



The Commonwealth of Massachusetts
AUDITOR OF THE COMMONWEALTH

ONE ASHBURTON PLACE, ROOM 1819
BOSTON, MASSACHUSETTS 02108

A. JOSEPH DeNUCCI

AUDITOR

TEL (617) 727-6200

NO. 2009-1374-3S1

INDEPENDENT STATE AUDITOR'S REPORT ON
MASSHEALTH'S ADMINISTRATION OF THE
HOME HEALTH SERVICES PROGRAM

JULY 1, 2007 TO JUNE 30, 2008

OFFICIAL AUDIT
REPORT
DECEMBER 17, 2010

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MassHealth, the state's Medicaid program, is under the Executive Office of Health and Human Services (EOHHS), the largest secretariat in the Commonwealth. More than 1.2 million low-income or disabled children, families, and elders receive health care in Massachusetts under MassHealth programs. In fiscal year 2008, MassHealth paid in excess of \$6.8 billion on approximately 58 million claims to 30,000 providers. The Medicaid program, which represents approximately 30% of the Commonwealth's annual budget, is funded by the state and federal governments.

MassHealth's Home Health Services (HHS) program provides payment for HHS, including skilled nursing, home health aide, and therapeutic services (physical, occupational, and speech and language) that are medically necessary to eligible MassHealth members who are under the care of a physician and who reside in non-institutional settings, which may include the member's home, a homeless shelter, or other temporary residence in a community setting. HHS are provided through contracts with home health agencies (HHAs) and independent nurses (INs). In fiscal year 2008, MassHealth processed approximately 1.2 million HHS claims and paid approximately \$145 million to HHAs and INs for the care of approximately 18,000 MassHealth members. The HHS program is representative of the Commonwealth's "Community First Policy," which follows a national trend towards generally less costly community-based services. It is intended to reduce the need for more costly hospitalization and institutionalization and to help members maintain their independence and quality of life.

In accordance with Chapter 11, Section 12, of the Massachusetts General Laws, the Office of the State Auditor conducted an audit of MassHealth's administration of the HHS program. Our audit was conducted in accordance with applicable generally accepted government auditing standards. The objectives of the audit were to: (1) determine whether MassHealth has established adequate internal controls over the payments of claims for HHS; (2) determine whether claims were paid in compliance with applicable laws, rules, and regulations and MassHealth's policies and procedures; and (3) make recommendations to improve MassHealth's oversight and internal controls, including policies, procedures, and regulations, in the HHS program.

Our audit revealed that MassHealth has not established adequate internal controls over certain activities in its HHS program. As a result, we found that MassHealth paid a number of questionable and potentially fraudulent claims. MassHealth should consider making improvements to the administration of program services to better ensure that quality care is provided to its members in a safe environment and in the most efficient and cost-effective manner. Our audit makes a number of recommendations on how to address these issues.

AUDIT RESULTS**5****INADEQUATE INTERNAL CONTROLS IN MASSHEALTH'S HHS PROGRAM HAVE RESULTED IN QUESTIONABLE PAYMENTS FOR HOME HEALTH SERVICES AND A LACK OF ASSURANCE THAT PROGRAM SERVICES ARE BEING PROVIDED IN THE SAFEST AND MOST EFFICIENT MANNER****5**

Our audit revealed that inadequate internal controls over MassHealth's HHS program have resulted in claims being paid that were: (a) potentially fraudulent; (b) inaccurately billed; (c) not billed in compliance with regulations; (d) not representative of the least costly form of comparable care available in the community; and (e) for services that may have been rendered under conditions that may compromise the safety and quality of care of MassHealth members.

a. Potentially Fraudulent Claims Were Paid**5**

We found that MassHealth has not established effective oversight activities and internal controls to prevent, deter, and detect HHS providers who bill for services that may have not been performed. For example, the hours worked by self-employed INs are not verified by an employer, the MassHealth members for whom they are providing services or their family members, or MassHealth. Further, although employees of HHAs have their hours reviewed by their employer, they are not verified by the members to whom they provide services or their immediate family, or by MassHealth. Finally, the records of time worked and notes of services performed by nurses for providing HHS are maintained by the providers in the members' residences and are not regularly reviewed by MassHealth.

As a result, we found a number of questionable overpayments and a greater than normal risk of potential fraud in the following circumstances: (1) multiple nurses reported working excessive hours, including some who purportedly worked 60 to 111 hours per week in multiple jobs, one who billed for 44 consecutive hours of service without sleep, another who in a 45-hour period could have only had seven hours of sleep with no consecutive sleep period longer than three hours, and two INs who billed for continuous service to multiple patients, leaving no time for travel; (2) there was an above-average risk that two INs may have colluded and misrepresented their billings to MassHealth when one IN allegedly provided services to the other IN's daughter; and (3) one IN billed for hours and constructed detailed nursing care notes for the alleged care of children during a period in which she was participating in a national sporting event out of state.

b. Inaccurate Claims Were Billed and Paid**7**

MassHealth regulations stipulate that the medical services for which payment is claimed must actually be provided to the person identified as the member at the time and in the manner stated. However, we found that MassHealth lacks adequate internal controls to prevent, deter, and detect inaccurate claims being billed and submitted by HHS providers. As a result, more than 50% of the HHAs and INs in our sample billed and were paid for hours that did not agree with hours indicated in the nurses' records. The providers: (1) billed for more or fewer hours than recorded in their records; (2) billed for travel time which is not allowable under MassHealth

regulations; and (3) billed for higher-paid nighttime hours, when daytime hours were recorded in their records, and vice versa.

c. Claims Were Paid That Were Not Billed in Compliance with Regulations 8

MassHealth regulations limit the number of hours that an IN will be paid to no more than 60 hours during a consecutive seven-day period. However, MassHealth has not established adequate internal controls within its payment processing system to effectively monitor and ensure compliance with this regulatory requirement. Specifically, MassHealth has not established billing procedures that establish specific billing periods. Consequently, we found that the providers in our sample submitted bills for various set time periods (e.g., daily, weekly, monthly, bimonthly), whereas others submitted bills that covered random periods of time. This lack of a consistent billing method makes it difficult, if not impossible, for MassHealth to monitor compliance with its regulations relative to the number of hours an IN can bill. Furthermore, many of the INs with whom we spoke stated that they were not aware of this limitation. Accordingly, we determined that 12 of 22 (55%) of the INs in our sample billed and were paid for more than 60 hours in a consecutive seven-day period, contrary to MassHealth regulations. We also found that some nurses did not properly record the beginning and ending dates of work shifts that extended beyond midnight and into the next day.

In one instance, we found a member who was receiving 24-hour nursing services (168 hours per week), every day in fiscal year 2008 at a cost of \$422,000, which was not in compliance with regulations. The quantity of hours of nursing services is limited to a maximum of 112 per week and can exceed this for only a short-term basis, if certain conditions are met. These conditions were not met. We estimate the amount of unallowable payments MassHealth made on behalf of this one consumer to be approximately \$172,000 in fiscal year 2008.

