DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region VII
601 East 12th Street
Room 0429
Kansas City, Missouri 64106

November 9, 2010

Report Number: A-07-10-01083

Ms. Joan Henneberry
Executive Director
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Dear Ms. Henneberry:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Colorado 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-07-10-01083 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 COLORADO MEDICAID PAYMENTS FOR HOME HEALTH AGENCY CLAIMS

Daniel R. Levinson
Inspector General

November 2010
A-07-10-01083

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 Colorado, the Department of Health Care Policy and Financing (State agency) administers the State's Medicaid program in accordance with its CMS-approved State plan.

A home health agency (HHA) provides nursing services, home health aide services, and therapy services to Medicaid recipients. State regulations at 10 Code of Colorado Regulations (CCR) 2505-10, section 8.523.11, specify that HHA services are eligible for reimbursement under Medicaid only when the services are provided under a physician-signed plan of care and are medically necessary. Further, according to 10 CCR 2505-10, section 8.130.2, each provider shall maintain legible records necessary to disclose the nature and extent of goods and services provided to clients, records which fully substantiate or verify claims submitted for payment. 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, and to ensure that it pays medical claims pursuant to Federal and State requirements, the State agency's Medicaid Quality Assurance Unit periodically conducts post-payment reviews of selected HHA services. The State agency then submits to CMS its Medicaid expenditures for the Federal share of its claimed costs.

For the period October 1, 2008, through September 30, 2009, the State agency claimed HHA services totaling approximately $158.4 million (approximately $95.4 million Federal share) for 129 HHA providers. For this review, we focused on 127 HHA providers throughout the State of Colorado that claimed a total of approximately $119.9 million (approximately $72.2 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 beneficiary-months (a beneficiary-month represents a payment for one beneficiary for one month) in our sample showed that 14

beneficiary-months had errors (2 beneficiary-months had two types of errors) totaling $6,552 ($4,020 Federal share) of improper Medicaid reimbursement. The errors included 10 beneficiary-months with unsupported services, 4 beneficiary-months with unauthorized services, 1 beneficiary-month with a billing error, and 1 beneficiary-month with insufficient documentation.

Based on the results of our sample, we estimated that the State agency improperly claimed $818,336 ($494,040 Federal share) for HHA services that did not comply with Federal and State requirements. Although the State agency periodically performed post-payment reviews to ensure that payments were appropriate for HHA claims, these reviews did not always detect the overpayments.

RECOMMENDATIONS

We recommend that the State agency:

- refund $494,040 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 partially concurred with our first recommendation because it disagreed with our sampling methodology. The State agency agreed to refund the Federal share of unallowable services identified from the sampled items ($4,020). However, the State agency did not concur with our recommendation that it refund the amount that we estimated to be in error ($494,040) because our sample "… did not appear to be representative of the population …."

The State agency concurred with our second recommendation and described corrective actions that it planned to take.

The State agency's comments appear in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

Nothing in the State agency's written comments caused us to change our findings or our recommendations. Statistical sampling depends on the principle of random selection. Random sampling eliminates personal bias and subjective considerations.

We completed this review in accordance with our longstanding policies with regard to statistical sampling. The U.S. Department of Health & Human Services, Departmental Appeals Board, has supported the Office of Inspector General's use of statistical sampling to calculate disallowances in accordance with these policies. (Details of our sampling and projection methodologies,

including our use of random sample selection, appear in Appendixes A and B.) Therefore, we continue to recommend that the State agency refund the entire $494,040 (Federal share) for unallowable HHA services claims.

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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.

Colorado Department of Health Care Policy and Financing

In Colorado, the Department of Health Care Policy and Financing (State agency) administers the State's Medicaid program. During the period October 1, 2008, through September 30, 2009 (our audit period), the State agency paid approximately 230,000 Medicaid claims for HHA services. We grouped these claims into 79,860 beneficiary-months (a beneficiary-month represents a payment for one beneficiary for one month).

