OHIO AUDITOR OF STATE
KEITH FABER

HORIZON HEALTH SERVICES, LLC
CUYAHOGA COUNTY

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OHIO AUDITOR OF STATE
KEITH FABER

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

Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215

RE: Horizon Health Services, LLC
Ohio Medicaid # 2533726

We were engaged to examine Horizon Health Services, LLC's (Horizon's) compliance with specified Medicaid requirements for service documentation, service authorization and provider qualifications related to the provision of home health nursing, home health aide, private duty nursing and personal care aide services during the period of July 1, 2013 through June 30, 2016. Management of Horizon Health Services, LLC is responsible for its compliance with the specified requirements.

Horizon entered into an agreement (the Provider Agreement) with the Ohio Department of Medicaid (ODM) to provide services to Medicaid recipients and to adhere to the terms of the agreement, state statutes and rules and federal statutes and rules, including the duty to maintain records supporting claims for payment made by Ohio Medicaid.

Our responsibility is to express an opinion on Horizon's compliance with the specified Medicaid requirements based on conducting the examination in accordance with attestation standards established by the American Institute of Certified Public Accountants. An examination involves performing procedures to obtain evidence about whether Horizon complied with the specified requirements. The nature, timing and extent of the procedures selected depend on our judgment, including an assessment of the risks of material noncompliance, whether due to fraud or error. Our examination does not provide a legal determination on the Horizon's compliance with the specified requirements.

Internal Control Over Compliance

Horizon is responsible for establishing and maintaining effective internal control over compliance with the Medicaid requirements. We did not perform any test of the internal controls and we did not rely on the internal controls in determining our examination procedures. Accordingly, we do not express an opinion on the effectiveness of Horizon's internal control over compliance.

Basis for Disclaimer of Opinion

As described in the attached Compliance Examination Report, there was no documentation to support the Medicaid payments to Horizon for 477 of the 2,654 selected services (18 percent) and no required authorization for 296 of the 2,041 selected services (14 percent). As such we were unable to gain sufficient reliance on the documentation to determine Horizon's compliance with the specified Medicaid requirements. Nor were we able to satisfy ourselves as to Horizon's compliance with these requirements by other examination procedures.

Disclaimer of Opinion

Because of the limitation on the scope of our examination discussed in the preceding paragraph, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the Horizon's compliance with the specified Medicaid requirements for the period of July 1, 2013 through June 30, 2016.

Our testing was limited to the specified Medicaid requirements detailed in the Compliance Examination Report. We did not test other requirements and, accordingly, we do not express an opinion on Horizon's compliance with other requirements.

We calculated improper Medicaid payments in the amount of $3,681,822. This finding plus interest in the amount of $519,843 (calculated as of February 20, 2019) totaling $4,201,665 is due and payable to the ODM upon its adoption and adjudication of this examination report. Services billed to and reimbursed by the ODM, which are not validated in the records, are subject to recoupment through the audit process. *See* Ohio Admin. Code § 5160-1-27 In addition, if fraud, waste and abuse[1] are suspected or apparent, the ODM and/or the office of the attorney general will take action to gain compliance and recoup inappropriate or excess payments in accordance with rule 5160-1-27 or 5160-26-06 of the Administrative Code.

This report is intended solely for the information and use of Horizon, the ODM and other regulatory and oversight entities, and is not intended to be, and should not be used by anyone other than these specified parties.

Keith Faber
Auditor of State
Columbus, Ohio

February 20, 2019

[1] "Fraud" is an intentional deception, false statement, or misrepresentation made with the knowledge that the deception, false statement, or misrepresentation could result in some unauthorized benefit to oneself or another person. "Waste and abuse" are practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitutes an overutilization of Medicaid covered services and result in an unnecessary cost to the Medicaid program. Ohio Admin. Code § 5160-1-29(A)