MassHealth regulations also require INs and HHAs to maintain various records regarding the services they provide to their members, and during our audit we found that all of the HHAs in our sample were in compliance with MassHealth's recordkeeping requirements for the transactions we tested. However, our review of the records provided to us by the 22 INs in our sample determined that 12 of the 22 INs (55%) were not in compliance with MassHealth's recordkeeping requirements.

d. Services May Not Have Represented the Least Costly Form of Comparable Care Available 12

MassHealth regulations require that both HHAs and INs provide services that are no more costly than medically comparable care in an appropriate institution and the least costly form of comparable care available in the community. However, we found instances in which HHAs and INs in our sample did not appear to comply with this requirement. For example, we found instances in which HHAs in our sample arbitrarily utilized more costly Registered Nurses (RNs) instead of Licensed Practical Nurses (LPNs) to provide HHS. We also found instances in which Home Health Aides performed tasks for members that possibly could have been provided by less costly Personal Care Attendants (PCAs). Additionally, we found instances in which nurses employed by HHAs made multiple 15-minute visits to members' homes. These types of services are paid at the rate per visit, whether it is a 15-

minute or two-hour visit, no matter the service provided. HHA officials stated that although family members could be safely providing the services performed during these 15-minute visits, they refused to do so. In one instance, we found that one IN had a daughter living in her home receiving 24-hour HHS in fiscal year 2008. The member's mother did not provide any of these services, although she is an IN provider for MassHealth and her daughter's primary caregiver. As a result, in this instance MassHealth may have incurred increased costs for these services.

e. Services May Have Been Rendered under Conditions That May Compromise the Safety and Quality of Care of Members

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We identified areas in which MassHealth could effect changes in the ways in which it administers the HHS program to better ensure the safety and quality of care that its members receive, as follows:

- A 2004 report from the Institute of Medicine of the National Academies entitled "Keeping Patients Safe: Transforming the Work Environment for Nurses" recommended limiting the total amount of time that a nurse may work in a 24-hour or seven-day period, as follows:

To reduce error-producing fatigue, state regulatory bodies should prohibit nursing staff from providing patient care in any combination of scheduled shifts, mandatory overtime, or voluntary overtime in excess of 12 hours in any given 24-hour period and in excess of 60 hours per 7-day period.

As previously noted, MassHealth has not implemented adequate internal controls to ensure compliance with its regulations that limit the number of hours an IN can work during a consecutive seven-day period to 60 hours. Also, MassHealth does not obtain information from the INs about their non-MassHealth-related employment activities. As a result, as noted above, we found that 55% of the INs in our sample billed and were paid for claims for working between 61 to 94 hours in a consecutive seven-day period. Moreover, many INs in our sample regularly worked 16-hour shifts (there is no regulation that limits the length of a shift). One IN in our sample worked for 44 consecutive hours caring for a single patient/member, allegedly without sleep. Some nurses stated that they have second and third jobs causing them to work 60 to 111 hours per week. However, MassHealth does not obtain information from the INs about their non-provider employment activities.

- Under MassHealth's conditions of payment and clinical criteria for HHAs, if a service is performed by an LPN, he or she must be under the supervision of an RN. However, this supervision requirement does not apply to LPNs who are also INs and are performing the same complex nursing services.
- Our audit also revealed recordkeeping deficiencies that could affect the quality of care that is provided to MassHealth members. Significant documentation required to be maintained by MassHealth regulations was missing for 12 of the 22 (55%) self-employed and unsupervised INs in our sample. We also found no standardization in nurses' notes, plans of care, and medicine disbursement sheets, which were inconsistent in both quality and content. Consequently, there could be misunderstandings of the condition and treatment of members when there is

a turnover in nursing staff or when members are receiving services from more than one nurse.

- HHAs are required by regulation to conduct a Criminal Offender Record Information (CORI) check on employee applicants whose services may entail the potential for unsupervised client contact. Although they perform identical services as nurses at HHAs, INs are not required by regulation to undergo a CORI check. MassHealth voluntarily performed CORI checks on all INs enrolled after August 1, 2008. However, the large majority of INs have not undergone a CORI check, as they were enrolled prior to August 1, 2008.
- Case management is an invaluable service that provides safeguards to members' care and oversight of services when provided by a professional who is independent of the provider. Skilled case managers from the University of Massachusetts Medical School oversee the care of all members less than 22 years of age receiving HHS. However, there is no case management by an independent party of the providers for those members who begin receiving HHS at 22 years of age and older. Although not required by regulation, all but one of the HHAs had malpractice insurance; however, 46% of the 13 INs responding to our inquiry did not have malpractice insurance. Since malpractice insurance would compensate MassHealth members under certain circumstances, members may have limited financial recourse if they are injured due to certain gross negligent or egregious behavior by uninsured HHAs and INs. Consequently, MassHealth may want to consider recommending to INs that they obtain malpractice insurance.

INTRODUCTION

Background

MassHealth, the state's Medicaid program, is under the Executive Office of Health and Human Services (EOHHS), the largest secretariat in the Commonwealth. More than 1.2 million low-income or disabled children, families, and elders receive health care in Massachusetts under MassHealth programs. In fiscal year 2008, MassHealth paid in excess of \$6.8 billion on approximately 58 million claims to 30,000 providers. The Medicaid program represents approximately 30% of the Commonwealth's annual budget and is jointly funded by the state and federal governments. During fiscal year 2008, the federal government reimbursed Massachusetts for 50% of the claims paid by MassHealth.¹

Among the many programs that MassHealth offers to its members is the Home Health Services (HHS) program, which provides payments for services on behalf of approximately 18,000 eligible MassHealth members annually. HHS program services include skilled nursing services, home health aide services, and therapeutic services (physical, occupational, and speech and language). The program limits the provision of HHS to individuals who are under the care of a physician and who are residing in non-institutional settings, which may include the member's home, a homeless shelter, or other temporary residence or community setting. Furthermore, MassHealth pays for HHS only if a physician certifies the medical necessity for such services and establishes an individual plan of care. The HHS program is representative of the Commonwealth's "Community First Policy," which follows a national trend towards generally less costly community-based services. It is intended to reduce the need for more costly hospitalization and institutionalization and to help members maintain their independence and quality of life.

MassHealth has contracted both with Home Health Agencies (HHAs) and independent nurses (TNs) as providers for its HHS services. HHAs are public or private organizations that provide skilled nursing, home health aide, and therapeutic services to patients. In order to provide these services, the HHAs employ registered nurses (RN), licensed practical nurses (LPN), licensed vocational nurses (LVN), home health aides, and therapists (physical, occupational, and speech and language). During fiscal year 2008, 119 HHAs were paid approximately \$135 million on 1.16 million claims, an increase

¹ The American Recovery and Reinvestment Act (ARRA) has made funding available to states in the form of an increase in the federal reimbursement rate or Federal Medicaid Assistance Percentage (FMAP) paid to states for their Medicaid spending. The increase in the federal reimbursement rate applies to the period Oct. 1, 2008 through Dec. 31, 2010.

of 15% and 17%, respectively, over fiscal year 2007. The INs are self-employed RNs, LPNs, or LVNs who are enrolled to provide only continuous skilled nursing services for MassHealth's HHS program. Continuous skilled nursing services are the provision of skilled nursing services for at least two consecutive hours in duration. During fiscal year 2008, MassHealth paid 252 INs approximately \$10 million on 27,000 claims, an increase of 51% and 41%, respectively, over fiscal year 2007.

MassHealth automatically enrolls members under the age of 22 who require a nursing visit of more than two continuous hours as a complex care member and assigns each a case manager² as part of the Community Case Management (CCM) program. Case managers may perform an in-person visit with the member to evaluate whether the member meets the criteria to be a complex care member and to complete a comprehensive needs assessment. They develop a service plan, in consultation with the member, the member's physician, the primary caregiver, and where appropriate, the HHA or IN. The case manager regularly communicates and coordinates with the HHAs, INs, and the members' primary caregivers about the status of the members' home health needs. In contrast, members who begin receiving HHS at 22 years of age or older are not provided with case management services.

The Massachusetts Division of Health Care Finance and Policy (DHCFP) within EOHHS determines the maximum allowable fees for HHS as set forth in 114.3 Code of Massachusetts Regulations (CMR) 50.00. In effect, the maximum allowable payment for HHS is the lower of the providers' usual and customary fee or the rate that DHCFP has established for that service. Nursing services provided are classified for billing purposes as either continuous skilled nursing or intermittent services. Continuous skilled nursing services, home health aide services, and therapeutic services are paid in 15-minute units. Intermittent nursing services are paid on a per-visit basis. (A visit is defined as a patient encounter of up to two hours, and the same rate is paid whether the visit is for 15 minutes or two hours.) During fiscal year 2008, intermittent nursing services represented approximately 51%, continuous skilled nursing represented approximately 37%, home health aides accounted for approximately 9%, and therapeutic and other services represented 3% of HHS.

² MassHealth has an interagency agreement with the UMass Medical School to perform this function.

