ACCENTCARE HOME HEALTH OF CALIFORNIA, INC., DBA ACCENTCARE ALSO KNOWN AS SUNPLUS HOME CARE - CIRCLEVILLE
PICKAWAY COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JULY 1, 2008 THROUGH JUNE 30, 2011

Dave Yost • Auditor of State

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ACCENTCARE HOME HEALTH OF CALIFORNIA, INC., DBA ACCENTCARE

PICKAWAY COUNTY

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

AccentCare Home Health of California, Inc., DBA AccentCare
also known as SunPlus Home Care – Circleville
Steve Rodgers, Chief Executive Officer
17855 North Dallas Parkway, Suite 200
Dallas, Texas 75287

RE: Medicaid Provider Number 2062904 and 2896817

Dear Mr. Rodgers:

We examined your (the Provider) compliance with specified Medicaid requirements for service documentation and service authorization related to the provision of home health aide and personal care aide services during the period of July 1, 2008 through June 30, 2011. We tested service documentation to verify that there was support for the date of service, the procedure code, and the units billed to and paid by Ohio Medicaid. We also examined the all services plans and plans of care to determine if the Provider was authorized to render personal care aide services and/or home health care aide services and reviewed provider qualifications. 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 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 Adverse Opinion

Our examination disclosed that in a material number of instances the Provider did not have service documentation to support billed services, aides did not meet the provider qualification requirements, and service documentation for personal care aide services did not include the signature of the recipient or authorized representative. The Provider declined to submit a signed representation letter acknowledging responsibility for maintaining records and complying with applicable laws and regulations regarding Ohio Medicaid reimbursement; establishing and maintaining effective internal control over compliance; making available all documentation related to compliance; and responding fully to our inquiries during the examination.

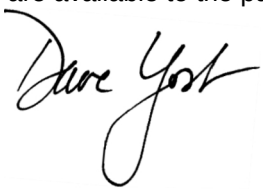
Adverse Opinion on Compliance

In our opinion, the Provider has not complied, in all material respects, with the aforementioned requirements for the period of July 1, 2008 through June 30, 2011.

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 the Ohio Medicaid for services rendered between July 1, 2008 and June 30, 2011 in the amount of $1,202,598.31 (see Results section for period to recover overpayments). This finding plus interest in the amount of $150,876.67 totaling $1,353,474.98 is due and payable to the Ohio Department of Medicaid (ODM) upon ODM's adjudication of this examination report. When the Auditor of State (AOS) 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 Ohio Department of Medicaid, the Medicaid Fraud Control Unit of 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

September 25, 2015

[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 FOR
ACCENTCARE HOME HEALTH OF CALIFORNIA, INC., DBA ACCENTCARE

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 diagnosis or treatment of disease, illness, or injury, and which, among other things, meet requirements for reimbursement of Medicaid covered services. *See* Ohio Admin. Code § 5160-1-01(A). 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 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 Provider renders healthcare services through various locations in multiple states. In Ohio, the Provider operates as a Medicare Certified Home Health Agency (MCRHHA) with offices located in Circleville and Marion. The Provider furnished home health aide, nursing services, private duty nursing, waiver nursing, personal care aide services, and physical, occupational and speech therapy services during our examination period. The Provider received a total reimbursement of $14,923,188.75 which included $2,006,281.30 for 44,321 home health aide services and $7,053,806.43 for 96,721 personal care aide services rendered on 108,881 recipient dates of service (RDOS) during our examination period. An RDOS is defined as all services for a given recipient on a specific date of service. The home health aide services and personal care aide services accounted for 60.71 percent of the Provider's total reimbursement received from Ohio Medicaid.

Ohio Medicaid recipients may be eligible to receive home health aide services, personal care aide services or both. The only provider of home health aide services is a MCRHHA that meets the requirements in accordance with Ohio Admin. Code § 5160-12-03. Personal care aide services can be provided by a MCRHHA, an otherwise-accredited home health agency or a non-agency personal care aide.

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 home health aide services, 15 minute unit (procedure code G0156) and personal care aide services, 15 minute unit (procedure code T1019) that the Provider rendered to Medicaid recipients and received payment during the period of July 1, 2008 through June 30, 2011.

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, services with third party payments and services previously recouped by the Surveillance and Utilization Review Section of ODM. From the remaining population we extracted all home health aide services (procedure code G0156) and all personal care aide services (procedure code T1019) and summarized them by date of service. We adopted a two stage cluster sample: in stage one we selected a simple random sample of 50 dates of service and in stage two we selected a stratified random sample of 25 RDOS in each of the 50 dates of service. This resulted in a sample of 545 home health aide services (procedure code G0156) and 1,058 personal care aide services (procedure code T1019) for a total of 1,603 services.

An engagement letter was sent to the Provider on June 5, 2014, setting forth the purpose and scope of the examination. An entrance conference was held with the Provider on August 4, 2014. During the entrance conference, the Provider described its documentation practices, personnel procedures and billing process. Our field work was performed following the entrance conference. A list of missing records was supplied to the Provider on four occasions during the course of our examination.