COMPLIANCE EXAMINATION REPORT

Background

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each State's Medicaid program. The rules and regulations that providers must follow are specified in the Ohio Administrative Code and the Ohio Revised Code. The fundamental concept underlying the Medicaid program is medical necessity of services: defined as services which are necessary for the prevention, diagnosis, evaluation or treatment of an adverse health condition. *See* Ohio Admin. Code § 5160-1-01(A) and (B)

Medicaid providers must "maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions" for a period of six years from receipt of payment or until any audit initiated within the six year period is completed. Providers must furnish such records for audit and review purposes. Ohio Admin Code § 5160-1-17.2(D) and (E)

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

Horizon is a MCRHHA and received reimbursement of $12,633,919 for 221,829 services, including the following:

- 106,413 home health aide services (procedure code G0156);
- 80,526 personal care services (procedure code T1019);
- 27,070 skilled nursing services (procedure code G0154);
- 6,503 private duty nursing services (procedure code T1000);
- 673 registered nursing services (procedure code T1002);
- 536 nursing assessment services (procedure code T1001); and
- 108 licensed practical nursing services (procedure code T1003).

Horizon had four active Medicaid provider numbers during the examination period. The additional three numbers and their associated payments include:

- 2828659 – Reimbursements of $2,742,076 for PASSPORT[2] waiver services;
- 2463338 – Reimbursements of $403,394 for developmental disabilities waiver services; and
- 0056851 – No reimbursement during the examination period.

The scope of this examination was limited to services billed to number 2828659. In total, for all active numbers, Ohio Medicaid paid Horizon approximately $15.8 million.

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether Horizon's Medicaid claims for reimbursement complied with Ohio Medicaid regulations. Please note that all rules and code sections relied upon in this report were those in effect during the examination period and may be different from those currently in effect. The scope of the engagement was limited to home health services; specifically, home health nursing, private duty nursing and home health aide services, and personal care aide services that Horizon billed to Ohio Medicaid with dates of service between July, 1, 2013 and June 30, 2016 and received payment.

[2] PASSPORT is an acronym for preadmission screening system providing options and resources today

Purpose, Scope, and Methodology (Continued)

We received Horizon's claims history from the Medicaid database of services billed to and paid by Ohio's Medicaid program. We removed one service with a third party payment. While planning for this examination, we became aware of potential links between Horizon and three other home health agencies: Xcel Healthcare Providers, Inc. (Xcel) - Medicaid number 2469118; Imani Home Health Care, LLC (Imani) - Medicaid number 2795202; and Generations Health Services, LLC (Generations) - Medicaid number 0170657.

We created a file containing services for Horizon and Xcel and identified instances in which both agencies were reimbursed for services to the same recipient identification number on the same date of service. From this file we extracted all of the Horizon services as an exception test (Shared Recipients with Xcel). This exception test includes home health aide services, personal care aide services, skilled nursing, and nursing assessments.

Next we created a file containing services for Horizon and Imani with service dates between July 1, 2013 and February 9, 2015[3]. From the file we identified instances in which both agencies were reimbursed for services to the same recipient identification number on the same date of service. We extracted all of the Horizon services as an exception test (Shared Recipients with Imani). This exception test includes home health aide services, personal care aide services, skilled nursing services and private duty nursing services.

We then created a file containing services for Horizon and Generations that included service dates between February 11, 2015 and June 30, 2016. We identified instances in which both agencies were reimbursed for services to the same recipient identification number on the same date of service. We extracted all of the Horizon services as an exception test (Shared Recipients with Generations). This exception test includes home health aide services, personal care aide services, skilled nursing services and private duty nursing services.

Table 1: Exception Tests

Description	Services Selected
Shared Recipients with Xcel	444
Shared Recipients with Imani	393
Shared Recipients with Generations	159
Total	996

We removed the Horizon services selected for the exception tests from the population of paid Horizon services. From the remaining population, we extracted home health and private duty nursing services, home health aide services and personal care aide services. We used statistical methods to facilitate a timely and efficient examination as permitted by Ohio Admin. Code § 5160-1-27(B)(1) as shown in Table 2.