The responsibilities of the State agency include processing and monitoring HHA claims. As part of its monitoring responsibilities, and to ensure that it pays medical claims pursuant to Federal and State requirements, the State agency's Medicaid Quality Assurance Unit periodically conducts post-payment reviews of selected HHA services.

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 Colorado's FMAP for our audit period was originally 50.00 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 Colorado's FMAP was increased to 58.78 percent under the provisions of the Recovery Act. For the period April 1, 2009, through September 30, 2009, the State of Colorado's FMAP was increased to 61.59 percent under these same provisions.

Colorado Home Health Agency Services

State regulations at 10 Code of Colorado Regulations (CCR) 2505-10, section 8.523.11, require that HHA services be provided under a plan of care as ordered and signed by a physician. Specifically, pursuant to Federal regulations at 42 CFR § 484.18(a), the plan of care must cover the types of services required and the frequency of visits.

HHAs submit claims to the State agency in order to receive compensation for the services they provide to Medicaid recipients. According to 10 CCR 2505-10, section 8.528.11, reimbursement for the services of nursing, physical therapy, occupational therapy, and speech therapy is made on a per-visit basis, whereby a visit is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours. Home health aide services are reimbursed through the use of two billing units: Basic Units (the first hour of the visit) and, for visits that last longer than one hour, Extended Units (increments of fifteen minutes up to one-half hour). In addition, pursuant to 10 CCR 2505-10, section 8.523.11, HHA services are eligible for reimbursement under Medicaid only when the services are provided under a physician-signed plan of care and are medically necessary. Further, according to 10 CCR 2505-10, section 8.130.2, each provider shall maintain legible records necessary to disclose the nature and extent of goods and services provided to clients, records which fully substantiate or verify claims submitted for payment. HHAs submit claims covering a period of time to the State agency; each claim may contain multiple types of service.

For the period October 1, 2008, through September 30, 2009, the State agency claimed HHA services totaling approximately $158.4 million (approximately $95.4 million Federal share) for 129 HHA providers. We reviewed the amounts claimed for 2 of these 129 HHA providers (Personal Assistance Services of Colorado (approximately $28.5 million; approximately $17.2 million Federal share) and Professional Pediatric Home Care, Inc. (approximately $10.0 million; approximately $6.0 million Federal share)), in separate audits (report numbers A-07-10-01087 and A-07-10-01088, respectively).

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 127 HHA providers throughout the State of Colorado totaling $119,856,383 ($72,189,464 Federal share) received from the State agency as reimbursement for the period October 1, 2008, through September 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 February through June 2010 at the State agency in Denver, Colorado, and at the 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,
- 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 October 1, 2008, through September 30, 2009;
- grouped the claims data for the 127 HHA providers into 66,784 beneficiary-months;
- selected a simple random sample of 100 HHA beneficiary-months from 53 HHA providers in the State of Colorado, totaling $216,952 ($130,615 Federal share);
- obtained and reviewed the supporting documentation for each sampled beneficiary-month to determine the allowability of the services claimed (each beneficiary-month may contain multiple types of services);
- determined the amount in error for each beneficiary-month with unallowable services; and
- provided the results of our review and discussed those results with State officials on June 21, 2010.

Appendixes A and B contain 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 beneficiary-months in our sample showed that 14 beneficiary-months had errors (2 beneficiary-months had two types of errors) totaling $6,552 ($4,020 Federal share) of improper Medicaid reimbursement. The errors included 10 beneficiary-months with unsupported services, 4 beneficiary-months with unauthorized services,

1 beneficiary-month with a billing error, and 1 beneficiary-month with insufficient documentation.

Based on the results of our sample, we estimated that the State agency improperly claimed $818,336 ($494,040 Federal share) for HHA services that did not comply with Federal and State requirements.

