Office of the Auditor General
Performance Audit Report

Home Health Services

Michigan Department of Health and Human Services

May 2016

State of Michigan Auditor General
Doug A. Ringler, CPA, CIA

391-0700-15

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

Article IV, Section 53 of the Michigan Constitution

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Report Summary

Performance Audit

Home Health Services

Michigan Department of Health and Human Services (MDHHS)

Report Number:
391-0700-15

Released:
May 2016

MDHHS's Medical Services Administration is responsible for the oversight of Michigan's Medicaid program. Home health services are covered Medicaid benefits for beneficiaries whose conditions do not require continuous medical/nursing and related care but do require health services on an intermittent basis in the home setting for the treatment of an injury, illness, or disability. During the audit period, MDHHS paid fee-for-service claims for 11,481 beneficiaries and Medicaid Health Plan rates for 31,995 beneficiaries who received home health services.

Audit Objective			Conclusion
Objective #1: To assess the sufficiency of MDHHS's administration of Medicaid home health services benefits.			Sufficient
Findings Related to This Audit Objective	**Material Condition**	**Reportable Condition**	**Agency Preliminary Response**
MDHHS did not ensure that home health agencies (HHAs) always obtained the necessary approvals prior to providing services and that HHAs always maintained appropriate documentation (Finding #1).		X	Agrees

Audit Objective			Conclusion
Objective #2: To assess the effectiveness of MDHHS in ensuring the propriety of home health services payments.			Effective
Findings Related to This Audit Objective	**Material Condition**	**Reportable Condition**	**Agency Preliminary Response**
See Finding #1.		X	Agrees

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Office of the Auditor General
201 N. Washington Square, Sixth Floor
Lansing, Michigan 48913

Doug A. Ringler, CPA, CIA
Auditor General

Laura J. Hirst, CPA
Deputy Auditor General

OAG
Office of the Auditor General
201 N. Washington Square, Sixth Floor • Lansing, Michigan 48913 • Phone: (517) 334-8050 • www.audgen.michigan.gov

Doug A. Ringler, CPA, CIA
Auditor General

May 5, 2016

Mr. Nick Lyon, Director
Michigan Department of Health and Human Services
Capitol View Building
Lansing, Michigan

Dear Mr. Lyon:

I am pleased to provide this performance audit report on Home Health Services, Michigan Department of Health and Human Services.

We organize our findings and observations by audit objective. Your agency provided a preliminary response to the recommendation at the end of our fieldwork. The *Michigan Compiled Laws* and administrative procedures require an audited agency to develop a plan to comply with the recommendations and submit it within 60 days of the date above to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

Doug Ringler

Doug Ringler
Auditor General

TABLE OF CONTENTS

HOME HEALTH SERVICES

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AUDIT OBJECTIVES, CONCLUSIONS, FINDINGS, AND OBSERVATIONS

ADMINISTRATION OF HOME HEALTH SERVICES BENEFITS

BACKGROUND

Home health services are covered benefits for Medicaid beneficiaries whose conditions do not require continuous medical/nursing and related care but do require health services on an intermittent basis in the home setting for the treatment of an injury, illness, or disability. Home health services include:

- Skilled nursing care
- Physical therapy
- Occupational therapy
- Home health aide care

Home health services are provided by home health agencies (HHAs). HHAs must be Medicare certified to enroll as a Medicaid provider and must comply with Medicare/Medicaid Conditions of Participation (Title 42, Part 484 of the *Code of Federal Regulations*) and the policies within the Michigan Department of Health and Human Services' (MDHHS's) Medicaid Provider Manual.

MDHHS establishes policies for HHAs to follow, creates and utilizes edits within its Community Health Automated Medicaid Processing System (CHAMPS) to help ensure that fee-for-service (FFS) claims are proper, and reviews medical documentation for preauthorization of therapy services when applicable.

AUDIT OBJECTIVE

To assess the sufficiency of MDHHS's administration of Medicaid home health services benefits.

CONCLUSION

Sufficient.