The sampling unit for the three samples is a recipient date of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date of service. From the three populations, an estimate of the population overpayment standard deviation was made using the standard deviation of the actual amount paid per service and a 50 percent error rate for the nursing services sample and a 48 percent error rate for the home health aide services sample and the personal care aide services sample as conservative estimates of the potential error rate.

[3] Imani was purchased by Generations on February 10, 2015.

Purpose, Scope, and Methodology (Continued)

To increase sampling efficiency, each of the three populations was divided into three strata using a modified cumulative frequency square root method (Dalenius-Hodge Rule)[4]. We used the U.S. Department of Health and Human Services/Office of Inspector General's (HHS/OIG) RATSTATS[5] statistical program to calculate the overall sample sizes. The final sample sizes are shown in the Tables 2, 3 and 4 below.

Table 2: Nursing Services Sample		
Universe/Strata	**Population Size (RDOS)**	**Sample Size (RDOS)**
RDOS Paid at $74.99 and Below	16,490	131
RDOS Paid Between $75 and $199.99	6,796	124
RDOS Paid $200 and Over	3,706	156
Total	**26,992**	**411**

We then obtained the detailed services for the 411 RDOS which resulted in a sample of 548 services.

Table 3: Home Health Aide Services Sample		
Universe/Strata	**Population Size (RDOS)**	**Sample Size (RDOS)**
RDOS Paid at $49.99 and Below	92,179	356
RDOS Paid Between $50 and $74.99	11,362	68
RDOS Paid $75 and Over	857	30
Total	**104,398**	**454**

We then obtained the detailed services for the 454 RDOS which resulted in a sample of 497 services.

Table 4: Personal Care Aide Services Sample		
Universe/Strata	**Population Size (RDOS)**	**Sample Size (RDOS)**
RDOS Paid at $74.99 and Below	25,069	114

[4] Sampling of Populations: Methods and Applications 3rd Ed. by P.S. Levy and S. Lemeshow, Wile Series in Probability and Statistics, pp. 179-183
[5] RAT-STATS is a free statistical software package that providers can download to assist in a claims review. The package, created by OIG in the late 1970s, is also the primary statistical tool for OIG's Office of Audit Services.

Table 4: Personal Care Aide Services Sample		
Universe/Strata	**Population Size (RDOS)**	**Sample Size (RDOS)**
RDOS Paid Between $75 and $124.99	23,270	181
RDOS Paid $125 and Over	12,085	138
Total	**60,424**	**433**

We then obtained the detailed services for the 433 RDOS which resulted in a sample of 613 services. A total of 2,654 services were selected for examination in the three exception tests and the three random samples.

A notification letter was sent to Horizon setting forth the purpose and scope of the examination. During the entrance conference, Horizon representatives described its documentation practices and process for submitting billing to the Ohio Medicaid program. During the on-site fieldwork, we requested to see the area used to store current records. Horizon staff initially indicated the records were in the same building where the site visit was being conducted but upon seeing the identified area it was clear that it did not contain the records. Horizon staff then directed us to another building which had been previously used by Horizon but upon viewing that location it was evident that the records were not stored there either. Horizon staff provided no additional information as to the location of their records. We reviewed all documentation submitted by the Provider for compliance.

Results

While certain services had more than one error, only one finding was made per service. The non-compliance and basis for our findings is discussed below in more detail.

Exception Test – Shared Recipients with Xcel[6]

We examined 444 services associated with four recipients that also received services from Xcel and found that Horizon lacked supporting documentation for 41 (9 percent) of these Medicaid payments. The paid services for these recipients show that one agency provided nursing and the other aide services (home health aide and personal care aide) although they varied in which agency provided which category of service. Both agencies billed for a nursing assessment for one recipient which indicates possible overutilization of services. We identified an additional 244 errors in the exception test for a total of 285 errors resulting in an improper payment of $14,279.86.