UNALLOWABLE HOME HEALTH AGENCY SERVICES

Unsupported Services

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

According to 10 CCR 2505-10, section 8.130.2, each provider shall maintain legible records necessary to disclose the nature and extent of goods and services provided to clients, records which fully substantiate or verify claims submitted for payment.

For 10 of the 100 sampled beneficiary-months, the State agency claimed costs for HHA services for which it did not maintain supporting documentation pursuant to Federal and State requirements. For 5 of these 10 beneficiary-months, home health agencies were unable to provide us with any documentation to support the services billed. For the other five beneficiary-months, the provider billed for at least one unit of service in excess of what was supported in the visit notes; thus the supporting documentation did not fully substantiate or verify claims submitted for payment.

Unauthorized Services

Pursuant to 42 CFR § 440.70(a), HHA services are provided to a recipient at his or her place of residence under a physician's orders as a part of a written plan of care. Further, 42 CFR § 484.18(a) states that the plan of care must cover the types of services required and the frequency of visits.

According to 10 CCR 2505-10, section 8.523.11, HHA services are eligible for reimbursement under Medicaid only when services are provided under a plan of care. A plan of care is a coordinated plan developed by the HHA as ordered by the attending physician for provision of services to a client at his or her residence, and periodically reviewed and signed by the physician.

For 4 of the 100 sampled beneficiary-months, 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 plan of care.

For each of these four beneficiary-months, the HHA billed either skilled nursing visits or home health aide Extended Units that were in excess of the limit prescribed on the written plan of care.

Billing Error

According to 10 CCR 2505-10, section 8.130.2, each provider shall maintain legible records which fully substantiate or verify claims submitted for payment. The State agency's fee schedule for private duty nursing identifies both an hourly payment rate for visits in which a service is performed by a registered nurse (RN) and a lower payment rate for visits in which a service is performed by a licensed practical nurse (LPN).

For 1 of the 100 beneficiary-months, the State agency did not claim some costs for HHA services pursuant to the State agency's fee schedule. For this beneficiary-month, a provider billed and was paid for 10 hours of LPN service at the higher RN payment rate.

Insufficient Documentation

According to 10 CCR 2505-10, section 8.130.2, each provider shall maintain legible records which fully substantiate or verify claims submitted for payment. Further, 10 CCR 2505-10, section 8.526.19(C)(1) states: "Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and out of the client's home."

For 1 of the 100 sampled beneficiary-months, the State agency did not claim some costs for HHA services pursuant to State requirements.

For this beneficiary-month, the visit notes for the home health aide services did not include the exact time in and out of the client's home. Therefore, the documentation did not fully substantiate or verify the claim submitted for payment.

UNALLOWABLE CLAIMS FOR FEDERAL REIMBURSEMENT

Of the 100 HHA beneficiary-months in our sample, 14 had errors totaling $6,552 ($4,020 Federal share) of improper Medicaid reimbursement. Based on the results of our sample, we estimated that the State agency improperly claimed $818,336 ($494,040 Federal share) for HHA services that did not comply with Federal and State requirements. Although the State agency periodically performed post-payment reviews to ensure that payments were appropriate for HHA claims, these reviews did not always detect the overpayments.

RECOMMENDATIONS

We recommend that the State agency:

- refund $494,040 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 partially concurred with our first recommendation because it disagreed with our sampling methodology. The State agency agreed to refund the Federal share of unallowable services identified from the sampled items ($4,020). However, the State agency did not concur with our recommendation that it refund the amount that we estimated to be in error ($494,040) because our sample "… did not appear to be representative of the population since the average cost of a beneficiary month from the sample was over 20% higher than the average cost of a beneficiary month for the population."

The State agency concurred with our second recommendation and described corrective actions that it planned to take.

The State agency's comments appear in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

Nothing in the State agency's written comments caused us to change our findings or our recommendations. Statistical sampling depends on the principle of random selection. Random sampling eliminates personal bias and subjective considerations.