FACTORS IMPACTING CONCLUSION

- 100% of the HHAs reviewed were properly enrolled.
- None of the HHAs reviewed were included on the federal Excluded Parties List System and the federal Office of Inspector General's List of Excluded Individuals and Entities.
- 100% of the required site visits reviewed were completed in a timely manner and were properly documented.
- 96% of the site visits were being properly scheduled.
- 100% of the providers reviewed were properly revalidated every five years.

- We did not identify any HHAs that were improperly opened under different names or in the area under a federal moratorium.

- We did not identify any payments made to closed HHAs.

- Of those reviewed, 99% of the nurses, occupational therapists (OTs), physical therapists (PTs), occupational therapist assistants (OTAs), and physical therapist assistants (PTAs) were properly licensed; 100% of the home health aides and administrators met their respective educational requirements; and 97% of HHA staff met other required qualifications tested.

- Reportable condition* related to the need to improve the monitoring of home health agencies.

** See glossary at end of report for definition.*

FINDING #1

Monitoring of HHAs needs improvement.

MDHHS did not ensure that HHAs always obtained the necessary approvals prior to providing services and that HHAs always maintained appropriate documentation, potentially risking beneficiaries' health and federal funding and excessively inflating future Medicaid Health Plan (MHP) capitated rates.

The Medicaid Provider Manual, which is intended to disseminate federal and State Medicaid program compliance requirements, identifies the policies and procedures that all HHAs are required to follow. MDHHS communicates policy and procedure changes through the issuance of periodic bulletins.

Our review of 11 HHAs' documentation of services provided to 153 FFS and 64 MHP beneficiaries and our analysis of all FFS home health claims paid during the period October 1, 2012 through April 30, 2015 indicated:

a. HHAs did not always obtain the necessary approvals prior to providing services:

   (1) HHAs provided services to 91 (43%) of the 213 beneficiaries prior to having the required signed or verbal physician orders.

   (2) HHAs provided unallowed intermittent nurse visits on behalf of 51 beneficiaries who were concurrently receiving private duty nursing services. MDHHS identified the underlying weakness in its claim processing edits in January 2015 and implemented corrective action in December 2015.

b. HHAs did not always maintain appropriate documentation:

   (1) HHAs provided services to 4 (2%) of the 217 beneficiaries without having a required signed plan of care.

   (2) Beneficiaries' plans of care did not include required elements 3% to 98% of the time.

   (3) No documentation of 86 (40%) of the 217 beneficiaries' advance directives.

   (4) No documentation that 23 (19%) of the 121 beneficiaries had a required face-to-face encounter with their physician.

   (5) No documentation of the required supervision for nursing, home health aide, and therapy services provided to 57 (32%) of the 179 beneficiaries.

   (6) No documentation of prior authorization for 794 physical and occupational therapy services provided to 43 beneficiaries.

The noted exceptions may have been a result of the following:

a. The home health chapter of MDHHS's Medicaid Provider Manual did not provide clear guidance related to the following home health services requirements:

   - Face-to-face encounters
   - Plans of care
   - Nursing services
   - Resuming therapy services
   - Supervisory visits
   - Evaluation visits

b. MDHHS issues home health policy changes, on an as needed basis, to providers who have subscribed to the electronic notification service (Listserv). We determined that 16 (8%) of the 192 HHAs providing home health services had not subscribed to the Listserv and did not receive notification of the two policy changes issued during the audit period.

RECOMMENDATION

We recommend that MDHHS ensure that HHAs obtain the necessary approvals prior to providing services and that HHAs maintain appropriate documentation.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that HHAs did not always obtain the necessary approvals prior to providing services and that appropriate documentation was not always maintained to support services.

