GREAT NURSING CARE, INC. ALSO KNOWN AS GOOD NURSING CARE, INC.
FRANKLIN COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JULY 1, 2011 THROUGH JUNE 30, 2014

Dave Yost · Auditor of State

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GREAT NURSING CARE, INC. ALSO KNOWN AS GOOD NURSING CARE, INC.
FRANKLIN COUNTY

TABLE OF CONTENTS

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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH REQUIREMENTS OF THE MEDICAID PROGRAM APPLICABLE TO HOME HEALTH SERVICES

James Boltz, President
Great Nursing Care, Inc. also known as Good Nursing Care, Inc.
1653 Brice Road
Reynoldsburg, Ohio 43068

RE: *Medicaid Provider Number 2317951*

Dear Mr. Boltz:

We examined your (the Provider) compliance with specified Medicaid requirements for service documentation, service authorization and provider qualifications related to the provision of home health nursing, home health aide, private duty nursing, waiver nursing and personal care aide during the period of July 1, 2011 through June 30, 2014. We reviewed the Provider's records to determine if it had support for services billed to and paid by Ohio Medicaid and compared the elements contained in the documentation to the Medicaid rules. In addition, we determined if the services were authorized in the plan of care and all services plans and reviewed personnel records to verify that nursing and aide qualifications were met. The accompanying Compliance Examination Report identifies the specific requirements examined.

Provider's Responsibility

The Provider entered into an agreement with the Ohio Department of Medicaid (ODM) to provide services to Medicaid recipients (the Provider Agreement). The Provider Agreement outlines the responsibility to adhere to the terms of the agreement, state statutes and rules, federal statutes and rules, and the regulations and policies set forth in the Medicaid Handbook including the duty to maintain records supporting claims for reimbursement made by Ohio Medicaid. Therefore, the Provider is responsible for complying with the requirements and laws outlined by the Medicaid program.

Auditor's Responsibility

Our responsibility is to express an opinion and report on the Provider's compliance with the specified Medicaid requirements based on our examination. Our examination was performed under our authority in Section 117.10 of the Ohio Revised Code and conducted in accordance with the American Institute of Certified Public Accountants' attestation standards and, accordingly, included examining, on a test basis, evidence supporting the Provider's compliance with those Medicaid requirements and performing such other procedures as we considered necessary in the circumstances. We believe our examination provides a reasonable basis for our opinion. However, our examination does not provide a legal determination on the Provider's compliance with the specified Medicaid requirements.

Internal Control Over Compliance

The Provider is responsible for establishing and maintaining effective internal control over compliance with the Medicaid requirements. We did not perform any test of the internal controls and we did not rely on the internal controls in determining our examination procedures. Accordingly, we do not express an opinion on the effectiveness of the Provider's internal control over compliance.

Basis for Qualified Opinion

Our examination disclosed that in a material number of instances aides did not meet the minimum qualifications and plans of care were not signed by the physician before the service was submitted for reimbursement. In addition, in one exception test, we found material non-compliance with services lacking supporting documentation.

Qualified Opinion on Compliance

In our opinion, except for the effects of the matters described in the Basis for Qualified Opinion paragraph, the Provider has complied, in all material respects, with the aforementioned requirements pertaining to service documentation, service authorization and provider qualifications for the period of July 1, 2011 through June 30, 2014.

Our testing was limited to the specified Medicaid requirements detailed in the Compliance Examination Report. We did not test other requirements and, accordingly, we do not express an opinion on the Provider's compliance with other requirements.

We found the Provider was overpaid by Ohio Medicaid for services rendered between July 1, 2011 and June 30, 2014 in the amount of $4,960,319.74. This finding plus interest in the amount of $257,053.28 totaling $5,217,373.02 is due and payable to the ODM upon its adoption and adjudication of this examination report. When the Auditor of State identifies fraud, waste or abuse by a provider in an examination,[1] any payment amount in excess of that legitimately due to the provider will be recouped by ODM, the state auditor, or the office of the attorney general. Ohio Admin. Code § 5160-1-29(B)

This report is intended solely for the information and use of the ODM, the Ohio Attorney General's Office, the U.S. Department of Health and Human Services/Office of Inspector General and other regulatory and oversight bodies, and is not intended to be, and should not be used by anyone other than these specified parties. In addition, copies are available to the public on the Auditor of State website at www.ohioauditor.gov.

