Audit of Heart to Heart Health Care Services, LLC's (D/B/A Heart to Heart Home Care) Medicaid Billing Practices

Medicaid Fraud Division Report

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For the period August 1, 2014 through July 31, 2019

NEW JERSEY
OFFICE OF THE STATE
COMPTROLLER

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I. Introduction

As part of its oversight of the New Jersey Medicaid program (Medicaid), the Office of the State Comptroller, Medicaid Fraud Division (OSC) conducted an audit of Heart to Heart Health Care Services, LLC, d/b/a Heart to Heart Home Care (HTH), a Personal Care Services (PCS) provider, to determine whether HTH appropriately billed Medicaid for PCS services in accordance with applicable state and federal laws and regulations. OSC's audit was for the period from August 1, 2014 through July 31, 2019 (audit period).

OSC conducted an audit of Medicaid claims submitted by and paid to HTH to determine whether HTH billed for home-based PCS in accordance with applicable state and federal laws and regulations. Specifically, OSC reviewed HTH's PCS claims billed under the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System (HCPCS) code T1019. From its audit of 118 statistically selected claims, totaling $7,177.46 in Medicaid funds paid to HTH, OSC determined that 19 of the 118 claims, totaling $929.68 paid to HTH, failed to comply with state regulations. Apart from the sample claims, OSC also found that HTH improperly billed for 46 claims, totaling $2,155.42 paid to HTH that overlapped with hospital claims on the same dates for the same beneficiaries.

For audit testing purposes, OSC first identified HTH PCS claims coinciding with hospital claims for the same beneficiaries for overlapping periods. From a universe of 296,420 PCS claims, totaling $16,094,897 paid to HTH under HCPCS code T1019, OSC identified 46 claims, totaling $2,155.42 for which HTH was paid for PCS provided to beneficiaries in their homes while these beneficiaries had inpatient status in a hospital setting. HTH should not have billed for these PCS claims because the beneficiaries for whom HTH purportedly provided at home services were in a hospital. To perform a more comprehensive review of the remainder of HTH's PCS claims, OSC removed these 46 improperly billed and paid claims from the universe of 296,420 claims, leaving a net universe of 296,374 claims, totaling $16,092,741.69 paid to HTH. OSC then selected and reviewed a statistically valid sample of 118 claims, totaling $7,177.46 in Medicaid reimbursement.

OSC determined that 19 of the 118 sampled claims, totaling $929.68 in reimbursement, failed to comply with state regulations. Specifically, OSC found that HTH failed to: a) verify that a homemaker-home health aide (HHA) was certified, thus allowing an uncertified HHA to provide PCS for 1 claim; b) conduct supervisory evaluation of the Plan of Care (POC) and HHA once every 60 days or less for 14 claims; c) substantiate services billed for 3 claims; and d) complete a POC prior to initiating services for 1 claim.

In sum, OSC determined that HTH improperly billed 19 of the 118 sample claims, for which HTH received total payment of $929.68. For purposes of ascertaining a final recovery amount, OSC extrapolated the dollars in error for these 19 failed claims to the total dollars in the population of claims from which the sample claims was drawn, which in this case was 296,374 claims with a total payment amount of $16,092,741.69. After extrapolating the sample dollars in error over the entire universe of claims, OSC calculated that HTH received an overpayment of $2,384,132.55. Additionally, OSC determined that HTH improperly billed and received payment for 46 claims, totaling $2,155.42, which overlapped with hospital claims for the same beneficiary and for the same date of service. In total, OSC determined that HTH received an overpayment of $2,386,287.97 ($2,384,132.55 plus $2,155.42) that it must repay to the Medicaid program.

II. Background

The Division of Medical Assistance and Health Services (DMAHS), within the New Jersey Department of Human Services (DHS), administers New Jersey's Medicaid program. Medicaid is a program through which individuals with disabilities and/or low incomes receive health care services. DMAHS contracts with five managed care organizations (MCOs) to administer certain health care services to Medicaid beneficiaries. PCS are provided to Medicaid beneficiaries who experience functional impairments and need assistance with activities of daily living, such as dressing, bathing, toileting, or feeding, or with instrumental activities of daily living, such as meal preparation and grocery shopping. These services enable Medicaid beneficiaries to remain in their homes and minimize reliance on institutionalized settings, such as nursing facilities.

HTH has locations in New Jersey (Paterson, Hackensack, East Orange, Lakewood, and Vineland) and New York (Brooklyn, Flushing, and Bronx). HTH has participated as a home care provider in the New Jersey Medicaid program since July 2008.

