



Commonwealth of Massachusetts  
Office of the State Auditor  
Suzanne M. Bump

*Making government work better*

Official Audit Report – Issued May 23, 2017

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## Community Connection Healthcare, LLC

For the period July 1, 2011 through June 30, 2016





Commonwealth of Massachusetts  
Office of the State Auditor  
Suzanne M. Bump

*Making government work better*

May 23, 2017

Mr. Brian Harvey, Chief Executive Officer  
Community Connection Healthcare, LLC  
1266 Furnace Brook Parkway, Suite 104  
Quincy, MA 02169

Dear Mr. Harvey:

I am pleased to provide this performance audit of Community Connection Healthcare, LLC. This report details the audit objectives, scope, methodology, and conclusions for the audit period, July 1, 2011 through June 30, 2016. My audit staff discussed the contents of this report with management of the agency, whose comments are reflected in this report.

I would also like to express my appreciation to Community Connection Healthcare, LLC for the cooperation and assistance provided to my staff during the audit.

Sincerely,

A handwritten signature in blue ink, appearing to read "SMBump".

Suzanne M. Bump  
Auditor of the Commonwealth

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## LIST OF ABBREVIATIONS

ADL	activity of daily living
AFC	adult foster care
CCH	Community Connection Healthcare, LLC
CMR	Code of Massachusetts Regulations
CNA	certified nursing assistant
EOHHS	Executive Office of Health and Human Services
GAFC	group adult foster care
HHA	home health aide
IADL	instrumental activity of daily living
MMIS	Medicaid Management Information System
OSA	Office of the State Auditor
RN	registered nurse
VNA	visiting nurse association

## **EXECUTIVE SUMMARY**

Community Connection Healthcare, LLC (CCH) was established in 2011 as a private for-profit human-service agency. During the audit period, CCH received the majority of its payments for services from MassHealth (the state's Medicaid program) and functioned as a group adult foster care (GAFC) provider for patients throughout Massachusetts under MassHealth's Office of Long-Term Care.

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor (OSA) has conducted a performance audit of CCH for the period July 1, 2011 through June 30, 2016. The purpose of our audit was to determine whether CCH administered its GAFC program in accordance with applicable regulations and contractual requirements. In addition, we conducted data analytics on the claims that CCH submitted to MassHealth for GAFC to determine whether they were in accordance with MassHealth regulations. This audit was conducted as part of OSA's ongoing efforts to audit human-service contracting activity by state agencies and to promote accountability, transparency, and cost-effectiveness in state contracting.

Our audit revealed no significant instances of noncompliance that must be reported under generally accepted government auditing standards.

## OVERVIEW OF AUDITED ENTITY

Community Connection Healthcare, LLC (CCH), located in Quincy, was established in 2011 as a group adult foster care (GAFC) provider under the Office of Long-Term Care within the state’s Medicaid program, MassHealth.

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services is responsible for the administration of MassHealth. For the five-year period July 1, 2011 through June 30, 2016, MassHealth paid approximately \$1.4 billion to 296 providers of home health services for GAFC and adult foster care (AFC) for a non-duplicated total of 30,889 members,<sup>1</sup> as detailed below.

### GAFC and AFC Services

Fiscal Year	GAFC Amount Paid	Number of GAFC Claims	AFC Amount Paid	Number of AFC Claims	Total Amount Paid	Total Claims
2012	\$ 89,489,451	2,232,534	\$131,785,027	1,938,192	\$ 221,274,478	4,170,726
2013	89,212,542	2,224,641	156,592,097	2,303,876	245,804,639	4,528,517
2014	85,997,168	2,139,365	186,631,899	2,665,749	272,629,067	4,805,114
2015	84,646,269	2,107,886	219,740,660	3,076,802	304,386,929	5,184,688
2016	81,520,915	2,032,711	244,592,964	3,418,503	326,113,879	5,451,214
<b>Total</b>	<u>\$430,866,345</u>	<u>10,737,137</u>	<u>\$939,342,647</u>	<u>13,403,122</u>	<u>\$1,370,208,992</u>	<u>24,140,259</u>

Over the five-year audit period, MassHealth expenditures for GAFC and AFC grew by more than 47%.