Dave Yost
Auditor of State

June 9, 2016

[1] "Fraud" is an intentional deception, false statement, or misrepresentation made with the knowledge that the deception, false statement, or misrepresentation could result in some unauthorized benefit to oneself or another person. "Waste and abuse" are practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an overutilization of Medicaid covered services and result in an unnecessary cost to the Medicaid program. Ohio Admin. Code § 5160-1-29(A)

COMPLIANCE EXAMINATION REPORT

Background

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. The rules and regulations that providers must follow are specified in the Ohio Administrative Code and the Ohio Revised Code. The fundamental concept underlying the Medicaid program is medical necessity of services: defined as services which are necessary for the prevention, diagnosis, evaluation or treatment of an adverse health condition. *See* Ohio Admin. Code § 5160-1-01(B) According to Ohio Admin Code § 5160-1-17.2(D), Medicaid providers must "maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions" for a period of six years from receipt of payment or until any audit initiated within the six year period is completed. Providers must furnish such records for audit and review purposes. Ohio Admin Code § 5160-1-17.2(E)

The only provider of home health aide services is a Medicare certified home health agency (MCRHHA) that meets the requirements in accordance with Ohio Admin. Code § 5160-12-03. Personal care aide and waiver nursing services, which are waiver services, can be provided by a MCRHHA, an otherwise-accredited home health agency or a non-agency home care provider.

The Provider is a MCRHHA that furnishes home health services. During our examination period, the Provider received reimbursement of $12,059,214.93 for 193,349 home health services rendered on 113,472 recipient dates of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date of service. These home health services included the following:

- $5,096,127.16 for skilled nursing services (procedure code G0154);
- $2,948,809.19 for personal care services (procedure code T1019);
- $1,092,970.20 for home health aide services (procedure code G0156);
- $2,149,970.61 for private duty nursing services (procedure code T1000);
- $633,842.67 for waiver nursing services (procedure codes T1002 and T1003);
- $113,081.54 for physical therapy services (procedure code G0151);
- $22,105.54 for occupational therapy services (procedure code G0152); and
- $2,308.02 for speech pathology services (procedure code G0153).

The Provider also uses the name Good Nursing Care, Inc.; however, we found no business registered with the Ohio Secretary of State matching this name.

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether the Provider's Medicaid claims for reimbursement complied with Ohio Medicaid regulations. Please note that all rules and code sections relied upon in this report were those in effect during the examination period and may be different from those currently in effect.

The scope of the engagement was limited to an examination of the following home health services: home health (skilled) nursing (procedure code G0154); private duty nursing (procedure code T1000); waiver nursing (procedure codes T1002 and T1003); home health aide (procedure code G0156); and personal care aide (procedure code T1019) that the Provider rendered to Medicaid recipients and received payment during the period of July 1, 2011 through June 30, 2014.

We received the Provider's claims history from the Medicaid Management Information System (MMIS) and the Medicaid Information Technology System (MITS) database of services billed to and paid by Ohio's Medicaid program. We removed any voids, services paid at zero and services with third party payments.

Purpose, Scope, and Methodology (Continued)

We then extracted three exception tests to examine these services in their entirety. Frist, we extracted RDOS with 10 or more services (Exception Test 1). Second, we extracted all services provided during September 2013 for two recipients with the same address and same dates of service (Exception Test 2). Third, we extracted all services in October 2013 rendered to a recipient who resided in Washington County (Exception Test 3).

After removing the services in the three exception tests, we used statistical sampling approach to facilitate a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code § 5160-1-27(B)(1). From the population of 112,738 RDOS, we selected a random sample of 746 RDOS. We then obtained the detailed services for the 746 RDOS which resulted in a sample of 1,283 services.