In April, 2015, two weeks after the exit conference was held with the Provider to explain the results of the compliance examination, the Provider submitted a substantial number of records to support its services. We had previously requested these records be made available for our on-site fieldwork in August, 2014 and had submitted several missing records requests to the Provider to obtain all of the requested information during our regular fieldwork. The documentation provided after the exit conference included records that had never been provided for our examination. In addition, the additional documents included some of the same records previously submitted and we noted instances in which some of the documents had changes from the previously submitted version. We re-performed our tests, incorporating the additional records, and the results below were updated accordingly.

Results

We reviewed a statistical sample of 1,603 services and identified 416 errors. ODM may recover an overpayment during the five-year period immediately following the end of the state fiscal year in which the overpayment was made according to Ohio Rev. Code § 5164.57. The overpayments identified for 36 of 50 statistically sampled dates of service were projected to the Provider's population of paid claims, where services paid prior to July 1, 2009 were given an overpayment value of $0.00, using a two-stage cluster sampling approach. Dates of service were the primary units and RDOS were the secondary units in the projection which resulted in a projected overpayment of $1,505,519.69 with a 95 percent degree of certainty with a precision of $360,959.72. Since the precision achieved was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed lower limit estimate (equivalent to method used in Medicare audits). This allows us to say that we are 95 percent certain that the population overpayment is at least $1,202,598.31. A detailed summary of our statistical sample and projection results is presented in **Appendix I.**

A. Provider Qualifications

Prior to rendering services, home health aides are required to complete home health aide training and 12 hours of in-service continuing education annually. In addition, the home health aide must successfully complete a competency evaluation program which includes an annual performance review that addresses the same required subject areas as the home health aide training, except for communication skills.

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 eight hours of in-service continuing education. The requirement for a personal care aide's continuing education increased to 12 hours annually on October 25, 2010. *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 tested 19 aides that rendered home health aide services and/or personal care aide services during our examination period. The Provider could not submit a list of staff that differentiated between home health aides and personal care aides. For those aides that provided services in the sample, we used the type of services provided in the sample to apply qualification requirements for our test. For those employees that did not render a service included in the sample, we applied the requirements for the home health aide services.

First Aid Certification

Our sample included 16 aides that rendered personal care aide services during our examination period. Our review of personnel records found one aide that had obtained first aid certification in October, 2010 (approximately nine months of our examination period); however, this aide had rendered services prior to obtaining the certification. We found 15 aides with no first aid certification. The Provider stated that it was unaware of the first aide requirement for personal care aides. We concluded that these 15 aides were ineligible to render services during our examination period and one aide was ineligible for a portion of the examination period.

Annual Competency Evaluation

We found one home health aide that did not have an annual competency evaluation. We concluded that this aide was ineligible to render services; however, this individual did not render any of the services included in the sample.

Annual Continuing Education

To test compliance with the requirement for annual training, we obtained an understanding of how the Provider documented continuing education hours completed by aides. The Provider indicated that training logs were completed for each aide by calendar year. The Provider further stated that a different training topic was covered each month and that each training session was one hour in duration. Using the information provided, we compiled the training topics completed for the 19 aides in our sample.

After the exit conference, the Provider submitted additional documentation which included training logs that were previously provided. We noted that 15 of the training logs had been altered from the version originally provided. The Provider stated that the training logs had been altered in an attempt to "fix" them after the initial version was provided to us for this examination.

The training documentation does not reflect the duration of any of the training sessions so we were unable to verify that any of the aides completed the required annual hours of continuing education. While the Provider initially stated that each training topic was one hour in duration, it later indicated that duration varied by topic. While we were unable to verify the number of continuing education hours completed, the training logs for16 of the aides tested showed 11 or 12 training topics with dates during the calendar year.

We found three aides in the sample in which the documentation indicated that little training was completed. The Provider conducted its own review and reported that these three aides had not completed the required annual continuing education. These errors include one aide with only one continuing education topic noted in a four year period and two aides who did not complete 12 training topics in at least two of the four years tested. We concluded that these three aides were not eligible to render services during the years in which they did not complete the required annual training.

While reviewing the training logs we also noted instances where the topics and dates on the training log did not match the topics and dates on the posttests submitted by the Provider. For example, one training log showed that "safety first" was the topic covered in September and December; however, the posttests for this topic are dated in April of the same year. The training logs contained pre-printed monthly topics and on some logs the pre-printed topic was marked out and replaced with one section of the "safety first" manual. The logs show the training was held on one day indicating the aides completed most of the required hours on that one day. On some training logs, safety was listed as a topic for one month while for others it was a topic for two or three months.

We identified overpayments for all services rendered by an aide that did not meet the provider qualifications on the date of service. These errors, for those services that were paid on, or subsequent to, July 1, 2009, were used in the overall finding projection of $1,202,598.31.

Recommendation:

The Provider should ensure that all employees meet the required qualifications prior to rendering services. The Provider should also develop and implement a system to ensure continuing education requirements are met. In addition, the Provider should review its process for providing and documenting training, including duration, and develop internal controls to ensure procedures are consistently implemented. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

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 records 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(B)(8) According to Ohio Admin Code § 5101:3-45-10(A), for each unit of personal care aide service provided, the Provider is required to obtain the signature of the recipient on the dated document. This requirement was amended on October 25, 2010 to require the dated signature of the recipient or authorized representative verifying the service delivery upon completion of service delivery.