- *MDHHS will reiterate the requirement for obtaining documentation of physician orders (written or verbal) prior to providing care or services. Subsequent to implementation of enhanced claim edits in December 2015, MDHHS recouped payments associated with inappropriate intermittent nurse visits.*

- *The Medicaid Provider Manual HHA chapter will be reviewed for areas that may benefit from additional guidance on documentation requirements and updated as necessary.*

- *MDHHS will reiterate to HHAs their obligation to abide by all Medicare Conditions of Participation and policies in the Medicaid Provider Manual. In addition, providers are contractually responsible for being informed of all Medicaid updates. The MDHHS Listserv is offered as a means to communicate changes directly to providers. However, an HHA provider may choose to forego this option and instead manually obtain updates through the MDHHS website.*

Communication will be sent to all HHAs via the HHAs' addresses listed in CHAMPS reminding providers of their contractual obligation to be informed of all Medicaid updates.

PROPRIETY OF HOME HEALTH SERVICES PAYMENTS

BACKGROUND

Medicaid-covered services may be provided in the home only if circumstances exist that prevent the beneficiary from being served in a physician's office or other outpatient setting. An HHA is an organization that provides home care services, such as skilled nursing care, physical therapy, occupational therapy, and home health aide care.

Michigan's Medicaid Provider Manual provides guidance to HHAs to ensure that home health services provided to Medicaid beneficiaries meet specific criteria. Medicaid beneficiaries may be covered either on an FFS basis or under an MHP.

FFS Coverage:
MDHHS reimburses HHAs on an FFS basis for home health services provided to Medicaid beneficiaries with FFS coverage. HHAs submit claims to MDHHS for reimbursement through CHAMPS. Claims are subjected to 1,180 edit checks, such as provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services, and validity of service.

MHP Coverage:
MDHHS contracts with and pays a monthly capitated rate to MHPs to provide specific covered services to Medicaid beneficiaries with MHP coverage.

MHPs are responsible for providing, arranging for, and reimbursing providers for most medical services. Coverage includes current Medicaid-covered services, including home health services and additional services that MHPs choose to provide other than those specifically excluded in the Medicaid Provider Manual.

AUDIT OBJECTIVE

To assess the effectiveness* of MDHHS in ensuring the propriety of home health services payments.

CONCLUSION

Effective.

FACTORS IMPACTING CONCLUSION

- We identified $378,183 of improper FFS claim payments. Also, based on the claim data submitted by the MHPs, we estimated $61,695 of improper payments by the MHPs for home health services. Although these would not be allowable Medicaid costs, they represent only 1% of home

** See glossary at end of report for definition.*

health services costs, projected at $38.0 million. These improper FFS claim payments were forwarded to the fiscal year 2015 Statewide Single Audit.

- Reportable condition related to the need to improve the monitoring of HHAs (reported in Finding #1 within Objective #1).

AGENCY DESCRIPTION

Under the authority of the Medicaid State Plan, MDHHS provides home health services benefits to Medicaid beneficiaries whose conditions do not require continuous medical/nursing and related care but do require health services on an intermittent basis in the home setting for the treatment of an injury, illness, or disability. Home health services include:

- Skilled nursing care
- Physical therapy
- Occupational therapy
- Home health aide care

MDHHS's Medical Services Administration is responsible for the oversight of Michigan's Medicaid program. Medicaid provides medical assistance for low-income residents who meet certain eligibility criteria. The Medicaid program pays for a broad range of services including home health care.

During the audit period, MDHHS paid FFS claims for 11,481 beneficiaries and MHP rates for 31,995 beneficiaries who received home health services. In addition to the one MDHHS policy specialist staff dedicated to home health services, MDHHS staff within the Provider Enrollment Unit, the Medicaid Payments Division, and the Program Review Division perform respective duties related to home health services.

Executive Order No. 2015-4, effective April 10, 2015, created MDHHS, combining the former Department of Human Services and Department of Community Health into one principal department.

AUDIT SCOPE, METHODOLOGY, AND OTHER INFORMATION

AUDIT SCOPE

To examine the records and processes related to MDHHS's administration of home health services benefits. We conducted this performance audit* in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We did not include within the scope of this audit the verification of Medicaid eligibility. Medicaid eligibility is determined by MDHHS's local offices and is generally audited as part of the annual State of Michigan Single Audit.