An engagement letter was sent to the Provider setting forth the purpose and scope of the examination. During the entrance conference, the Provider described its documentation practices and process for submitting billing to the Ohio Medicaid program. During fieldwork we reviewed personnel records and service documentation. We sent a missing records list and a subsequent final request for information to the Provider and we reviewed all documents received for compliance.

Results

We examined 31 home health nursing, waiver nursing and personal care aide services in our exception test of RDOS with 10 or more services (Exception Test 1) and found 14 errors. As a result, we identified $763.48 as an overpayment.

We examined 38 home health nursing services in our exception test of services rendered in September 2013 to two recipients with the same address and same dates of service (Exception Test 2) and found one error. As a result, we identified $52.20 as an overpayment.

We examined 62 home health aide and personal care aide services in our exception test of services rendered in October 2013 to a recipient who resided in Washington County (Exception Test 3) and found 31 errors. As a result, we identified $1,465.06 as an overpayment.

We examined 1,283 home health nursing, waiver nursing, private duty nursing, home health aide and personal care aide services in our statistical sample and found 553 errors. The overpayments identified for 373 of 746 statistically sampled RDOS (528 of 1,283 services) were projected to the Provider's population of paid claims resulting in a projected overpayment of $4,958,039 with a 95 percent degree of certainty that the true population overpayment amount fell within the range of $4,491,694 to $5,424,384 (+/- 9.41 percent.). A detailed summary of our statistical sample and projection results is presented in **Appendix I**. While certain services had more than one error, only one finding was made per service. The basis for our findings is discussed below in more detail.

A. Provider Qualifications

Nursing Services

According to Ohio Admin. Code §§ 5101:3-12-01(A)[2], 5101:3-46-04(A), 5101:3-47-04(A), 5101:3-50-04(A), home health and waiver nursing requires the skills of and is performed by either a registered nurse or a licensed practical nurse at the direction of a registered nurse.

[2] Per Section 323.10.70 of Am. Sub. H. B. 59 of the 130th General Assembly, the Legislative Services Commission renumbered the rules of the Office of Medical Assistance within the Department of Job and Family services to reflect its transfer to ODM. The renumbering became effective on October 1, 2013.

A. Provider Qualifications (Continued)

Nursing Services (Continued)

We searched the names of the 47 nurses that rendered services in our exception tests and statistical sample on the Ohio e-License Center website to ensure that their professional license was current and valid on the first date of service in our tests and was active during remainder of examination period.

We found no instances of non-compliance.

Aide Services

Prior to rendering services, home health aides are required to obtain state licensure or complete training and/or a competency evaluation program that meets the requirements of 42 CFR 484.36 (a) or (b). The competency evaluation program includes an annual performance review and 12 hours of in-service continuing education annually. *See* Ohio Admin. Code § 5101:3-1-01(G)(2)

In order to submit a claim for reimbursement, all individuals providing personal care aide services must complete a competency evaluation program and obtain and maintain a current first aid certification. In addition, personal care aides must complete 12 hours of in-service continuing education. *See* Ohio Admin. Code §§ 5101:3-12-03(B), 5101:3-46-04(B), 5101:3-47-04(B) and 5101:3-50-04(B)

We judgmentally selected 80 aides that rendered home health aide services and/or personal care aide services in our exception tests and/or statistical samples. The Provider could not submit a list of staff that differentiated between home health aides and personal care aides so we used the type of services provided in the exception tests and statistical sample to apply qualification requirements for our testing.

First Aid Certification

All 80 aides tested provided personal care aide services. We reviewed personnel records to verify that the aide had obtained and maintained first aid certification. Of the 80 tested, 62 did not have a first aid certification and 12 of the 18 with first aid certification had lapses in time without a current certification. We determined that the aides with no first aid certification were ineligible to render personal care aide services during our examination period and aides with lapses in certification were ineligible to render personal care aide services during the lapse. The Provider's current administrative staff was unaware of the reason for the high number of aides with no certification.

