Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump
Making government work better

Official Audit Report – Issued April 6, 2017

Medical Community Services, Inc.

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

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Mr. George Akinkuoye, Chief Executive Officer
Medical Community Services, Inc.
264 Union Avenue, Suite 3
Framingham, MA 01702

Dear Mr. Akinkuoye:

I am pleased to provide this performance audit of Medical Community Services, Inc. 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 Medical Community Services, Inc. for the cooperation and assistance provided to my staff during the audit.

Sincerely,

Suzanne M. Bump
Auditor of the Commonwealth

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LIST OF ABBREVIATIONS

ADL	activity of daily living
AFC	adult foster care
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
MCS	Medical Community Services, Inc.
MMIS	Medicaid Management Information System
OSA	Office of the State Auditor
RN	registered nurse
VNA	visiting nurse association

EXECUTIVE SUMMARY

Medical Community Services, Inc. (MCS) was incorporated in June 2013 as a domestic for-profit corporation to provide group adult foster care (GAFC) and adult foster care. Between 2011 and 2013, MCS did business in Massachusetts as a provider of home health services under the name Medicol Inc. MCS's management structure and process were identical to those of Medicol Inc.[1] During the audit period, MCS was a GAFC provider for the Office of Long-Term Care within the Commonwealth's Medicaid program, known as MassHealth. MCS serves citizens living in locations throughout Massachusetts, including Framingham, Boston, Springfield, and Worcester. It receives the majority of its payments for services from MassHealth.

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 MCS for the period July 1, 2011 through June 30, 2016. The purpose of this audit was to determine whether MCS administered its GAFC program in accordance with applicable regulations and contractual requirements. In addition, we conducted data analytics on the claims that MCS 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.

1. The audit team used the claims from both MCS and Medicol Inc. in reviewing GAFC claims.

OVERVIEW OF AUDITED ENTITY

Medical Community Services, Inc. (MCS), located in Framingham, was incorporated in June 2013 and, during the audit period, was a group adult foster care (GAFC) provider for MassHealth's Office of Long-Term Care.

Under Chapter 118E of the Massachusetts General Laws, the state's 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[2] of 30,889 members (see below for details).

GAFC and AFC

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
Total	$430,866,345	10,737,137	$939,342,647	13,403,122	$1,370,208,992	24,140,259

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

During the audit period, MCS received a total of $11,087,644 in GAFC payments from MassHealth for 274,923 paid claims for 542 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

2. "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. The Adult Foster Care and Group Adult Foster Care 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.[3]

3. MCS is not part of this program.

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 Medical Community Services, Inc. (MCS) for the period July 1, 2011 through June 30, 2016. We reviewed claims from Medicol Inc. from 2011 through September 2013 and from MCS for the rest of the audit period. Both companies originally operated under the name Medicol Inc. as a single group adult foster care (GAFC) entity; in September 2013, Medicol Inc. broke away to become a home healthcare business, and MCS was formed to continue its mission of providing GAFC. Since both companies submitted GAFC claims under the same management, we reviewed the claims from both entities for our audit period.

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 MCS properly administer its GAFC program?	**Yes; see Other Matters**

Auditee Selection

MassHealth paid providers approximately $1.4 billion for adult foster care (AFC) and GAFC during the 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 MCS 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 MCS. We evaluated the design and effectiveness of controls related to verifying that nursing visits were scheduled and approved, and we assessed whether they were operating as MCS management intended. MCS provided us with its sub-regulatory guidance for the Group Adult Foster Care Program,[4] provided to it by MassHealth.

In addition, we performed the following procedures:

- We separately assessed the reliability of information stored in MassHealth's Medicaid Management Information System (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.

- We queried all of MCS's claims for GAFC and home health services from MMIS for the audit period. We performed data analytics on these claims to identify cases where MassHealth paid a GAFC claim and a home healthcare claim for the same date of service.

- We selected a nonstatistical random sample of GAFC payments to determine whether they were billed appropriately. We selected 45 of MCS's 35,810 payments from MassHealth from the audit period, totaling $1,448,331. We used the outcome of our sample tests to assess compliance of requested documentation, including plans of care, physician summary approval forms, member discharge plans, nurses' progress notes, caregiver logs, 60-day nursing visits,[5] semiannual health assessments, and timesheets to support each visit and concurrent home health services. Because the sample was nonstatistical, we could not project the results of the test to the entire population.

4. 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.
5. 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.

OTHER MATTERS

1. MassHealth allowed Medical Community Services, Inc. to bill $1,434,256 for unallowable group adult foster care.

During the audit period, Medical Community Services, Inc. (MCS) billed, and received payments totaling as much as $1,434,256 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 the MCS 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 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 GAFC for

MassHealth members who receive these and similar services while living in rest homes. MCS 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 MCS and MassHealth an opportunity to review, and comment 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 Home Health Services Program. Rather, MassHealth regulations require the AFC or 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.

In response to this issue, MCS stated,

> *It is difficult to follow guidelines that are not in place or explicitly explained. Having definitive guidelines in place would help to solve some of these interpretation issues. It is our goal to provide the best quality care to our clients and we look forward to seeing updated, detailed guidelines that will provide GAFC agencies with sufficient guidance to administer the best care possible, while maintaining compliance with standard guidelines for all companies to follow. . . .*
>
> *Every claim reviewed had a referral for [visiting nurse association, or VNA] services documented. Services provided were reviewed on a regular basis to ensure that duplication of services was not occurring. At times it is necessary to refer out for intensive medication management and monitoring of comorbidities to ensure client safety and compliance with a medical plan of care prescribed by the primary care physician.*

We do not dispute that all the claims in question may have had referrals for VNA services. However, our concern, as noted above, is that these services were duplicative because MassHealth regulations required the AFC or GAFC provider to provide them.

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 VNA to provide the needed services and then 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 the administration of prescription medication to perform medication management. Therefore, MassHealth 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[6] for a two-hour HHA visit to approximately $55.00 for a CNA visit, but MassHealth would save the approximately $28.06 per visit that it is now paying VNAs for medication management. This would result in a net savings to the Commonwealth of $13.39 per visit. During our audit period, MCS members had approximately $4.7 million in GAFC costs and $3.2 million in skilled-nursing costs, for a total of $7.9 million. If MassHealth had assigned medication management to CNAs, it would have decreased this cost to $6.4 million, resulting in savings of as much as $1.5 million at MCS alone.

Moreover, during the five-year period covered by our audit, MassHealth paid all GAFC providers, including MCS, 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.

6. 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.

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