Audit Scope, Objectives, and Methodology

In accordance with Chapter 11, Section 12, of the Massachusetts General Laws, the OSA conducted an audit of MassHealth's administration of the HHS program. Our audit, which covered the period July 1, 2007 to June 30, 2008, was conducted in accordance with applicable generally accepted government auditing standards and included tests we deemed necessary to meet our audit objectives. The objectives of the audit were to: (1) determine whether MassHealth has established adequate internal controls over the payment of HHS program claims; (2) determine whether claims were paid in compliance with applicable laws, rules, and regulations and MassHealth's policies and procedures; and (3) make recommendations to improve MassHealth's oversight and internal controls, including policies, procedures, and regulations, in the HHS program.

To achieve our objectives, we reviewed applicable state and federal laws and regulations, as well as MassHealth's policies and procedures relative to its administration of HHS program services. We also conducted interviews with officials of MassHealth, EOHHS, and the Office of the Attorney General's Medicaid Fraud Control Unit. We obtained information and developed reports utilizing MassHealth's Medicaid Management Information System (MMIS)³ and its Data Warehouse.⁴ The information and data was analyzed to identify (a) the amount and number of paid claims per participating HHA and IN service provider during the audit period, (b) the type and frequency of services performed by participating providers, and (c) service trends and billing anomalies indicative of systemic billing problems. Utilizing the data and information obtained, we then judgmentally selected 11 HHAs and examined certain claims paid by MassHealth for 54 members who received services from these HHAs during fiscal year 2008, when these 11 HHAs were paid a total of \$55,139,486 on claims they submitted to MassHealth. We conducted site visits to each HHA and during these visits, collected documentation relative to the operation of the HHA, as well as the specific transactions we were testing, and also interviewed members of each HHA's management staff. Additionally, we selected 22 INs and audited certain claims paid to 42 MassHealth members serviced by these INs. During fiscal year 2008, these 22 INs were paid a total of \$2,476,546 on claims they submitted to MassHealth. We administered survey questions to each selected IN, requested all of their records relative to their specific transactions under review, and conducted follow-up telephone and email inquiries as necessary with the INs. We reviewed the case

³ MassHealth's claims processing system

⁴ The Data Warehouse is a consolidated repository of claims and eligibility data that provides the ability to develop standard and ad hoc reports.

management files for members cared for by both HHAs and INs, where applicable. The claims we audited were for HHS services provided to MassHealth members over different periods of time during the audit period, ranging from one day to over a month. All of the documentation reviewed was relative to MassHealth members who were, based on their physical condition, in a long-term care situation.

Our audit was conducted as part of the OSA's ongoing independent statutory oversight of the Commonwealth's Medicaid Program.

AUDIT RESULTS

INADEQUATE INTERNAL CONTROLS IN MASSHEALTH'S HHS PROGRAM HAVE RESULTED IN QUESTIONABLE PAYMENTS FOR HOME HEALTH SERVICES AND A LACK OF ASSURANCE THAT PROGRAM SERVICES ARE BEING PROVIDED IN THE SAFEST AND MOST EFFICIENT MANNER

Our audit revealed that inadequate internal controls in MassHealth's Home Health Services (HHS) program have resulted in claims being paid that were: (a) potentially fraudulent; (b) inaccurately billed; (c) not billed in compliance with regulations; (d) not representative of the least costly form of comparable care available in the community; and (e) for services that may have been rendered under conditions that may compromise the quality of care and put MassHealth members' safety at risk.

a. Potentially Fraudulent Claims Were Paid

We found that MassHealth has not established effective oversight activities and internal controls to prevent, deter, and detect HHS providers who bill for services that may have not been performed. For example, the hours worked by self-employed independent nurses (INs) are not verified by an employer, the MassHealth members for whom they are providing services or their immediate family, or MassHealth. Also, although employees of home health agencies (HHAs) have their hours reviewed by their employers, they are not verified by the members or their immediate family or by MassHealth. Finally, the records of time worked and notes of services performed by nurses for providing HHS are maintained by the providers in the members' residences and are not regularly reviewed by MassHealth.

130 Code of Massachusetts Regulations (CMR) 450.235 and 130 CMR 450.261, respectively, state, in part:

Overpayments include, but are not limited to, payments to a provider: (A) for services that were not actually provided or that were provided to a person who was not a member on the date of service

All members and providers must comply with all federal and state laws and regulations prohibiting fraudulent acts and false reporting

Despite these requirements, we found a number of questionable overpayments and a greater than normal risk of potential fraud in the following circumstances:

- 1) Multiple nurses in our sample reported working excessive hours, as follows:

- a. An IN who billed 40 to 55 hours per week and earned \$107,000 for services provided in fiscal year 2008 was also working an additional 40 hours per week full-time for a hospice provider. Her total work week was 80 to 95 hours, and she regularly worked the same days, from 8:30 a.m. to 4:30 p.m. for the hospice provider, and from 10:00 p.m. to 7:00 a.m. as an IN, leaving little time for sleep and travel.
 - b. An LPN, working as an IN, billed MassHealth for an average of 94 hours per week and earned \$175,000 for services provided in fiscal year 2008 and, contrary to MassHealth regulations, billed for time traveled from member to member in separate households.
 - c. An RN who was terminated by a HHA for allegedly falsifying her timesheet subsequently became an IN. In her new role, she earned \$73,000 for services provided in fiscal year 2008 and, in one instance, billed for 44 consecutive hours of service to a single member, allegedly without sleep.
 - d. An IN, within a 45-hour period, billed for 35.5 hours of work and traveled 2.5 hours, leaving only seven hours for sleep with no potential sleep period longer than three hours. Also, in a separate 69-hour period, the IN billed for 48.5 hours of work and traveled 3.7 hours, leaving only a possible 17 hours for sleep during this period.
- 2) Another IN has a daughter living in her home who receives daily 24-hour HHS from HHAs and other INs. During fiscal year 2008, MassHealth paid the HHAs and the other INs a total of \$386,000 for services provided to this individual's daughter. Even though this member's mother is contracted with MassHealth as an IN and is a RN, according to MassHealth's records, none of the daughter's services were provided by her mother. An IN, who was paid for providing services to the daughter, coincidentally also cared for the same MassHealth member as did the mother. This IN earned \$95,000 for services provided during fiscal year 2008 and, contrary to MassHealth regulations, billed for travel time between member households. Given the fact that the member's mother and the IN who was providing services to the daughter were both providing services to the same MassHealth member, there is an above-average risk that these two INs could collude and misrepresent which members to whom they are providing services. For example, the member's mother could provide some of the nursing services to her daughter and let the other IN bill for these services while the other IN is actually caring for the member reportedly cared for by the mother. If the member's mother had been providing the services, she would not be eligible for payment according to 130 CMR 414.409 (G):

The MassHealth agency does not pay for nursing services when such services are provided by the spouse of a member, the parent of a minor member, including an adoptive parent, or the member's foster parent, or any other individual with legally binding financial or caregiving responsibility for the member.

- 3) One IN was reported in the newspaper as participating in a national sporting event in Georgia on the same dates that she billed for providing services in Massachusetts. The IN provided us with her nursing notes for the identical dates of the sporting event, which were very precise in detailing the treatment provided and the hours allegedly worked while caring for multiple children in their Massachusetts home. The IN was paid
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\$167,000 for services provided to the children in fiscal year 2008. We corresponded with the IN several times requesting additional information on this matter; however, we subsequently received a letter from the IN's attorney notifying the Office of the State Auditor (OSA) that he had been retained as her counsel in the matter under question and that he requested that all future correspondence regarding this matter be directed to him. This matter was referred to the Bureau of Special Investigations (BSI) within the OSA for further investigation and resolution.