Initial Competency Evaluation

We tested the 43 aides that were hired during our examination period to determine compliance with the initial competency evaluation requirement. The Provider confirmed that no aides were hired to provide only waiver services. We tested to ensure that an initial competency evaluation was completed, that it addressed all of the required elements including the four areas that must be observed and that the evaluation was performed by a registered nurse. We found 42 aides were non-compliant and ineligible to render services. Of these 42 aides, nine had no competency evaluation; 34 had no evidence of the four observation areas, and 16 had no evidence that a registered nurse conducted the evaluation.

Provider Qualifications (Continued)

Aide Services

In-Service Hours

For compliance of in-service continuing education hours, we limited our testing to aides who were employed for the full calendar year of 2012 and/or 2013. We tested 16 aides for continuing education hours for calendar year 2012 and 20 aides for calendar year 2013. We noted that documentation to support in-service continuing education did not always include the number of hours earned. At least one hour was earned in all instances where the hours were documented so we considered documentation without duration to support one hour.

We applied an 80 percent threshold in determining eligibility. If an aide completed less than 80 percent (10 of the 12 required hours), we identified the aide as ineligible to render services for that year. For aides that completed at least 10 but not all 12 hours, we identified the aide as not materially compliant but eligible to render services.

We found 12 of the 16 aides tested obtained less than 10 of the required 12 hours of in-service continuing education in 2012 and 11 of the 20 aides tested in 2013 obtained less than 10 the required 12 hours of in-service continuing education. We concluded these aides were ineligible to render services in the year(s) of non-compliance.

We also identified one aide in 2012 that obtained 11 the required 12 hours of in-service continuing education. We concluded this aide was non-compliant but did not consider the aide ineligible or associate an overpayment with the services rendered while non-compliant. We identified no errors for this aide in our testing.

Exception Test 1 – RDOS with 10 or More Services

We reviewed 31 services and identified six services rendered by an aide who was ineligible to render services. These six services are included in the overpayment of $763.48.

Exception Test 2 - Services for Two Recipients Residing at the Same Address, September, 2013

We noted no errors.

Exception Test 3 – Services for Recipient Residing in Washington County, October 2013

We reviewed 62 services and identified 31 services rendered by an aide who was ineligible to render services. These 31 services are included in the overpayment of $1,465.06.

Statistical Sample

We reviewed 1,283 services and identified 359 services rendered by an aide who was ineligible to render services. These 359 errors were used in the overall projection of $4,958,039.

B. Service Documentation

The MCRHHA must maintain documentation of home health services provided that includes, but is not limited to, clinical records and time keeping that indicate time span of the service and the type of service provided. See Ohio Admin. Code § 5101:3-12-03(C)(4) Documentation to support personal care aide services must include the tasks performed or not performed and the arrival and departure times. See Ohio Admin. Code §§ 5101:3-46-04(B)(8), 5101:3-47-04(B)(8) and 5101:3-50-04(B)(8)

B. Service Documentation (Continued)

According to Ohio Admin. Code § 5101:3-45-10(A), providers of waiver services must maintain and retain all required documentation including, but not limited to, the dated signatures of the provider and the recipient or authorized representative verifying the service delivery upon completion of service delivery.

We reviewed all documentation submitted by the Provider to verify that there was documentation which supported the services and units billed and contained the required elements.

Exception Test 1 – RDOS with 10 or More Services

We reviewed 31 services and identified eight services in which there were no documentation to support the service. These eight services are included in the overpayment of $763.48.

Exception Test 2 and Exception Test 3

We noted no errors.

Statistical Sample

We reviewed 1,283 services and identified the following errors:

- 57 services in which there was no supporting documentation;
- 10 services in which the units billed exceeded units documented;
- 1 personal care aide service in which no time in or time out was recorded; and
- 1 waiver service in which the documentation was not signed by the nurse who rendered the service.