During the audit period, CCH received a total of \$11,810,801 in GAFC payments from MassHealth for 311,970 claims for 848 members.

### Adult Foster Care and Group Adult Foster Care Programs

The Adult Foster Care and Group Adult Foster Care Programs provide elderly or disabled MassHealth members with assistance performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include activities such as eating, toileting, dressing, bathing, and walking. IADLs are

1. “Non-duplicated” means that each member is only counted once even if that member received services in each of the audited years.

activities related to independent living that are incidental to a member's care, such as household management, laundry, shopping, housekeeping, meal preparation and cleanup, transportation, and medication management. Members are eligible to receive AFC or GAFC if they require assistance or supervision with at least one ADL. Both programs are designed to provide sufficient assistance to allow members to continue to live independently and avoid the high cost of a long-term-care facility.

Members enrolled in the Group Adult Foster Care Program typically live in assisted-living residences or subsidized group housing. Members receive assistance with ADLs and IADLs from GAFC aides for one to two hours each day. GAFC providers also employ nurses and case managers who meet with members at least once every two months to develop and revise member-specific care plans.

Members who receive AFC live in the private residences of caregivers employed by MassHealth-contracted AFC providers and receive 24-hour supervision and assistance with ADLs and IADLs. Each AFC residence may house up to three members. AFC providers must provide nursing and case management for each member.

### **Home Health Services Program**

The Home Health Services Program pays for home health services, including skilled nursing, home health aides (for ADLs and IADLs), and therapeutic services (physical, occupational, and speech and language therapy), that are medically necessary for eligible MassHealth members who are under the care of physicians and who live in non-institutional settings. These settings may include their homes, homeless shelters, or other temporary residences in community settings. The program provides home health services through contracts with home health agencies and independent nurses.<sup>2</sup>

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2. CCH is not part of this program.

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## AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor (OSA) has conducted a performance audit of certain activities of Community Connection Healthcare, LLC (CCH) for the period July 1, 2011 through June 30, 2016.

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.

Below is our audit objective, indicating the question we intended our audit to answer, the conclusion we reached regarding the objective, and where the objective is discussed in this report.

Objective	Conclusion
1. Did CCH properly administer its group adult foster care (GAFC) program?	Yes; see <u>Other Matters</u>

### Auditee Selection

MassHealth paid providers approximately \$1.4 billion for adult foster care (AFC) and GAFC during our audit period. Because of the amount of these expenditures, as well as prior OSA reports that identified unallowable claims for AFC and GAFC, OSA is conducting a series of audits focusing on providers of AFC and GAFC. We performed data analytics on these AFC and GAFC claims to identify (1) the frequency and cost of AFC and GAFC and (2) service trends and billing anomalies indicating potential fraud, waste, and abuse. Our data analytics identified the providers that billed for AFC and GAFC most often. We selected CCH for audit because we determined that its billings (more than \$11 million) were in the highest 10 billing totals of all GAFC providers during the audit period.

### Methodology

We gained an understanding of the internal controls we deemed significant to our audit objective through document reviews, interviews, and observation of GAFC provided by CCH. We evaluated the design and effectiveness of controls related to verifying that nursing visits were scheduled and verified,



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and we assessed whether they were operating as CCH management intended. We designed procedures to obtain sufficient, appropriate evidence to support our assessment.

CCH provided us with its sub-regulatory guidance for the Group Adult Foster Care Program,<sup>3</sup> provided to it by MassHealth.

In addition, we performed the following procedures:

- We queried all CCH’s claims for GAFC and home health services from MassHealth’s Medicaid Management Information System (MMIS) for the audit period. We performed data analytics on these claims to identify cases where MassHealth paid a GAFC claim and a home health claim for the same date of service.
- We selected a statistically random sample of GAFC payments—54 of CCH’s 22,970 claims from the audit period—to determine whether they were billed appropriately. We used the outcome of our sample tests to assess the compliance of requested documentation, including plans of care, physician summary approval forms, member discharge plans, nurses’ progress notes, caregiver logs, records of 60-day nursing visits,<sup>4</sup> semiannual health assessments, and timesheets to support each visit and concurrent home health services.

