10-01086.

SAMPLING FRAME

The sampling frame is a database of claim records consisting of 20,091 claims totaling $20,310,628 ($13,070,329 Federal share) for home health services paid during the period July 1, 2008, through June 30, 2009. The sampling frame includes only those claims paid to all providers that were not sampled as part of review A-07-10-01086.

SAMPLE UNIT

The sampling unit is one Medicaid paid claim.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected 100 sample units (paid claims).

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 home health services. Because of the significant increase in the Federal medical assistance percentage rate provided under the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5, we made separate estimations for the total unallowable costs and for the Federal share of those unallowable costs.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Frame Size	Frame Value	Sample Size	Value of Sample	Number With Unallowable Payments	Value of Unallowable Payments
20,091	$20,310,628	100	$113,043	9	$764

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

	Total Estimated Unallowable Services	Total Estimated Unallowable Services (Federal Share)
Point estimate	$153,530	$98,318
Lower limit	$56,049	$36,761
Upper limit	$251,012	$159,876

APPENDIX C: STATE AGENCY COMMENTS

Nebraska Department of Health and Human Services

Division of Medicaid and Long-Term Care

State of Nebraska

Dave Heineman, Governor

September 17, 2010

Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Inspector General
Department of Health and Human Services, Region VII
601 East 12th Street, Room 0429
Kansas City, Missouri 64106

RE: Report Number A-07-09-01077

Dear Mr. Cogley:

The Nebraska Department of Health and Human Services (DHHS) Division of Medicaid and Long-Term Care is pleased to have the opportunity to respond to the Draft Audit Report entitled *Review of Nebraska Medicaid Payments for Home Health Agency Claims*. DHHS has strived to administer Medicaid reimbursement in compliance with current Federal and State law, policies, and procedures and is committed to working to resolve the issues identified in this audit review.

DHHS is also appreciative of the hard work on the part of OIG staff to gather information from Medicaid staff and providers. We are appreciative of your observations in helping improve policies and procedures already in place to ensure continued compliance. Set forth below are DHHS' specific responses to each of the preliminary findings and recommendations identified in the Draft Audit Report.

OIG RECOMMENDATION: Refund $36,761 to the Federal Government for unallowable HHA services claims.

DHHS RESPONSE: DHHS concurs with this recommendation. Medicaid providers are aware that they must bill Medicaid appropriately and maintain complete and accurate client records. Nebraska Medicaid will refund this amount to the Federal Government and Program Integrity staff will communicate with the identified Home Health providers to recoup any overpayments.

OIG RECOMMENDATION: Continue to strengthen internal controls to detect and recover improper payments for HHA services.

DHHS RESPONSE: DHHS concurs with this recommendation. Medicaid will explore options for MMIS modifications that will automatically reject claims for unauthorized services. Medicaid will work with the Division of Public Health to address and resolve concerns regarding inadequate provider documentation of client services. Medicaid will also educate providers on the importance of maintaining appropriate documentation.

Sincerely,

Vivianne M. Chaumont, Director
Division of Medicaid & Long-Term Care
Department of Health and Human Services