These 69 errors were used in the overall projection of $4,958,039.

We also noted two nursing services in which there was no documentation of duration or time of departure. Since the first hour (four units) of nursing is paid at the base rate, we did not associate overpayments in those instances where there was supporting documentation and the Provider billed four units or less.

C. Authorization to Provide Services

Plan of Care

All home health providers are required by Ohio Admin. Code § 5101:3-12-03(B)(3)(b) to create a plan of care for recipients including recipients' medical condition and treatment plans anticipated by provider. The plan of care is also required to be signed by the treating physician of the recipient. Home health providers must obtain the completed, signed and dated plan of care prior to billing ODM for the service.

We reviewed records to verify that there was a signed and dated plan of care which authorized the service and it contained frequency and duration. In addition, we compared the date of the physician's signature to the date the service was submitted to ODM for payment.

Exception Test 1 and Exception Test 3

We noted no errors.

C. Authorization to Provide Services (Continued)

Exception Test 2 - Services for Two Recipients Residing at the Same Address, September, 2013

We reviewed 38 services and identified one service that was submitted for reimbursement prior to the date the physician signed the plan of care. This one service is included in the overpayment of $52.20.

Statistical Sample

We reviewed 1,283 services and found the following errors:

- 86 services that were submitted for reimbursement prior to the date the physician signed the plan of care;
- 22 services with no plan of care to authorize the services;
- 6 services in which the plan of care was signed but not dated by the physician (and there was no fax date from the physician); and
- 1 service in which the plan of care did not authorize the home health aide service.

These 115 errors were used in the overall projection of $4,958,039.

All Services Plan

According to Ohio Admin. Code § 5101:3:12-01, the Medicare certified home health agency must be identified on the all services plan when a recipient is enrolled in home and community based waiver.

We obtained one all services plan for every recipient that received a waiver service in the sample and verified that the Provider was identified and authorized to provide the rendered service.

Statistical Sample

We reviewed 415 waiver services and found one service in which there was no all services plan and one personal care aide service that was not authorized on the all services plan. These two errors were used in the overall projection of $4,958,039.

D. Healthchek Services

According to Ohio Admin. Code § 5101:3-12-01(H), a recipient may qualify for increased services if (1) the individual is under age 21; (2) requires more than, as ordered by the treating physician, eight hours per day of any home health service or a combined total of 14 hours per week of home health aide and home health nursing services; (3) has a comparable level of care as evidenced by either enrollment in a home and community based service waiver or a level of care initially and annually evaluated by ODM or its designee; and (4) requires nursing or combination of nursing and skilled therapy visits at least once per week as ordered by treating physician. The MCRHHA must assure and document the consumer meets all requirements prior to increasing services. The U5 modifier must be used when billing for Healthchek services in accordance to Ohio Admin. Code § 5101:3-12-05 which indicates that all conditions of this rule have been met.

We identified all services that were billed with a U5 modifier and, using information in ODM's care management system, determined that the individual was not on a waiver on the date of service. We reviewed the records for these recipients to verify that an initial and/or annual level of care evaluation form was completed and it demonstrated the comparable level of care. We found no instances of services with U5 modifier in any of our exception tests.

C. Healthchek Services (Continued)

Statistical Sample

We reviewed the 57 services modified with U5 and identified six services in which there was no Healthchek certification form. These six errors were used in the overall projection of $4,958,039.

Subsequent Events:

The Provider disclosed that after receipt of the draft compliance examination report, it ceased operations and is no longer rendering services.

Provider Response:

The Provider submitted an official response to the results of this examination which is presented in **Appendix II**. We did not examine the Provider's response and, accordingly, we express no opinion on it.

Auditor of State Response:

During the exit conference on August 16, 2016, the owners stated that they had taken steps to ensure continuity of care by linking all recipients with another home health agency, with most recipients going to one specific agency. In addition, this specific home health agency agreed to be the custodian of the Provider's medical records. The owners also stated that many of its employees were hired by the same agency.