OSA separately assessed the reliability of information stored in MMIS, tested selected system controls, and interviewed knowledgeable agency officials about the data. We performed additional validity and integrity tests on all claim data, including (1) testing for missing data, (2) scanning for duplicate records, (3) testing for values outside a designated range, and (4) looking for dates outside specific time periods. Based on the analyses conducted, we determined that the data obtained were sufficiently reliable for the purposes of this audit.

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3. During the audit period, MassHealth had not enacted regulations governing the Group Adult Foster Care Program. Instead, it relied on a set of sub-regulatory guidelines to communicate program standards and requirements to GAFC providers. The Group Adult Foster Care Guidelines require GAFC providers to ensure “that all regulations and guidelines of [MassHealth] for the Adult Foster Care Program are met” for the Group Adult Foster Care Program as well.

4. These visits are performed to assess a member’s medical condition and use this information to determine whether any changes in the care plan are warranted.

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## OTHER MATTERS

### **1. MassHealth allowed Community Connection Healthcare, LLC to bill \$1,814,810 for unallowable group adult foster care.**

During the audit period, Community Connection Healthcare, LLC (CCH) billed, and received payments totaling as much as \$1,814,810 from MassHealth, for group adult foster care (GAFC) services that were duplicative and therefore not allowable under MassHealth regulations. These GAFC services were provided on the same days that the CCH patients received skilled nursing in their homes.

MassHealth does not have regulations governing the Group Adult Foster Care Program and relies on a set of sub-regulatory guidelines to communicate program standards and requirements to GAFC providers. The Group Adult Foster Care Guidelines require GAFC providers to ensure “that all regulations and guidelines of [MassHealth] for the Adult Foster Care Program are met” for the Group Adult Foster Care Program as well.

For the Adult Foster Care Program, Section 408.437 of Title 130 of the Code of Massachusetts Regulations (CMR) states, in part,

*The MassHealth agency does not pay an [adult foster care, or AFC] provider when*

*(A) the member is receiving any other personal care services, including, but not limited to . . . home care services under the Executive Office of Elder Affairs regulation 651 CMR 3.03(5).*

According to 651 CMR 3.01(2), these services (referred to therein as “home health services”) include “skilled nursing care and home health aide” services. Home health aide (HHA) services, in turn, are defined under the same regulation as including the following:

*Services provided to Clients under the supervision of a registered nurse, or a speech, occupational, or physical therapist. This includes personal care; simple dressing changes that do not require the skills of a registered nurse; [and] assistance with medications that are ordinarily self-administered and that do not require the skills of a registered or licensed nurse.*

MassHealth enabled this improper practice in a September 15, 2014 email to AFC providers from its then-director of Long-Term Services and Supports. This email informed providers that they could bill for certain home health services that are not allowable under MassHealth’s regulations. We originally identified the issue of duplicative services in an audit of MassHealth (No. 2016-1374-3M2) and made several recommendations to MassHealth to address it, including a recommendation that it not pay for

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GAFC for MassHealth members who receive these and similar services while living in rest homes. CCH should collaborate with MassHealth to find out whether MassHealth intends to cease paying for these duplicative services.

At the end of our audit, we gave CCH and MassHealth an opportunity to review, and provide comments on, this section of the report. MassHealth stated that it disagreed with our conclusion that GAFC services were duplicative and therefore not allowable under MassHealth regulations:

*MassHealth regulations **do allow** for individuals in GAFC to also receive skilled nursing services. In other words, members who have both personal care needs and medical needs for skilled nursing services are entitled to receive **both** skilled nursing services from a home health provider and personal care services from a GAFC provider.*

MassHealth also discussed its Home Health Services Program, which it referred to as “the EOEA Home Care Program,” in its response:

*The EOEA Home Care Program includes **both personal care services and non-personal care services**. Non-personal care services in the EOEA Home Care Program include home adaptations, translation services as well as home health skilled nursing. GAFC services may not be concurrently provided with personal care services in the EOEA Home Care Program. However . . . MassHealth regulations **do allow** for individuals in GAFC to also receive skilled nursing services through the EOEA Home Care Program.*