We reviewed 1,603 services in our statistical sample and identified the following errors:

- 101 personal care aide services in which the service documentation was not signed by the recipient or authorized representative;
- 68 services in which there was no supporting documentation;
- 9 services in which the units reimbursed did not agree to the units on the service documentation; and
- 3 services in which the service documentation did not include tasks performed.

The overpayments associated with the errors for services that were paid on, or subsequent to, July 1, 2009 were used in the overall finding projection of $1,202,598.31.

Recommendation:

The Provider should strengthen its internal controls to ensure that services for which there is no supporting documentation are not billed, that the correct number of units is billed and that documentation includes all required elements. The Provider should also ensure that documentation for personal care aide services includes the signature of the recipient or authorized representative, upon completion of service delivery. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

C. Authorization to Provide Services

Plan of Care

In order for home health services to be covered, MCRHHA's must provide home health services as specified in the plan of care in accordance with rule 5101:3-12-03 of the Administrative Code. *See* Ohio Admin. Code § 5101:3:12-01(E)(3)(a) In addition, Ohio Admin. Code § 5101:3:12-03(B) requires that MCRHHA's implement policy components as specified in the Medicare Benefit Policy Manual,

Chapter Seven: Home Health Services for "Content of the Plan of Care" section 30.2 which states the plan of care must be reviewed and signed by the physician who established the plan of care, at least every 60 days. Each review of a recipient's plan of care must contain the signature of the physician and the date of review.

We reviewed the plans of care in effect for the 545 home health aide services in our statistical sample and identified the following errors:

- 21 services in which the plan of care was not signed and/or dated by the physician;
- 2 services in which the plan of care did not authorize home health aide services; and
- 1 service in which there was no plan of care.

We noted that in at least one instance the Provider obtained a copy of the original signed plan of care from the physician while we were conducting our examination. We concluded this plan of care was signed and dated by the physician during the certification period and before the service was billed. We also noted that in at least two instances the Provider attempted to obtain a copy of the signed plan of care from the physician while we were conducting our examination but the physician affixed a current date. We concluded these plans of care were not valid because they were dated after the certification period and after the service was billed.

The overpayments associated with the errors for services that were paid on, or subsequent to, July 1, 2009 were used in the overall finding projection of $1,202,598.31.

We also identified 27 services in which either the plan or care or the addendum to the plan of care was signed and dated but both pages were not signed. In these instances, we accepted either the plan of care or the addendum to the plan of care as authorization for the services.

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 haphazardly selected one all services plan from our examination period for each of the 149 waiver recipients in our statistical sample and verified that the Provider was listed as an authorized practitioner to render personal care aide services. We noted no errors.

Recommendation:

The Provider should develop and implement procedures to ensure all plans of care are signed and dated by the recipient's treating physician prior to rendering services. The Provider should also ensure the signed and dated plans of care are maintained in the patient files. The Provider should address the identified issue to ensure compliance with Medicaid rules and avoid future findings.

Provider Response:

AccentCare was provided an opportunity to respond to this report. The response was evaluated and changes were made to this report as AOS deemed necessary. The response can be obtained by contacting AccentCare at the address listed on the first page of this report. We did not examine the Provider's response and, accordingly, we express no opinion on it.

APPENDIX I

POPULATION
The population is all paid Medicaid home health aide (G0156) and personal care aide (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 primary sampling unit was date of service and the secondary sampling unit was a recipient date of service (RDOS). A date of service is defined as all services furnished by and paid to the Provider on a specific date of service and RDOS is defined as all services for a given recipient on a specific date.

SAMPLE DESIGN
We used a two stage cluster random sample.

Summary of Sample Record Analysis
For the period July 1, 2008 to June 30, 2011
Where the payment was made by ODM on, or subsequent to, July 1, 2009

Description	Results
Number of Population Dates of Service (Primary Units)	1,095
Number of Population Dates of Service Sampled	50
Number of Population Dates of Service Sampled with Errors	36
Number of Population RDOS Provided (Secondary Units)	108,881
Number of RDOS in Sampled Dates of Service	4,919
Number of RDOS Sampled from Sample Dates of Service	1,250
Number of Population Services	141,042
Number of Population Services Sampled	1,603
Number of Services Sampled with Errors	246
Total Medicaid Amount Paid for Population	$9,060,087.73
Amount Paid for Population Services Sampled	$99,968.06
Estimated Population Overpayment Amount (Point Estimate)	$1,505,519.69
Precision of Estimate at 95 Percent Confidence Level	$360,959.72
Precision of Estimate at 90 Percent Confidence Level	$302,921.38
Single-tailed Lower Limit Overpayment Estimate at 95 Percent Confidence Level (Calculated by subtracting the 90 percent overpayment precision from the point estimate) (Equivalent to the estimate method used for Medicare audits)	$1,202,598.31

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

Dave Yost • Auditor of State

ACCENT CARE

PICKAWAY 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
OCTOBER 8, 2015

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