PERIOD

Our audit procedures, which included a preliminary survey, audit fieldwork, report preparation, analysis of agency responses, and quality assurance, generally covered the period October 1, 2012 through April 30, 2015.

METHODOLOGY

We conducted a preliminary survey of the home health services benefits to formulate a basis for defining our audit objectives and methodology. During our preliminary survey, we:

- Interviewed policy specialist for home health services and staff from the Medicaid Payments Division to obtain an understanding of MDHHS's administration and payment of the benefit claims, including the claim edit process and automated edits within CHAMPS.
- Interviewed staff from the Provider Enrollment Unit to obtain an understanding of enrollment, revalidation, and site visit process for HHAs.
- Interviewed Office of Inspector General staff to obtain understanding of their reviews of HHAs and paid claims.
- Interviewed staff from the Department of Licensing and Regulatory Affairs' Bureau of Community and Health Care Systems to obtain an understanding of their process to certify and survey HHAs.
- Reviewed MDHHS's Medicaid Provider Manual and Medicaid State Plan, applicable laws, and appropriations acts.

** See glossary at end of report for definition.*

- Visited two judgmentally selected HHAs to obtain an understanding of the contents of their clinical records to plan for further testing.

OBJECTIVE #1

To assess the sufficiency of MDHHS's administration of Medicaid home health services benefits.

To accomplish this objective, we:

- Reviewed provider enrollment data; the federal lists of excluded parties, individuals, and entities; and MDHHS's site visit documentation for 20 of the 192 HHAs that received FFS claim payments during the period October 1, 2012 through April 30, 2015 to determine if the HHAs were properly enrolled; if any of the HHA owners, board of directors, and managing employees were included on the lists; and if the site visits were completed and documented.

  We judgmentally selected the 10 HHAs that received the highest amount of FFS claim payments and randomly selected an additional 10 HHAs from the remaining population to enable us to project the results to the overall population.

- Analyzed site visit data for the 279 HHAs that were required to have site visits conducted to determine if they were properly scheduled.

- Selected and tested 40 of the 397 HHAs that were enrolled in CHAMPS to determine if they were revalidated every 5 years. Our sample was randomly selected to eliminate any bias and to enable us to project the results to the entire population.

- Analyzed MDHHS data to identify inactive HHAs receiving FFS claim payments and to determine if HHA owners improperly opened HHAs under different names or in the area under a federal moratorium.

- Conducted site visits of 11 HHAs and obtained an understanding of their processes and reviewed documentation of services provided to 153 FFS and 64 MHP beneficiaries during the period October 1, 2012 through April 30, 2015.

- Reviewed the home health chapter of the Medicaid Provider Manual for clarity and held discussions with MDHHS policy specialist and HHA staff regarding policy interpretation.

- Determined MDHHS's process for notifying HHAs of policy changes and reviewed Listserv data to determine who was notified of the changes.

- Selected and tested the propriety of licenses or verified that staff met educational requirements for 229 of the 1,290 nurses, OTs, PTs, OTAs, PTAs, home health aides, and administrators. We judgmentally and haphazardly selected our samples to ensure that they were representative of the diversity of each HHA's organization. Therefore, we could not project the results to the overall population.

- Selected and tested the documentation of criminal background checks being performed for 119 of the 1,290 nurses, OTs, PTs, OTAs, PTAs, home health aides, and administrators. We judgmentally and haphazardly selected our samples to ensure that they were representative of the diversity of each HHA's organization. Therefore, we could not project the results to the overall population.

OBJECTIVE #2

To assess the effectiveness of MDHHS in ensuring the propriety of home health services payments.

To accomplish this objective, we:

- Performed data analytics on home health services FFS claim payment data paid during the period October 1, 2012 through April 20, 2015 for propriety.