III. Audit Objective, Scope and Methodology

The objective of this audit was to evaluate claims billed by and paid to HTH to determine whether these claims complied with applicable state and federal laws and regulations.

The scope of the audit was August 1, 2014 through July 31, 2019. The audit was conducted under the authority of the Office of the State Comptroller as set forth in *N.J.S.A.*52:15C- 23 and the Medicaid Program Integrity and Protection Act, *N.J.S.A.*30:4D-53 et seq.

To accomplish this objective, OSC reviewed the universe of 296,420 claims, totaling $16,094,897 billed under HCPCS code T1019, and identified 46 claims in which services were provided to beneficiaries while these beneficiaries had inpatient status in a hospital setting. OSC then removed those 46 claims from the universe and selected a statistically valid random sample comprised of 118 claims, totaling $7,177.46 paid to HTH, from a net universe of 296,374 claims, totaling $16,092,741.69 billed by and paid to HTH under HCPCS code T1019.

OSC reviewed HTH's records related to these 118 claims to determine whether the documentation provided complied with the requirements of 42 *CFR* § 440.167(a)(1), *N.J.A.C.* 10:49-9.8(a), *N.J.A.C.* 10:49-9.8(b)(1), *N.J.A.C.* 10:49-5.5(a)(11), *N.J.A.C.* 10:49-5.5(a)(18), *N.J.A.C.* 10:49-11.1, *N.J.A.C.* 10:60-1.2(3),-(1), *N.J.A.C.* 10:60-3.5(a)(1), *N.J.A.C.* 10:60-3.5(a)(2), *N.J.A.C.* 10:60-3.8(a), *N.J.A.C.* 13:37-14.3, *N.J.A.C.* 13:45B-14.4(a),-(c), *N.J.A.C.* 13:45B-14.9(a), and *N.J.A.C.* 13:45B- 14.9(g).

IV. Discussion of Auditee Comments

The release of this Final Audit Report concludes a process during which OSC afforded HTH multiple opportunities to provide input regarding OSC's findings. Specifically, OSC provided HTH a Summary of Findings (SOF) and offered HTH an opportunity to discuss the SOF at an exit conference. OSC and HTH, represented by counsel, held an exit conference during which the parties discussed OSC's findings in the SOF. After the exit conference, HTH provided OSC comments and additional records. After considering HTH's submission, OSC provided HTH with a Draft Audit Report (DAR). HTH provided a formal response to the DAR, which is attached as Appendix C, entitled "HTH's Response to Draft Audit Report."

In its response to the DAR, HTH objected to OSC's sampling and extrapolation methodology as well as the audit findings. HTH, however, not only failed to address any of OSC's recommendations or submit a corrective action plan (CAP), it also failed to indicate whether it intended to repay the identified overpayment. OSC addresses each argument raised by HTH in Appendix D, entitled "HTH's Comments and OSC's Responses."

OSC notes that HTH's response to the audit, specifically its failure to provide a CAP, substantively address the recommendations, and state whether it intends to repay the identified overpayment, demonstrate its unwillingness to address the requirements and deficiencies that OSC identified in the audit. Should HTH fail to modify its behavior to adhere to the identified requirements, its actions would increase the level of risk for Medicaid beneficiaries served by HTH as well as the Medicaid funds associated with these services.

V. Audit Findings

A. HTH Failed to Verify the Professional Certification of an HHA Prior to Rendering Services

Pursuant to state regulations, HHAs must be certified prior to performing PCS and PCS providers, including HTH, must ensure that HHAs who perform PCS on their behalf possess the required certification before allowing such personnel to perform these services.

OSC found that for 1 of the 118 sample claims, totaling $44.40 paid to HTH, HTH failed to ensure that the HHA was properly certified, thus allowing an uncertified individual to perform services. In this instance, the HHA provided PCS on December 30, 2015, however, the HHA's temporary HHA permit had expired on June 30, 2015. By failing to verify that this HHA was certified and thereby allowing the HHA to perform services six months after the individual's temporary work permit had expired, HTH violated *N.J.A.C.* 10:60-1.2 (definition of "[h]omemaker-home health aide") and *N.J.A.C.* 13:45B-14.4 (a) and (c). *See* Appendix A for claim detail.