Recommendation

MassHealth should develop and implement internal controls to better prevent, deter, and detect HHA providers who bill for hours not worked. At a minimum, MassHealth should require a weekly attestation, under pains of perjury, by the MassHealth member or his or her parent, spouse, or guardian confirming the hours worked by both INs and HHAs. MassHealth should investigate these circumstances and, as required, refer potential fraud to BSI and the Medicaid Fraud Control Unit (MFCU) within the Office of the Attorney General. MassHealth's investigation should include all periods in which the nurses were enrolled as IN providers. The following are our recommendations for each of the unusual circumstances noted above:

- MassHealth should work closely with BSI to investigate the nurse who was reported to have been participating in an out-of-state sporting event while billing for services and constructing detailed nursing notes of those services. Additionally, if the children under care did not receive nursing services in that time period, or if the care was provided by the children's mother, the medical necessity of the services authorized should be reassessed.
- MassHealth should confirm that the mother/IN is working outside of her home and not caring for her daughter. It should also investigate whether collusion exists between the INs to misrepresent which members to whom they are providing services.
- MassHealth should verify directly with the members or their families that all services were provided as claimed and should seek reimbursement for all time billed while traveling.

b. Inaccurate Claims Were Billed and Paid

MassHealth regulations state that the medical services for which payment is claimed must actually be provided to the person identified as the member at the time and in the manner stated. However, our audit revealed that MassHealth has not established adequate internal controls to prevent, deter, and detect inaccurate claims being billed and submitted by HHS providers. Specifically, the records of time worked and notes of services performed are maintained by the providers in the members' residences and are not regularly reviewed by

MassHealth. Further, procedures do not require that actual timesheets be utilized; instead, the nurses make a notation in their notes as to the start and end time of a shift.

As a result of these internal control issues, we found that more than 50% of the HHAs and INs in our sample billed and were paid for hours of service that did not agree with the hours indicated in the nurses' notes. The providers billed for more or fewer hours than recorded on their notes; billed for travel time; and billed for higher-paid nighttime hours when daytime hours were recorded on their notes and vice versa.

A summary of our findings is as follows:

- Seven of 11 (64%) HHAs billed for hours that did not agree with the hours recorded on the nurses' notes. Five (46%) overbilled and two (18%) underbilled.
- Thirteen of 22 (59%) INs on multiple occasions billed for hours that did not agree with the hours recorded on the nurses' notes.
- HHAs and INs repeatedly billed for higher-paid nighttime hours, when daytime hours were recorded on their notes. To a lesser degree, lower-paid daytime hours were billed when nighttime hours were recorded on their notes. Two of 11 (18%) HHAs and eight of 22 (36%) INs billed day and nighttime hours incorrectly.
- Contrary to MassHealth regulations, two INs billed for travel time to members' homes.

Recommendation

MassHealth should develop and implement effective oversight activities and internal controls to prevent, deter, and detect INs and HHAs billing incorrect hours and when discovered, suspend payments. For example, a weekly attestation by the MassHealth member or his or her parent, spouse, or guardian confirming the hours worked by both INs and HHAs could be required. In addition, MassHealth should consider standardizing all IN timesheets and should regularly conduct reviews of the records of HHAs and INs to ensure that claims are billed appropriately and accurately. Moreover, MassHealth should seek reimbursement for all time billed while traveling.

c. Claims Were Paid That Were Not Billed in Compliance with Regulations

MassHealth has established regulations to safeguard its members and ensure the quality of their care that state, in part:

The MassHealth agency does not pay an independent nurse for more than 60 hours of nursing in a calendar week.⁵ Calendar Week — seven consecutive days⁶. . . .

In no event will any independent nurse be approved for a total of more than 60 hours of nursing care provided during any consecutive seven-day period⁷. . . .

However, we found that MassHealth has not established adequate internal controls within its payment processing system to effectively monitor and ensure compliance with this regulatory requirement. Specifically, MassHealth has not established billing procedures that establish specific billing periods. Consequently, we found that the providers in our sample submitted bills for various set time periods (e.g., daily, weekly, monthly, bi-monthly) whereas others submitted bills that covered random periods of time. This lack of a consistent billing method makes it difficult, if not impossible, for MassHealth to monitor compliance with its regulations relative to the number of hours an IN can bill. For example, if a provider on a single claim billed 200 hours for a 30-day period, MassHealth would not be able to create an edit in the system it uses to process payments (MMIS) that would detect whether the IN is being paid for more than 60 hours in a consecutive seven-day period. Accordingly, without a change in the providers' billing procedures, MassHealth would not detect overpayments for excessive hours. Only by examining the nurses' notes could many of the violations be uncovered, and MassHealth does not regularly examine this documentation as it is maintained by the providers. Furthermore, many of the INs with whom we spoke stated that they were not aware of this limitation.

Accordingly, we determined that 12 of 22 (55%) INs in our sample billed claims that were paid, even though they were not in compliance with regulations limiting the number of hours paid to an IN to no more than 60 hours in a consecutive seven-day period. There were multiple periods in which INs were not in compliance with this regulation. Further, in the surveys we administered to the INs in our sample, we inquired as to whether the INs had ever worked over 60 hours in a consecutive seven-day period and some replied that they had done so 50 or more times.

In one instance, we found that one member received 24-hour nursing services, seven days per week (168 hours per week) for 365 days during all of fiscal year 2008 at a cost of

⁵ 130 CMR 414.409 (C): Limit of Hours.

⁶ 130 CMR 414.402

⁷ 130 CMR 414.416(C)

\$422,000. This level of service is in violation of MassHealth regulations 130 CMR 414.409 which state in part:

(Maximum Nursing Hours: (1) A member may be eligible for up to a maximum of 112 hours of nursing services per calendar week if he or she meets the criteria for nursing services as stated in 130 CMR 414.408. (2) Members may be eligible on a short-term basis, not to exceed three months, for nursing services over the maximum amount if such additional services are determined to be medically necessary by the MassHealth agency or its designee, and at least one of the following criteria is met: (d) the member meets the clinical criteria for nursing services and the primary caregiver is temporarily unavailable because he or she (i) has an acute illness or has been hospitalized; (ii) has abandoned the member or has died within the past 30 days; (iii) has a high-risk pregnancy that requires significant restrictions; or (iv) has given birth within the four weeks before a request for additional services.

During our audit, we asked MassHealth officials to provide us with documentation to substantiate that the member in question was in fact eligible for services in excess of the maximum 112 hours per week. In response, MassHealth officials acknowledged that this individual may have received Home Health nursing services in excess of what is allowed by MassHealth regulations by stating in an email that in this case, “the number of hours set forth in the regulation did not appear to be taken into account.”

Based on this, we estimate the amount of questionable claims paid to be approximately \$172,000 (the actual amount paid in fiscal year 2008 less the amount that would have been paid, if services were limited to 112 hours per week at the same hourly rate).

In developing our testing in this area, we asked MassHealth officials to conduct a query of the billing information submitted by INs during a specified period and to track these billings on a rolling consecutive seven-day period. From this we could determine the number of instances in which all INs being utilized by MassHealth during this specified period had submitted bills and been paid for hours of service that exceeded 60 hours in a consecutive seven-day period. However, as of June 30, 2010, MassHealth officials have not provided us with this information. MassHealth responded that its interpretation of the regulations is that the calendar week referenced in the regulations means Sunday through Saturday and not a rolling consecutive seven-day period. However, we do not agree with this assertion, as a calendar week is defined as a consecutive seven-day period in 130 CMR 414.402 and 414.416. Moreover, it is important to note that we found several instances in which INs

were, in fact, paid for more than 60 hours of services provided between Sunday and Saturday.