Although we agree that MassHealth’s regulations allow people in GAFC to receive skilled nursing, we do not agree that they allow it to be provided through a separate program such as the EOEA Home Care Program. Rather, MassHealth regulations require the AFC/GAFC provider to provide these services. Specifically, for the Adult Foster Care Program, 130 CMR 408.402 defines AFC services as follows:

*Services ordered by a physician delivered to a member in a qualified setting as described in 130 CMR 408.435 by a multidisciplinary team and qualified AFC caregiver, that includes assistance with ADLs, IADLs, other personal care as needed, **nursing services and oversight**, and AFC care management. [Emphasis added.]*

Further, 130 CMR 408.415(B) discusses the scope of AFC services as follows:

*Nursing Services and Oversight. The AFC provider must provide nursing coverage by a registered nurse in compliance with 130 CMR 408.433(B)(2). Nursing services must be individualized to meet the needs of each member and must include all of the following activities . . .*

4. *conducting on-site visits with each member at the qualified setting:*
  - a. *for Level I, bimonthly (alternating with the bimonthly visit by the care manager);*

*b. for Level II, monthly, or **more often as the member's condition warrants.***  
[Emphasis added.]

Finally, MassHealth stated that in fall 2017, it will put forth regulations governing the GAFC program and “will clarify when GAFC services do not duplicate other services a member is receiving.” However, as long as MassHealth directs GAFC providers to follow AFC regulations, these services will continue to be unallowable.

Regarding this issue, CCH stated,

*Skilled nursing services are not allowed by the existing GAFC guidelines and as such, the client might need more than 1 service in order to be stabilized in the home. MassHealth has never explained it as duplicate services. GAFC is defined as a non-skilled service, where nursing is seen as skilled therefore no duplication was expressed.*

In our opinion, CCH’s response supports the need for MassHealth to promulgate GAFC-specific regulations to clarify this matter.

## **2. MassHealth may be able to realize significant savings by changing how it administers medications to GAFC members.**

Currently, when a GAFC member cannot manage his or her own medications, the GAFC provider notifies the member’s physician, who writes a referral for medication management and sends it to the GAFC provider. The GAFC provider then typically contracts with a visiting nurse association (VNA) to provide the needed services and bills MassHealth directly for the services. GAFC providers use registered nurses (RNs) to manage medication because the HHAs they use to provide services under the Group Adult Foster Care Program are not qualified to manage medication according to MassHealth regulations. However, medication could be managed by certified nursing assistants (CNAs) who are certified in medication management.

As previously noted, consumers in MassHealth’s Group Adult Foster Care Program are not supposed to receive skilled nursing according to MassHealth’s sub-regulatory guidelines. However, in developing its GAFC regulations, if MassHealth chooses to allow its contracted GAFC providers to continue providing skilled nursing to members while they are receiving GAFC, it should consider a more cost-effective alternative. For example, under 105 CMR 700.003(F)(2), the Executive Office of Health and Human Services (EOHHS) allows unlicensed personnel who have successfully completed the required training in administering prescription medication to perform medication management. Therefore, MassHealth

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could allow CNAs with certification in medication management to administer medications to GAFC members. EOHHS has specifically developed a training manual (the MAP Policy Manual) that details its training and certification requirements for healthcare workers, including CNAs, to perform medication management.

We believe there appears to be an opportunity for significant savings if MassHealth, rather than paying directly for skilled nursing from RNs, directs GAFC providers to use CNAs who are certified in medication management to provide GAFC to members who need medication management. In these instances, the GAFC cost per visit would increase from \$40.33<sup>5</sup> for a two-hour HHA visit to approximately \$55.00 for a CNA visit, but MassHealth would save the approximately \$35.63 per visit that it is now paying VNAs for medication management. This would result in a net savings to the Commonwealth of \$20.96 per visit. During our audit period, CCH GAFC members had \$4.0 million in GAFC costs and \$3.6 million in skilled-nursing costs, including medication administration, for a total of \$7.6 million. If MassHealth had assigned medication management to CNAs, it would have decreased this cost to \$5.5 million, resulting in savings of as much as \$2.1 million at CCH alone.