Pursuant to *N.J.A.C.* 10:60-1.2, "'Homemaker-home health aide' means a person who: Successfully completes a training program in personal care assistant services and is certified by the New Jersey State Department of Law and Public Safety, Board of Nursing, as a homemaker-home health aide." That definition further provides that "[a] copy of the certificate issued by the New Jersey Department of Law and Public Safety, Board of Nursing or other documentation acceptable to the Division [must be] retained in the agency's personnel file."

Pursuant to *N.J.A.C.* 13:45B-14.4(a), "When licensure to perform a health care service or function is required by law, an agency shall refer or place only those health care practitioners who are currently licensed or certified and in good standing with their respective New Jersey licensing or registration boards." *N.J.A.C.* 13:45B-14.4(c) further provides that "[t]he agency shall, through its health care practitioner supervisor or other designated individual, verify the license status of each individual to be placed or referred prior to the referral or placement. Licensure shall be verified by obtaining a document, which verifies licensure from the Board or Committee that registers or licenses the individual and, within 45 days of obtaining the verification, by personally inspecting the current biennial registration or license or a copy of the current biennial registration or license."

B. HTH Failed to Perform Timely In-Home Evaluations of the HHA and POC

Medicaid PCS providers must perform an in-home evaluation of the HHA and the beneficiary's POC not less than once during each 60-day period. Timely completion of the in-home evaluation is required to evaluate the HHA's performance and to determine whether the services called for in the POC meet the needs of the beneficiary and, if not, to make any necessary changes thereto. Since a beneficiary's needs can change, the POC must be updated to account for such changes in a beneficiary's health and wellbeing.

OSC reviewed the documentation to determine whether HTH completed the in-home evaluation of the HHA and the POC at least once every 60 days. OSC found that for 14 of the 118 sample claims, totaling $689.06 paid to HTH, HTH did not perform the in-home evaluation of the HHA and the POC once every 60 days. For example, for services rendered by HTH to a beneficiary on February 28, 2018, HTH last completed the in-home evaluation of the beneficiary's HHA and POC on October 27, 2017, 124 days before the date of service. HTH did not complete any subsequent in-home evaluations for this beneficiary. See Exhibit I. In another instance, HTH billed for PCS services rendered on August 30, 2014, but the two in-home evaluation visits for that beneficiary took place on May 23, 2014 and November 13, 2014, resulting in a 174-day span between the two in-home evaluations. *See* Exhibit II. For these claims, HTH violated *N.J.A.C.* 10:49-9.8(a), *N.J.A.C.* 10:60-3.5(a)(2), and *N.J.A.C.* 13:45B-14.9(g) by not performing in-home evaluations of the POC within the required timeframe. See Appendix A for claim detail.

Pursuant to *N.J.A.C.* 10:49-9.8(a), "all providers shall certify that the information furnished on the claim is true, accurate, and complete."

Pursuant to *N.J.A.C.* 10:60-3.5(a)(2), "Direct supervision of the personal care assistant shall be provided by a registered nurse at a minimum of one visit every 60 days, initiated within 48 hours of the start of service, at the beneficiary's place of residence during the personal care assistant's assigned time. The purpose of the supervision is to evaluate the personal care assistant's performance, to determine that the plan of care has been properly implemented, and to document that hands-on personal care is being provided. At this time, appropriate revisions to the plan of care shall be made as needed . . . ."

Pursuant to *N.J.A.C.* 13:45B-14.9(g), "The health care practitioner supervisor shall make an on-site, in home evaluation of the plan of care not less than once during each 60 day period during which the agency has placed or referred a health care practitioner in the home care setting."

C. HTH Billed for Unsubstantiated Services

Medicaid PCS providers must maintain records that are true, accurate and complete. Further, the records must document fully the extent of services provided. OSC reviewed HTH's timesheets to determine whether HTH maintained proper documentation for its Medicaid-billed services. OSC found that for 3 of the 118 sample claims, totaling $166.62 paid to HTH, HTH billed for services that were not supported by documentation. Specifically, OSC found that HTH billed for PCS for 2 of the 3 claims, totaling $69.90, for which HTH did not provide a timesheet to support the PCS. Further, OSC found for 1 of the 3 claims, totaling $96.72, the timesheet was incomplete as the services performed were not documented. For these claims, HTH violated *N.J.A.C.* 10:49-9.8(a), and *N.J.A.C.* 10:49-9.8(b)(1) by failing to maintain appropriate records. *See* Appendix A for claim detail.

Pursuant to *N.J.A.C.* 10:49-9.8(a), "all providers shall certify that the information furnished on the claim is true, accurate, and complete." Moreover, pursuant to *N.J.A.C.* 10:49-9.8(b)(1), providers are required "to keep such records as are necessary to disclose fully the extent of services provided."