In addition to regulating the number of hours for which an IN can be paid, both HHAs and INs are required by MassHealth's regulation to maintain various records. For example, effective June 15, 2008, 130 CMR 414.417 established the following recordkeeping requirements for INs:

The record maintained by an independent nurse for each member must conform to MassHealth administrative and billing regulations at 130 CMR 450.000. Payment for any service listed in 130 CMR 414.000 requires full and complete documentation in the member's medical record. The independent nurse must maintain records for each member to whom nursing services are provided. (B) In order for a medical record to completely document a service to a member, the record must disclose fully the nature, extent, quality, and necessity of the care furnished to the member. When the information contained in a member's record does not provide sufficient documentation for the service, the MassHealth agency may disallow payment...The independent nurse must maintain a medical record of nursing services provided to each member. The medical record must be reviewed and updated by the independent nurse at least monthly. To ensure the continuity of care, the independent nurse and, if co-vending, the other providers must leave a copy of the member's original medical record, including current progress notes, medication-administration sheet, prior-authorization form, plan of care, and physician orders, including any verbal orders, in the member's home. The medical record must contain at least the following: (1) the member's name, address, phone number, date of birth, MassHealth ID number; (2) the name and phone number of the member's primary care physician; (3) the primary caregiver's name, address, phone number, and relationship to member; (4) the name and phone number of the member's emergency contact person; (5) a copy of the approved prior-authorization decision

Although MassHealth has established the aforementioned recordkeeping requirements, it has not established specific guidelines or standards as to how these records are to be maintained. As a result, our review revealed a wide diversity in the quality of documentation being maintained by the INs in our sample. We also determined that all of the HHAs in our sample were in compliance with MassHealth's recordkeeping requirements for the transactions we tested. However, we found that 12 of the 22 INs (55%) were not in compliance with recordkeeping regulations. Specifically, they were unable to provide us with various documents such as copies of the member's medical history, name and phone number of an emergency contact person, or a signed medical release form.

Recommendation

MassHealth should establish adequate internal controls, including more effective oversight activities, to ensure that HHS claims are paid in compliance with its regulations. Specifically, to the extent possible, MassHealth should standardize the billing procedures and recordkeeping forms for HHS providers, particularly INs. Further, we recommend that MassHealth:

- Standardize forms for the INs' notes, medicine distribution, and any other documentation required to be maintained under the recordkeeping requirements.
- Develop standardized timesheets to replace the current procedure of indicating beginning and ending times of shifts in the nurses' notes.
- Standardize the billing procedures of the INs in order to monitor compliance with the limit of hours worked in a consecutive seven-day period. We recommend that MassHealth require that all INs and HHAs submit claims weekly, with the same starting and ending days of the week (i.e., Sunday to Saturday) and include all the hours worked in that consecutive seven-day period.
- Create an edit in the MMIS claim review system that is used by MassHealth to process HHS claims that will reject and suspend payment on all claims from INs in excess of 60 hours worked in a consecutive seven-day period.
- Conduct annual reviews of the records being maintained by INs and HHAs to assess compliance with its recordkeeping regulations.
- Convene mandatory annual training sessions for INs to make them aware of MassHealth's recordkeeping requirements as well as its requirements pertaining to the maximum work hours allowed.
- Assign a manager or supervisor to each IN.
- Review all other cases where members are receiving in excess of 112 hours per week of nursing services for compliance with MassHealth regulations, and establish controls to ensure compliance with this requirement.

d. Services May Not Have Represented the Least Costly Form of Comparable Care Available

MassHealth regulations require that both HHAs and INs provide services that are no more costly than medically comparable care in an appropriate institution and the least costly form of comparable care available in the community. Specifically, 130 CMR 414.409(H) states:

Least Costly Form of Care: The MassHealth agency pays for nursing services only when services are no more costly than medically comparable care in an appropriate institution and the least costly form of comparable care available in the community.

During our audit, we asked MassHealth officials how the agency ensures compliance with these regulations. In response, MassHealth stated:

During the prior authorization review process, MassHealth reviewers seek to determine that certain home health services requested by a member are in fact medically necessary for the member and cannot be provided in the community through less costly means. MassHealth, through its Program Review unit, also periodically reviews a sample of the home health agency's medical records for members receiving home health services that were paid for by MassHealth. Such review includes a review of the physician's plan of care for the member and a review of the medical necessity of the services provided... MassHealth's program review unit seeks to determine that the services provided are of good quality, meet the member's medical needs, are cost effective, and result in positive outcomes for the member.

However, based on our audit, we believe that MassHealth needs to improve the controls it has established in this area. For example, MassHealth does not require HHAs to establish policies and procedures that describe how the HHA intends to comply with the requirements of this regulation, and HHAs are not required to document the process they use to determine that the least costly form of care is being provided to the MassHealth members they are servicing. Also, MassHealth does not routinely conduct analytical reviews of the services provided to its members to determine whether there were less costly options available within their community that could have been utilized to provide these services. As a result, we found several instances in which it appeared that the services being provided to members by the HHAs and INs may not have been provided at the lowest cost available, as follows:

- Some HHA officials indicated that they arbitrarily utilize more costly registered nurses (RNs) instead of licensed practical nurses (LPNs) because of scheduling or personnel reasons. Services rendered by RNs are paid at a rate approximately 20% higher than those of LPNs, and there are more RNs working for HHAs than LPNs.
- We noted instances in which Home Health Aides performed tasks which possibly could have been provided by less costly PCAs. In addition to assisting in the provision of nursing and therapeutic care to members, Home Health Aides also provide many of the same services as PCAs but are paid at approximately twice the rate of a PCA.
- Intermittent care, which represents approximately 50% of the services in the HHS program, is paid at the rate per visit set by the DHCFP, whether it is a 15-minute or two-

hour visit, no matter the service provided, and for which no prior authorization by MassHealth is required. We found, and HHA officials told us of, instances in which RNs and LPNs visited members' homes for medicine dispensing and insulin injections, which took only 15 minutes, and the claims were billed according to regulations at the fixed intermittent services rate. Further, some HHA officials stated that family members could be safely providing many of these services, but refuse to do so.

- We discovered that one IN is the primary caregiver for her adult daughter, who is living in her home. The daughter received 24-hour HHS, seven days per week (168 hours per week), at a cost of \$422,000 in fiscal year 2008. Even though the mother is enrolled with MassHealth as an IN, MassHealth records show that the mother did not provide any of the services to her daughter. However, the mother billed MassHealth for 62 to 81 hours per week for providing HHS to other non-household members for which she was paid \$115,000 in fiscal year 2008. She also stated that she worked another 30 hours per week as a nurse for a municipality. Clearly, if the member's mother provided some of her daughter's services, which it appears she was qualified to provide, it would have resulted in substantial savings, because according to MassHealth regulations:

The MassHealth agency does not pay for nursing services when such services are provided by the spouse of a member, the parent of a minor member, including an adoptive parent, or the member's foster parent, or any other individual with legally binding financial or caregiving responsibility for the member.⁸

- We found that hours worked by PCAs overlapped those of nurses working in member's households and both were present at the same time, potentially without need. There is no regulation preventing or prior authorization required for both a PCA and a nurse to be present at the same time.
- Physicians are required to certify and sign a member's plan of care every 60 days.⁹ These service plans are developed by the HHAs and INs and forwarded to the physician for his signature. We found instances in which a member may not have been seen by a physician within a year, yet the physician approved the plan of care. As a result, there could have been improvement in the member's condition that would warrant a decrease in services that the physician would be unaware of, if it was not disclosed by the HHA or IN.

Recommendation

We recommend that MassHealth consider improving the oversight and controls it has established to ensure that its providers comply with its requirements for providing the least costly care available to its members. Some improvements could include:

- Adjusting the rates for certain intermittent services that are known to require a visit of less than one hour.

⁸ 130 CMR 414.409 (G)

⁹ 130 CMR 414.412 & 130 CMR 403.419: The member's physician must establish a written plan of care and recertify and sign the plan of care every 60 calendar days.