We completed this review in accordance with our longstanding policies with regard to statistical sampling. The U.S. Department of Health & Human Services, Departmental Appeals Board, has supported the Office of Inspector General's use of statistical sampling to calculate disallowances in accordance with these policies. (Details of our sampling and projection methodologies, including our use of random sample selection, appear in Appendixes A and B.) Therefore, we continue to recommend that the State agency refund the entire $494,040 (Federal share) for unallowable HHA services claims.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of beneficiary-months (a beneficiary-month represents a payment for one beneficiary for one month) representing home health agency (HHA) services paid for the period October 1, 2008, through September 30, 2009. The population includes only those beneficiary-months that were not sampled as part of reviews A-07-10-01087 or A-07-10-01088.

SAMPLING FRAME

The sampling frame is a database of beneficiary-months consisting of 66,784 beneficiary-months totaling $119,856,383 ($72,189,464 Federal share) for home health services paid during the period October 1, 2008, through September 30, 2009.

SAMPLE UNIT

The sampling unit is one beneficiary-month.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected 100 sample units (beneficiary-months).

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 the Federal medical assistance percentage rate varied from quarter to quarter and was also increased under the provisions of 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
66,784	$119,856,383	100	$216,952	14	$6,552

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

	Total Estimated Unallowable Services	Total Estimated Unallowable Services (Federal Share)
Point estimate	$ 4,375,748	$ 2,684,662
Lower limit	$ 818,336	$ 494,040
Upper limit	$ 7,993,160	$ 4,875,284

APPENDIX C: STATE AGENCY COMMENTS

COLORADO DEPARTMENT OF HEALTH CARE POLICY

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

Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

October 22, 2010

Mr. Patrick Cogley, Regional Inspector General
Office of the Inspector General
Office of Audit Services
601 E. 12th Street, Room 0429
Kansas City, MO 64106

Re: Audit #A-07-10-01083

Dear Mr. Cogley:

Please find the Department of Health Care Policy and Financing's responses to the above-referenced audit report entitled, Review of Colorado Medicaid Payments for Home Health Agency Claims dated September 2010.

If you have any questions or comments, please feel free to contact me at 303-866-2590 or laurie.simon@state.co.us.

Sincerely,

Laurie Simon
Audit Coordinator

\las

cc: Greg Tanner
Nancy Downes

Department of Health Care Policy and Financing's
Initial Responses to the
Department of Health & Human Services
Office of Inspector General
Review of Colorado Medicaid Payments for Home Health Agency Claims
Control Number A-07-10-01083
September 2010

RECOMMENDATIONS

We recommend that the State Agency:

- **Refund $494,040 to the Federal Government for unallowable HHA services claims; and**

- ***Continue to strengthen internal controls to detect and recover improper payments for HHA services.***

Response to recommendation 1: *Partial Concurrence.*

The Department agrees to refund the federal financial participation for the actual amount of unallowable HHA services claims as determined by this audit. The total actual amount of unallowable HHA services claims as determined by this audit was $6,522 and the federal share of this amount was $4,020. This $4,020 in federal share will be refunded on the CMS-64 in the quarter in which this report is finalized and submitted to the Department as final.

Based on the Department's review, the sample chosen for review did not appear to be representative of the population since the average cost of a beneficiary month from the sample was over 20% higher than the average cost of a beneficiary month for the population.

Response to recommendation 2: *Concur*

The Department constantly strives for improvement therefore our Program Integrity Section will assign quarterly Home Health Agency record reviews to the Colorado Recovery Audit Contractor (RAC), when contracted to ensure that services billed are documented in addition to monitoring claims submitted for Medicare / Medicaid eligible clients when Medicare should be primary payer and Medicaid payer of last resort. In addition, Program Integrity and the RAC will share responsibility for reviewing home health services when clients are receiving hospice care, admitted to the hospital and for credit balances when providers do not know who to return money to when a third party paid.