D. HTH Failed to Prepare a POC Prior to Initiating Service

Medicaid PCS providers must evaluate the beneficiaries' needs and establish a written POC prior to initiating service. This requirement ensures that PCS providers identify the HHA tasks and hours of service needed before sending an HHA to provide services. It also ensures that the HHA knows the beneficiary's needs before providing services to the beneficiary. OSC found that HTH billed for PCS for

1 of the 118 sample claims, totaling $29.60 paid to HTH, without first having completed a POC before rendering services. For this claim, HTH violated *N.J.A.C.* 10:49-9.8(a) and *N.J.A.C.* 13:45B-14.9(a) by not preparing the POC prior to rendering services. *See* Appendix A for claim detail.

Pursuant to *N.J.A.C.* 10:49-9.8(a), "all providers shall certify that the information furnished on the claim is true, accurate, and complete."

Pursuant to *N.J.A.C.* 13:45B-14.9(a), "Prior to referring or placing a health care practitioner in a home care setting, an agency shall assure that an appropriately licensed person evaluates the patient's needs and establishes, in writing, a plan of care. The health care practitioner preparing the plan of care shall sign it and indicate thereon his or her license designation."

E. HTH Improperly Billed PCS while Beneficiaries Were Inpatient in a Hospital

Apart from the review of the sampled claims, OSC also reviewed HTH's home-based PCS claims billed under the HCPCS code T1019 to determine whether such claims overlapped with dates when beneficiaries were in a hospital. OSC found that HTH submitted 46 claims, totaling $2,155.42 paid to HTH, for services purportedly provided to beneficiaries in a home setting while these beneficiaries had inpatient status in a hospital. Pursuant to Medicaid regulations, a beneficiary cannot receive PCS, Private Duty Nursing, or In-Home-Nursing services, while Medicaid is paying a hospital for room and board services for the same beneficiary. Therefore, these 46 claims constitute overpayments that HTH must repay to the Medicaid program. For these claims, HTH violated *N.J.A.C.* 10:49-9.8(a) and *N.J.A.C.* 10:60-3.8(a) by improperly billing for PCS while a beneficiary has inpatient status in a hospital. *See* Appendix B for claim detail.

Pursuant to *N.J.A.C.* 10-49-9.8(a), "providers shall certify that the information furnished on the claim is true, accurate, and complete."

Pursuant to *N.J.A.C.* 10:60-3.8(a)(1)-(3) and (8), "Medicaid/NJFamilyCare reimbursement shall not be made for personal care assistant services provided to Medicaid or NJ FamilyCare –Plan A beneficiaries in the following settings: A residential health care facility; A Class C boarding home; A hospital; . . . Adult Family Care, Assisted Living Program, and Assisted Living Residence."

F. Summary of Medicaid Overpayment

OSC determined that HTH improperly billed and received payment for 19 of the 118 sample claims, totaling $929.68 paid to HTH. *See* Appendix A for Summary. For purposes of ascertaining a recovery amount, OSC extrapolated the dollars in error for these 19 claims to the total population of 296,374 claims from which the sample claims was drawn, totaling $16,092,741.69 paid to HTH. By extrapolating the sample of deficient claims to this universe of claims/reimbursement amount, OSC calculated that HTH received an overpayment of $2,384,132.55 that it must repay to the Medicaid program.[1] Additionally, OSC determined that HTH improperly billed and received payment for 46 claims, totaling $2,155.42, for services provided to beneficiaries while these beneficiaries had inpatient status in a hospital setting. In total, OSC determined that HTH received an overpayment of $2,386,287.97 ($2,384,132.55 plus $2,155.42) that it must repay to the Medicaid program.

1 OSC can reasonably assert with 90% confidence that the overpayment in the universe falls between $1,506,618 and $3,261,647 with the error point estimate as $2,384,132.55.

VI. Recommendations

1. HTH shall reimburse Medicaid the overpayment amount of $2,386,287.97.

2. HTH must adhere to state and federal regulations for Medicaid services provided by HTH and its health care professionals.

3. HTH must verify licensures and/or certifications before HHAs are assigned case referrals, and maintain documentation that ensures compliance with the state regulations.

4. HTH must ensure that HTH and its health care professionals receive training to foster compliance with applicable state and federal regulations.

5. HTH must provide OSC with a CAP indicating the steps HTH will take to implement procedures to correct the deficiencies identified herein.