- Requiring household members or primary caregivers to provide services, if they could be effectively and safely provided by these individuals.
- Requiring prior approval for PCA services when the time spent overlaps with HHS.
- Reviewing the reimbursements rates of RNs and LPNs enrolled as INs.
- Requiring that members receiving HHS be examined by a physician at least annually.

e. Services May Have Been Rendered under Conditions That May Compromise the Safety and Quality of Care of Members

We identified areas in which MassHealth could affect changes as to how it administers its HHS program that would better ensure the safety and quality of care that its members receive, as follows:

- We found a number of instances in which INs were working exceptionally long hours, which may put members' safety at risk. In this regard, MassHealth regulations limit the quantity of hours to 60 for which INs can be paid in a consecutive seven-day period. This limitation on the number of hours a nurse should work in order to maintain the quality of services provided appears to be an accepted best practice within the nursing industry. For example, a 2004 report from the Institute of Medicine of the National Academies entitled "Keeping Patients Safe: Transforming the Work Environment for Nurses" recommends:

To reduce error-producing fatigue, state regulatory bodies should prohibit nursing staff from providing patient care in any combination of scheduled shifts, mandatory overtime, or voluntary overtime in excess of 12 hours in any given 24-hour period and in excess of 60 hours per 7-day period

Further, the Massachusetts Nurses Association reported in December 2006:

The Centers for Disease Control, National Institute for Occupational Safety and Health (NIOSH) 2004 report entitled, Overtime and Extended Work Shifts: Recent Findings on Illnesses, Injuries, and Health Behaviors, notes, "Four studies that focused on effects during extended shifts reported that the ninth to twelfth hours of work were associated with feelings of decreased alertness and increased fatigue, lower cognitive function, declines in vigilance on task measures, and increased injuries. . . . One study revealed that the likelihood of a nurse making a mistake, such as giving the wrong medication, or the wrong dose, was tripled once a shift stretched past 12.5 hours.

Despite this, nurses working for HHAs are not limited in the quantity of hours worked. Also, as previously noted, we found that 12 of 22 (55%) INs were paid for working 61 to 94 hours in a consecutive seven-day period, contrary to regulations, and that many regularly worked 16-hour shifts. One IN worked for 44 consecutive hours caring for a single patient/member, allegedly without sleep. Additionally, some INs and nurses employed by the HHAs stated that they have second and third jobs which cause them to

work 60 to 111 hours per week. For example, a nurse regularly worked the same days from 8:30 a.m. to 4:30 p.m. for a hospice provider and from 10:00 p.m. to 7:00 a.m. as an IN. MassHealth does not obtain information from the INs about their non-provider employment activities. HHA-employed nurses are also working as self-employed INs, and sometimes caring for the same patient/member through self-employed and HHA-employed agreements. The combined hours worked both as an employee and as an IN could have exceeded 60 hours and been in compliance with regulations, yet could still be potentially unsafe. The American Nurses Association issued a position statement in 2006, which addressed the subject of nurses working multiple jobs. This position statement states, in part:

Registered nurses should consider the impact that multiple jobs have on their level of fatigue and ability to practice safely.

- We discovered INs who are LPNs working unsupervised by RNs. The INs do not share the same regulatory supervision standards as the HHAs. One of the conditions of payment to HHAs for nursing services established in 130 CMR 403.420 is that if the service is performed by a LPN, he or she must be under the supervision of an RN. In addition, a clinical criterion found in 130 CMR 403.420 also mandates that HHAs provide supervision over LPNs, as follows:

A nursing service is a service that must be provided by a registered nurse, or by a licensed practical nurse or licensed vocational nurse under the supervision of a registered nurse, to be safe and effective, considering the inherent complexity of the service, the condition of the patient, and accepted standards of medical and nursing practice.¹⁰ However, even though INs, who are LPNs, perform the same complex nursing services as those employed by HHAs, they are not required by regulation nor are supervised by a RN.

- Our audit revealed recordkeeping deficiencies that could result in a reduction in the quality of services to MassHealth members. Specifically, significant documentation required to be maintained under MassHealth's recordkeeping regulations was missing for 12 of the 22 (55%) self-employed and unsupervised INs. We found no standardization in the INs' notes, plans of care, and medicine disbursement sheets and they were inconsistent in quality and content. Consequently, there could be misunderstandings of the condition and treatment of members when there is a turnover in a member's nursing staff or when a member is receiving services from multiple nurses. All the HHAs were in compliance with their recordkeeping requirements.
- HHAs are required by regulation to conduct a Criminal Offender Record Information (CORI) check on employee applicants whose services may involve unsupervised client contact. Although performing identical services as nurses at HHAs, CORI checks on INs are not required by regulation. MassHealth has voluntarily performed CORI checks on all INs enrolled after August 1, 2008. However, the vast majority of the INs have not had a CORI check, as they were enrolled prior to August 1, 2008.

¹⁰ 130 CMR 403.420 (B) (1)

- Skilled case managers from the University of Massachusetts (UMass) Medical School oversee the care of all members who were authorized to receive HHS when they were less than 22 years of age. Annual in-home assessments of the member are performed and quarterly calls are made to the family caregivers (usually parents). We reviewed the case management files, where applicable, and concluded that it was an invaluable resource for ensuring that the quality of care provided was as prescribed. In this regard, MassHealth has commented on the importance of case management services as follows:

The annual assessments, quarterly calls, regular communication with family of member, tracking patient goals, identifying and recommending patient service needs, etc. are done for the proper and efficient administration of the Massachusetts Title XIX State plan to ensure that the MassHealth program pays for medically necessary care and services and to "safeguard against unnecessary utilization of such care and services" in accordance with 42 USC §1396a(a)(30)(A).

There is no case management by an independent party of the providers for those members who begin receiving HHS at 22 years of age and older that would provide safeguards to the members' personal safety, their care, and ensure against unnecessary utilization of such care and services.

- Malpractice insurance held by HHAs and INs would compensate the members under certain circumstances for gross negligent or egregious behavior. The providers reported that the insurance was not expensive and readily available for those with good past experience. HHAs or INs with prior malpractice claims may find the cost prohibitive or unavailable. While not required by regulation, all but one of the HHAs had malpractice insurance and 46% of the 13 INs responding to our inquiry did not have the insurance. As a result, MassHealth members injured due to some providers' grossly negligent or egregious behavior by uninsured providers may have limited financial recourse. Consequently, MassHealth may want to consider recommending to INs that they obtain malpractice insurance.

Recommendation

We recommend that MassHealth conduct a review of its regulations, policies, and procedures to determine whether they are adequate to ensure the quality of care and safety of members. In particular, we recommend that MassHealth:

- For INs: (a) strictly enforce the 60-hour limit in a consecutive seven-day period; (b) consider limiting shifts to 12 consecutive hours; and (c) consider limiting the quantity of hours they may work in a 24-hour period.
- Regulate the limits on the time worked in a consecutive seven-day period and the length of shifts by nurses employed by the HHAs.
- Establish guidelines for the maximum amount of total work hours its INs and nurse employees of the HHAs should be working during a specified period on all their jobs and

solicit total work hour information from the nurses so that it can monitor compliance with these guidelines.

- Require that a nursing service provided by an IN, who is a LPN or LVN, to be under the supervision of a RN.
- Establish greater oversight of INs and conduct regular on-site reviews of their activities.
- Conduct periodic CORI checks on all INs, given the fact that the majority of the INs were enrolled prior to August 1, 2008. CORI checks should also be updated at least every five years.
- Consider offering case management or similar services for all recipients of HHS who would benefit from these services, not only those enrolled at less than 22 years of age.
- Suggest to the HHAs and INs that they obtain malpractice insurance and advise MassHealth members receiving HHS to inquire whether the providers have malpractice insurance.

Auditee's Response

In response to our audit report, MassHealth officials provided the following general comments:

MassHealth began a focused review of continuous skilled nursing (CSN) close to three years ago and since has enhanced a number of internal controls, such as monitoring reports, data analytics, and algorithms, to prevent, deter and detect CSN providers who may have submitted potentially fraudulent claims, inaccurate claims, or bills that are out of compliance with regulations. MassHealth amended its Independent Nurse regulations in June of 2008 and has been working with the Provider Compliance Unit to identify weakness[es] and areas for improvement as a part of its ongoing effort to make improvements to its home health services program and to help ensure quality of care and safety of members. Some of these controls were implemented after the audit period of this report.

We do note that OSA included in its Draft Report some recommendations or suggestions which are not addressed in this response. We will take those under consideration.

Additionally, MassHealth officials provided comments to each Audit Result as follows:

a. Potentially Fraudulent Claims Were Paid

MassHealth has a variety of effective internal controls in place to prevent, deter and detect HHS providers who may have submitted potentially fraudulent claims, who submit inaccurate claims, or who submit bills not in compliance with regulations. Some of these controls were implemented since the audit period examined by OSA. Additionally in June 2008, MassHealth amended its Independent Nurse regulations. As part of its ongoing effort to make improvements to its home health services program, MassHealth also plans to implement additional controls to further that effort and to help ensure high quality of care and safety of members.