- Visited 11 of the 192 HHAs and tested documentation of services provided to 153 of their 2,775 FFS beneficiaries and 64 of their 6,301 MHP beneficiaries to determine the sufficiency of the HHAs' documentation including:

    - Plans of care
    - Face-to-face encounters
    - Advance directives
    - Prior authorizations
    - Physician orders
    - Supervision of staff that provided selected services

  We judgmentally selected the HHAs based on the number of beneficiaries served, the amount of FFS and MHP claims, and the geographic location within the State. We randomly and judgmentally selected 153 FFS and 64 MHP Medicaid beneficiaries to eliminate bias and to ensure that our samples were representative of the variety of services provided by the HHAs. Therefore, we could not project the results to the overall population.

CONCLUSIONS

We base our conclusions on our audit efforts and the resulting material conditions* and reportable conditions.

When selecting activities or programs for audit, we direct our efforts based on risk and opportunities to improve State government operations. Consequently, we prepare our performance audit reports on an exception basis.

AGENCY RESPONSES

Our audit report contains 1 finding and 1 corresponding recommendation. MDHHS's preliminary response indicates that it agrees with the recommendation.

The agency preliminary response that follows the recommendation in our report was taken from the agency's written comments and oral discussion at the end of our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require an audited agency to develop a plan to comply with the recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

PRIOR AUDIT FOLLOW-UP

Following is the status of the reported findings from our December 1999 performance audit of Home Health Care, Department of Community Health, Department of Consumer and Industry Services, and Family Independence Agency (39-700-98):

Prior Audit Finding Number	Topic Area	Current Status	Current Finding Number
1a	Program Monitoring - Failure to Use Established Edits and Monitoring Procedures	Not in scope of this audit.	
1b	Program Monitoring - Lack of Monitoring System to Ensure Provider Compliance	Rewritten	1
1c	Program Monitoring - Lack of Policies and Procedures and Did Not Conduct Monitoring Practices	Not in scope of this audit.	
2	Management of the Children's Waiver Waiting List	Not in scope of this audit.	

** See glossary at end of report for definition.*

PRIOR AUDIT FOLLOW-UP (*Continued*)

Prior Audit Finding Number	Topic Area	Current Status	Current Finding Number
3a	Policies and Procedures - CHILDS Hourly Program	Not in scope of this audit.	
3b	Policies and Procedures - SHCP Hourly Program	Not in scope of this audit.	
3c	Policies and Procedures - Conflicts With CHILDS, SHCP, and Medicaid Eligibility Requirements	Not in scope of this audit.	
3d	Policies and Procedures - Children's Waiver Practices	Not in scope of this audit.	
3e	Policies and Procedures - Documentation	Not in scope of this audit.	
3f	Policies and Procedures - Date Stamping Documents	Not in scope of this audit.	
3g	Policies and Procedures - Supervisory Nursing Visits	Rewritten	1
4	Client Eligibility	Not in scope of this audit.	
5	Survey Sample Sizes	Not in scope of this audit.	
6	Survey Intervals	Not in scope of this audit.	
7	Complaint Follow-Up	Not in scope of this audit.	
8	Home Help Program Controls	Not in scope of this audit.	
9	Home Help Procedure Manual	Not in scope of this audit.	

GLOSSARY OF ABBREVIATIONS AND TERMS

CHAMPS	Community Health Automated Medicaid Processing System.
effectiveness	Success in achieving mission and goals.
FFS	fee-for-service.
HHA	home health agency.
material condition	A matter that, in the auditor's judgment, is more severe than a reportable condition and could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program.
MDHHS	Michigan Department of Health and Human Services.
MHP	Medicaid Health Plan.
OT	occupational therapist.
OTA	occupational therapist assistant.
performance audit	An audit that provides findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria. Performance audits provide objective analysis to assist management and those charged with governance and oversight in using the information to improve program performance and operations, reduce costs, facilitate decision making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.
PT	physical therapist.
PTA	physical therapist assistant.

reportable condition	A matter that, in the auditor's judgment, is less severe than a material condition and falls within any of the following categories: an opportunity for improvement within the context of the audit objectives; a deficiency in internal control that is significant within the context of the audit objectives; all instances of fraud; illegal acts unless they are inconsequential within the context of the audit objectives; significant violations of provisions of contracts or grant agreements; and significant abuse that has occurred or is likely to have occurred.

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