The identified overpayments in this examination are the result of the Provider's failure to consistently meet selected requirements that were in place for all home health agencies reimbursed through Ohio's Medicaid program. We initially developed recommendations for the Provider to bring its practices into compliance; however, we removed those recommendations from the final report after the Provider reported that it had chosen to cease operations.

APPENDIX I

Summary of Sample Record Analysis
For the period July 1, 2011 to June 30, 2014

POPULATION
The population is all paid Medicaid home health (skilled) nursing (procedure code G0154), private duty nursing (procedure code T1000), waiver nursing (procedure codes T1002 and T1003), home health aide (procedure code G0156) and personal care aide (procedure code T1019) services, less certain excluded services, net of any adjustments, where the service was performed and payment was made by ODM.

SAMPLING FRAME
The sampling frame was paid and processed claims from MMIS and MITS. These systems contain all Medicaid payments and all adjustments made to Medicaid payments by the State of Ohio.

SAMPLE UNIT
The sampling unit was a recipient date of service (RDOS).

SAMPLE DESIGN
We used a simple random sample.

Description	Results
Number of Population RDOS Provided	112,738
Number of Population RDOS Sampled	746
Number of RDOS Sampled with Errors	373
Number of Population Services Provided	191,253
Number of Population Services Sampled	1,283
Number of Services Sampled with Errors	528
Total Medicaid Amount Paid for Population	$11,915,480.48
Actual Amount Paid for Population Services Sampled	$81,133.54
Projected Population Overpayment Amount	$4,958,039
Upper Limit Overpayment Estimate at 95 Percent Confidence Level	$5,424,384
Lower Limit Overpayment Estimate at 95 Percent Confidence Level	$4,491,694
Precision of Population Overpayment Projection at the 95 Percent Confidence Level	$466,345 (+/-9.41%)

Source: Analysis of MMIS and MITS information and the Provider's records

APPENDIX II

August 9, 2016

Re: Great Nursing Care Inc. (f/k/a Good Nursing Care, Inc.)
Medicaid Provider Number: 2317951

To Whom It May Concern,

In spite of not being active in the day-to-day management of Great Nursing Care, Inc. ("GNC"), we were responsible, as the agency's owners for nearly 2 decades, for providing the leadership that stressed core values of integrity and exceptional service with kindness and compassion.

Throughout that nearly 20-year time period, which included care of a significant census of very ill patient visits, GNC never had a significant adverse patient result. Additionally, in spite of the well-documented and rampant fraud issues that plague our industry, GNC never had any claims of unscrupulous billing procedures.

That being said, the ownership recognized shortcomings in some administrative practices and made the necessary changes to insure proper documentation of compliance. We especially appreciated the acknowledgement from the State Auditor's team that the current GNC team has been cooperative and professional. It was – and remains – our strong belief that the GNC administrative challenges of the past had been resolved and that our practices, and our organization, top to bottom, were exceptional.

It's not difficult to imagine that the State's demand of $5,217,373.02 as "due and payable" would be a death sentence for many, if not most, small businesses. Certainly, GNC is no longer viable under such a demand and unfortunately has had to be responsibly closed.

It is our opinion this demand for more than $5 million in reimbursement is unfortunate, unjustified and overly severe. The agency provided patients necessary quality care with no adverse results. Yet the State's expectation of 100% reimbursement of the visits' payments has resulted in 94 full-time, hard-working folks being laid off. More significantly, many of the well-deserving rural, mostly indigent, Medicaid patient pool are left to fend for themselves.

We have had much difficulty finding resources for this rural, indigent population to obtain the care they require and deserve. Nobody has benefited from the State's demand. Over nearly 2 decades of providing care, GNC never caused patients harm; we are deeply concerned that the actions of the State could!

With Great Sadness,
Former owners of Great Nursing Care, Inc.

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Dave Yost • Auditor of State

GREAT NURSING CARE, INC

FRANKLIN COUNTY

CLERK'S CERTIFICATION
This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
SEPTEMBER 1, 2016

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