MassHealth program staff works closely with the MassHealth Provider Compliance Unit (PCU) and the Program Review Unit (PRU) to regularly review and identify Independent Nurse Providers and Home Health Agency Providers who are not in compliance with applicable MassHealth regulations, and to refer cases of suspected provider fraud to the Medicaid Fraud Division (MFD) at the Attorney General's Office. Cases of suspected member fraud are referred to the Bureau of Special Investigations (BSI).

PCU and PRU conduct ongoing post-payment reviews of all home health services, including CSN services provided by Independent Nurse providers and Home Health Agency providers. These reviews include a sampling of Independent Nurse and Home Health Agency claims based on algorithms PCU created and may include requesting the medical records from the providers. The PCU/PRU review may also include a review of the physician's plan of care for the member, a review of medical necessity and quality of care, as well as Community Case Management (CCM) records.

PCU utilizes data mining techniques, such as algorithms, through the Surveillance and Utilization Review Subsystem (SURS) to generate reports of Independent Nurse provider claims to monitor compliance with MassHealth regulations. The PCU data report findings of non-compliance were confirmed by the OSA: including reporting of providers billing more than 60 hours during a seven consecutive day period; billing a night time rate when services were performed during day time hours; billing for a date of service on the same day as another provider for the same service; and billing for services while the member is in an inpatient facility. PCU also pulls provider profiles which identify and compare variables within each provider type, and reviews billing trends and patterns through analysis of various ad hoc reports.

These reports can be run quarterly, bi-annually or yearly. Once a billing issue is identified and analyzed, an Initial Notice of Overpayment, then a Final Notice of Overpayment, is issued to the provider (as appropriate). Also, as a follow up to identifying non-compliance, a provider education letter can be addressed to the provider to alert them of the billing issue. MassHealth may also send a message text to providers through a remittance advice if PCU identifies non-compliance issues.

After reviewing several providers, PCU has a benchmark to detect future violations. If future violations do occur, MassHealth can follow up by imposing provider sanctions, up to and including termination as a MassHealth provider. PCU found 49 instances where Independent Nurse claims warranted further review. Of those, 22 have undergone record review that will result in Notices of Overpayment being sent, 5 that have been reported to the Attorney General's Office, and 13 that have been reported to the Bureau of Special Investigations within the Office of the State Auditor.

PCU has also made a finding that some Independent Nurse Providers work a large number of hours within a twenty four hour period performing CSN services. As a result of these PCU reviews and findings, MassHealth is considering amendments to the Independent Nurse Provider regulations regarding the number of hours for which an Independent Nurse provider can provide CSN services under MassHealth within a twenty-four hour period, and to clarify the definition of calendar week and seven consecutive days. The report that OSA cites from IOM deals with nurses working in acute care hospital settings, where a nurse may simultaneously have 3-6 patients assigned per shift. In the CSN delivery system that is not the case.

As a result of these, and other monitoring activities, MassHealth has and will continue to take appropriate actions with respect to the providers in question, including referring

cases of suspicion of provider fraud to MFD, if appropriate. With regard to the six specific circumstances of potential fraud identified by OSA in its draft audit finding 1a, MassHealth is in the process of gathering data and will refer the cases to MFD, as appropriate. MassHealth will also work with MFD (and BSI, as appropriate) during any related investigation.

MassHealth is also in the process of working with its PCU to send letters to members who receive CSN services to obtain their confirmation on the number of CSN hours provided during a given period.

b. Inaccurate Claims Were Billed and Paid

MassHealth regulations at 130 CMR 403.426 and 403.427 and 130 CMR 414.417 require home health agencies and Independent Nurse providers, respectively, to maintain a copy of the member's medical record. The PCU conducts reviews of provider claims for continuous skilled nursing (CSN) services, and requests medical records when claims issues are identified. As stated in our response to draft audit finding 1a above, MassHealth and its PCU have been successful in identifying several Independent Nurse providers who have failed to bill claims in accordance with MassHealth regulations. Staff will continue to work with PCU and PRU to detect Independent Nurse and home health agency providers billing incorrectly, take action to recover the funds as appropriate, and report any suspicion of fraud to MFD as appropriate. In those cases where it is determined that MassHealth overpaid the providers, such as payment for time spent traveling, the PCU will take action to recoup the funds.

In addition, in 2005 EOHHS entered into an Interagency Services Agreement (ISA) with UMMS (mentioned in footnote 3, above) to provide in-person nursing assessments to MassHealth eligible members for the determination of coverage for CSN services. CCM performs in-person assessments for those members who require CSN services prior to age 22. MassHealth is in the process of expanding its CCM activities to include eligible members of all ages.

As part of the ISA with UMMS, MassHealth requires CCM to request nursing progress notes and plan of care documentation from each nursing provider at a minimum annually as part of CCM's assessment process for MassHealth coverage of nursing services. CCM will notify MassHealth and its PCU any time requested documentation from the nursing providers can't be obtained, or appear inaccurate or incorrect.

c. Claims Were Paid That Were Not Billed in Compliance with Regulations

As stated in our response to audit findings 1a and 1b, MassHealth and its PCU have been successful in identifying providers who failed to bill in compliance with MassHealth regulations. Both MassHealth and its PCU have created provider regulation algorithms that run data reports on consistent bases in an effort to monitor compliance with regulatory provisions. One algorithm developed by PCU specifically addresses the requirement that INs bill no more than 60 hours during a seven-consecutive-day period per MassHealth regulations.

Also, as mentioned in our response to audit finding 1b, CCM is requesting nursing provider nursing progress notes and plan of care documentation at a minimum at every annual CSN reassessment. CCM will notify MassHealth and its PCU any time requested documentation from the nursing providers can't be obtained, or appear inaccurate or incorrect.

In the fall of 2008, MassHealth conducted provider training for all MassHealth Independent Nurse providers on the then newly-revised MassHealth Independent Nurse program regulations at 130 CMR 414.000, et seq. The trainings were very successful, with 174 providers attending. All Independent Nurse providers who billed in 2007 and 2008 were invited, which at the time was 200 providers. Ongoing training is offered monthly to new providers as well as current providers through the MassHealth Customer Service Team.

d. Services May Not Have Represented the Least Costly Form of Comparable Care Available

MassHealth does require prior authorization (PA) for both Personal Care Attendant (PCA) services and continuous skilled nursing (CSN) services. The current MassHealth process is for one nurse in the PA unit or, if the member is assigned to CCM, for CCM to review both PCA and CSN services' authorization requests for a member. Having the same nurse review both authorization requests for a member was put in place to avoid duplication of service. There is nothing in the MassHealth regulations that would prohibit a member from receiving both skilled nursing and PCA services at the same time as long as the services are medically necessary, and they are not a duplication of services. PCAs provide services to assist a member with Activities of Daily Living ("ADLs") and Instrumental Activities of Daily Living ("IADLs"), while CSN provides nursing level care.

As stated in our response to audit finding 1b, MassHealth is in the process of expanding its CCM activities to include eligible members of all ages. CCM performs an in-person PCA evaluation for members who receive CSN services.

We also note that OSA included a number of other suggestions for improving the oversight and controls in this area in the Draft Report. We will take those under consideration.

e. Services May Have Been Rendered Under Conditions That May Compromise the Safety and Quality of Care of Members

As stated in our response to audit finding 1b, MassHealth is in the process of expanding its CCM activities to eligible members of all ages. Also, as stated in response to audit finding 1a, MassHealth is considering amendments to the Independent Nurse regulations regarding the number of hours an Independent Nurse provider can provide CSN services within a twenty-four hour period under MassHealth, and to clarify the definition of calendar week and seven consecutive days. Additionally, PCU has developed an algorithm to address the 60 hour limit for Independent Nurse providers per MassHealth Independent Nurse regulations.