Moreover, during the five-year period covered by our audit, MassHealth paid all GAFC providers, including CCH, a total of approximately \$94.2 million for skilled nursing for GAFC members. If all these providers had used CNAs rather than HHAs to provide services to members who needed medication management, it appears that MassHealth could have realized even greater savings.

In its comments on this section of the report, MassHealth stated,

*MassHealth appreciates the purpose and intent of the [OSA] recommendation for possible cost savings that might be achieved through a change in the design of the GAFC program. . . . However . . . medication administration is a skilled nursing service and, as such, MassHealth members who need personal care provided by GAFC and who also need assistance with medication administration may receive both GAFC and skilled nursing services concurrently.*

We do not dispute that GAFC program participants may need both personal care and skilled nursing. However, our analysis involved using CNAs who are, by virtue of their training, already certified in medication management to provide both home health and medication management services. In our

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5. Labor costs are based on average wage amounts reported by the United States Department of Labor, the United States Bureau of Labor Statistics, and MassHealth billing information. Our calculated costs for HHAs included various administrative expenses in addition to the hourly wages included in the fee that MassHealth charges GAFC providers.

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opinion, if changing how these services are delivered presents an opportunity for substantial savings, MassHealth should further investigate that option.

In response, CCH stated,

*Community Connection Healthcare, LLC (CCH) is of the opinion that the GAFC model could be changed to include CNA medication administrations. GAFC would be the least costly alternative. Being that the suggested change to the regulations would not only encompass the administration of medications, but also would include assistance with ADLs and IADLs.*

*Under current Rules of Payment, a Nurse RN or LPN can administer medications and leave within 15 minutes of engaging in the visit. This does not allow for assessment of the patient's reaction to the medications. Not only does it not allow for the assessment to be done, the 15 minutes would not encompass a complete visit under the Rules of Participation. Many agencies providing medication administration circumvent the Rules of Participation by insisting that a 15-minute visit is acceptable under the Rules of Payment. This 15-minute rule for payment was not intended to encompass a full visit in 15 minutes. This rule was intended for nurses doing block or hourly time for a company to bill in 15-minute increments. For instance, if a nurse was working block time and she/he worked 3 hours and 15 minutes. Not only would the 3 hours be billable, but also the 15 minutes. If the same nurse worked 3 hours and 5 minutes only the 3 hours would be billable, not the 5 minutes.*

*The standard in Massachusetts by the many Nursing Agencies has been to do an administering medications visit in 15 minutes. 15 minutes is sub standard. This standard was not for the well being of the patients, but in fact to commoditize the patient. The 15-minute standard is to get as many patients seen for billing as possible without care of the outcome, because to assess the effect of a medication orally administered it would take about 40 minutes. So doing a 15-minute oral medication administration visit does not require a nurse since there is no nursing skill required due to there not being an assessment of the medications effects.*

*Once again, we do agree that many of the medication functions do not need a skilled nurse, they are merely just reminding and assisting the client with the taking of simple medications. It is evident that the state could achieve significant cost savings from utilizing the GAFC program if the staff was MAP trained.*

*CCH does believe there should be some changes made to GAFC Guide Lines, being at the present time GAFC services has the lowest threshold to obtain care at home in GAFC approved settings. These settings must be enlarged to encompass a broader spectrum of housing and living situations to include single-family homes. If a client is Mass Health eligible, they should be able to be approved for GAFC as long it is not a duplication of services. **To bend the cost curve of medication administration, GAFC should be able to operate anywhere a VNA does.** Under this proposal, the GAFC could provide the Medication administration and ADLs. Currently the VNA has the nurse do the medication administration and has to bill the state more money in order to provide an HHA/CNA to do the ADLs.*

*CCH would like to make it known that we have many cost saving ideas that would benefit and save the state money, but have limited the topic of this response to coincide with the major focus of the audit. We would like to keep an open line of communication for any further questions.*

We agree that there are opportunities for savings in the area of providing medication management to GAFC members, and we encourage MassHealth to collaborate with CCH to further investigate this and other cost-saving options in conjunction with MassHealth's development of updated, GAFC-specific regulations.