As part of its regular business practice, MassHealth Provider Enrollment verifies that each Independent Nurse applicant is properly licensed and in good standing with the Massachusetts Board of Registration of Nursing before assigning an Independent Nurse a MassHealth provider number. Beginning in August 2008, MassHealth, as part of the enrollment process, requests a Criminal Offender Record Information (CORI) check of each Independent Nurse applicant. Independent Nurse applicants who have CORI findings are referred to MassHealth's Provider Review Committee (PRC) for final decision on the application. Provider Enrollment also compares the nurses against the [Office of the Inspector General] exclusion list.

Provider Enrollment also receives a listing from the Massachusetts Board of Registration of Nursing of those nurses who have been reprimanded or whose licenses have been suspended. This list is cross-checked against the MassHealth Independent Nurse provider list to see if there are any matches. If a provider is found to have been reprimanded, he/she is referred to MassHealth PRC for a final decision on whether the provider will be allowed to maintain his/her MassHealth provider number. PCU is also involved with the PRC review in determining recovery because providers are required to notify MassHealth of any changes in any of the information submitted in the provider application in accordance with 130 CMR 450.223 (B). If a provider is found to have lost his/her license, the provider is terminated from participating as a MassHealth provider. As part of the review of Independent Nurse provider claims, PCU also checks the Independent Nurse provider's license with the Massachusetts Board of Registration of Nursing.

Regarding the suggestion that home health agencies and Independent Nurse providers obtain malpractice insurance, MassHealth does not require those providers to obtain malpractice insurance and it is not required by the Massachusetts Department of Public Health, the Centers for Medicare and Medicaid Services (CMS), and the Board of Registration of Nursing.

Auditor's Reply

In its response, MassHealth states that it “has a variety of effective internal controls to prevent, deter and detect HHS providers, who may have submitted potentially fraudulent claims, who submit inaccurate claims, or who submit bills not in compliance with regulations.” In addition, MassHealth states that it has, and plans to, implement additional controls including amending its regulations. We believe that the additional measures that MassHealth is planning to take to improve its internal controls in this area are necessary and appropriate, and should further enhance its ability to detect questionable billings for home health services. In addition to those measures that MassHealth stated that it is taking to address our concerns relative to its payments for home health services, we recommend that the agency consider a number of other internal control improvements. Some of these recommendations, which in its response MassHealth states that it will consider, include: (1) requiring a weekly attestation, under pains of perjury, by the MassHealth member or require that his or her parent, spouse, or guardian confirm the hours worked by both INs and HHAs; (2) standardizing forms for the INs’ notes, medicine distribution, and any other documentation required to be maintained under the recordkeeping requirements; (3) developing standardized timesheets to replace the current procedure of indicating beginning and ending times of shifts in the nurses’ notes; and (4) assigning a manager or supervisor to each IN.

As stated in our report, we also believe that it is essential that MassHealth standardize its billing procedures for INs in order to monitor compliance with the limit of hours worked in a

consecutive seven-day period, because without this the algorithms that are currently utilized by the agency are ineffective in the detection of many of the hours billed in excess of those allowed by regulation. Further, while algorithms and data mining are useful tools in detecting potential problems, the information obtained performing these is only effective if done in concert with the hands-on inspection and review of nurses' notes and timesheets.

As MassHealth states in its response, several INs have failed to bill claims in accordance with regulations. While we commend MassHealth for identifying these problems, it is clearly more cost-effective to take the measures necessary to prevent these types of inappropriate payments from occurring. MassHealth states that it has conducted training, which was well attended and considered successful, with INs and offers ongoing training to both new and existing INs. We believe that this training is important and its success can be only be determined by improved practices. Therefore, we again recommend that MassHealth convene not only optional, but mandatory annual training sessions for INs to familiarize them with MassHealth's recordkeeping requirements as well as its maximum work hours requirements.

As stated in our report, we believe that MassHealth needs to improve the controls it has established to ensure that its consumers receive the least costly form of comparable care available. For example, MassHealth does not require HHAs to establish policies and procedures to document the process they use to determine that the least costly form of care is being provided to the MassHealth members they are servicing. As a result, during our audit we found a number of instances where we believe that adequate home health services could have been provided to MassHealth members at a lower cost. In order to better ensure that its providers comply with its requirements for providing the least costly care available to its members, we recommend that the agency consider: (1) adjusting the rates for certain intermittent services that are known to require a visit of less than one hour; (2) requiring household members or primary caregivers to provide services, if they could be effectively and safely provided by these individuals; (3) reviewing the reimbursements rates of RNs and LPNs enrolled as INs; and, (4) requiring that members receiving HHS be examined by a physician at least annually.

In its response, MassHealth comments on the instances where we found that hours worked by PCAs overlapped those of nurses working in members' households and both were present at the same time, potentially without need. Regarding this issue, MassHealth states that prior

authorization is required for these services and, "There is nothing in the MassHealth regulations that would prohibit a member from receiving both skilled nursing and PCA services at the same time as long as the services are medically necessary, and they are not a duplication of services." While we acknowledge the fact that there is no prohibition on a member receiving both skilled nursing and PCA services, without effective monitoring procedures, there is inadequate assurance that the instances discussed in our report do not represent a duplication of services and therefore could have been provided at a lower cost. Further, prior authorization is for the quantity of hours to be worked, not the schedule of those hours.

Our audit report also recommends that MassHealth conduct a review of its regulations, policies, and procedures to determine whether they are adequate to ensure the quality of care and safety of its members. To this end, MassHealth indicated that it is in the process of expanding its Community Case Management program activities to eligible members of all ages, not just those enrolled while under the age of 22. Also, MassHealth states that it is considering amendments to the IN regulations regarding hours worked. We believe that these actions are appropriate and should serve to enhance the quality of services provided to its members. However, we still have concerns with the fact that most INs have not had a Criminal Offender Record Information check, as they were enrolled prior to August 1, 2008. We are also concerned that nursing services provided by an IN, who is also an LPN or LVN, are not under the supervision of a RN. Additionally, as previously stated, the algorithm to address the excess hours worked by INs is ineffective without a corresponding standardization of billing procedures. We do not agree with MassHealth's assertion that studies on the limitations on the number of hours that nurses should work applies only to those situations where nurses are working in an acute care hospital setting. In fact, this is contradicted by the fact that MassHealth's own regulations establish such a work hour limitation for INs who are clearly not working in this type of a work environment. The report we cited by the Institute of Medicine of the National Academies was among several produced by professional organizations that have provided guidance as to the negative effects of nurses working excessive hours and the importance of limiting the number of hours they work in order to minimize the number of work-related problems that can arise from fatigue. For

example, the American Nurses Association (ANA) has issued a position statement¹¹ that applies to nurses working in all roles and settings which states, in part:

Given the well-documented relationship between nurse fatigue and an increased risk of nurse error with the potential for compromising patient care and safety, it is the position of the American Nurses Association that all employers of registered nurses should ensure sufficient system resources to provide the individual registered nurse in all roles and settings with:

1. *a work schedule that provides for adequate rest and recuperation between scheduled work; and*
2. *sufficient compensation and appropriate staffing systems that foster a safe and healthful environment in which the registered nurse does not feel compelled to seek supplemental income through overtime, extra shifts, and other practices that contribute to worker fatigue.*

Further, the ANA takes the following position:

Registered nurses should consider the impact that multiple jobs have on their level of fatigue and ability to practice safely.

As a result, we reassert our recommendation that MassHealth establish guidelines for the maximum amount of total work hours the IN providers and HHA-employed nurses should be working during a specified period on all their jobs and solicit total work hour information from the nurses so that it can monitor compliance with these guidelines.

Finally, we do not dispute the fact that there are no requirements for malpractice insurance for HHS providers. However, if MassHealth members are injured due to uninsured providers' grossly negligent or egregious behavior, they may have limited financial recourse. Consequently, we again recommend that HHAs and INs obtain malpractice insurance and advise MassHealth members receiving HHS to inquire whether the providers have such insurance.

¹¹ Assuring Patient Safety: Registered Nurses' Responsibility in All Roles and Settings to Guard Against Working When Fatigued, effective December 8, 2006