Exception Test – Shared Recipients with Imani[6]

We examined 393 services associated with 22 recipients that also received services from Imani and found that Horizon lacked supporting documentation for 230 (59 percent) of these Medicaid payments. The paid services for these recipients show that these agencies billed the same code on the same date of service but often one or the other agency lacked documentation to support the Medicaid payment. We identified an additional 228 errors for a total of 458 errors resulting in an improper payment of $10,474.88.

[6] Compliance examination reports for Xcel Healthcare Providers, Inc., Imani Home Health Care, LLC and Generations Health Services, LLC will be available on the Auditor of State website upon their completion.

Results (Continued)

Exception Test – Shared Recipients with Generations[6]

We examined 159 services associated with seven recipients that also received services from Generations and found that Horizon lacked supporting documentation for 22 (14 percent) of these Medicaid payments. The paid services show that for four of these recipients, one of the agencies that billed had no supporting documentation. For one recipient, neither agency had supporting documentation and for the remaining two recipients both agencies had records to support some of their payments. We noted that for one recipient, one agency billed nursing and the other billed aide services and both agencies billed with all of the exact same dates of services. We identified 34 additional errors for a total of 56 errors resulting in an improper payment of $1,584.26.

Nursing Sample

We examined 327 home health nursing and 221 private duty nursing services and found 233 errors. The overpayments identified for 164 of 411 RDOS (217 of 548 services) from our stratified statistical random sample were projected across Horizon's total population of paid RDOS (less excluded services). This resulted in a projected overpayment amount of $944,860 with a precision of plus or minus $123,633 at the 95 percent confidence level. Since the precision percentage achieved was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed lower limit estimate (equivalent to methods used in Medicare audits), and a finding was made for $841,104. This allows us to say that we are 95 percent certain that the population overpayment amount is at least $841,104. A detailed summary of our statistical sample and projection results is presented in **Appendix I**.

Home Health Aide Sample

We examined 497 home health aide services and found 244 errors. The overpayments identified for 187 of 454 statistically sampled RDOS (198 of 497 services) from a stratified random sample were projected to Horizon's population of paid RDOS (less excluded services) resulting in a projected overpayment of $1,302,194 with a precision of plus or minus $140,531 at the 95 percent confidence level. Since the precision percentage achieved was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed lower limit estimate (equivalent to methods used in Medicare audits), and a finding was made for $1,184,257. This allows us to say that we are 95 percent certain that the population overpayment amount is at least $1,184,257. A detailed summary of our statistical sample and projection results is presented in **Appendix II**.

Personal Care Aide Sample

We examined 613 services and found 211 errors. The overpayments identified for 155 of 433 RDOS (205 of 613 services) from our stratified statistical random sample were projected across Horizon's total population of paid RDOS (less excluded services). This resulted in a projected overpayment amount of $1,838,732 with a precision of plus or minus $248,574 at the 95 percent confidence level. Since the precision percentage achieved was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed lower limit estimate (equivalent to methods used in Medicare audits), and a finding was made for $1,630,122. This allows us to say that we are 95 percent certain that the population overpayment amount is at least $1,630,122. A detailed summary of our statistical sample and projection results is presented in **Appendix III**.

A. Provider Qualifications

Nursing Services

According to Ohio Admin. Code §§ 5160-12-01(G)[7] and 5160-12-02(A), home health nursing requires the skills of and is performed by either a registered nurse (RN) or a licensed practical nurse (LPN) at the direction of an RN.

We identified 13 RNs and 39 LPNs in the documentation of the selected services and verified via the Ohio e-License Center website that their professional licenses were current and valid on the first date of service in the sample and were active during the remainder of the examination period.

We found no instances of non-compliance with the nursing licenses.

Home Health Aide Services

We did not examine provider qualifications for home health aides.

Personal Care Aide Services

In order to submit a claim for reimbursement, all individuals providing personal care aide services must obtain and maintain first aid certification from a class this is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course. *See* Ohio Admin. Code §§ 5160-46-04(B)(6)(a)(ii), 5160-50-04(B)(6)(a)(ii) and 5123:2-9-56(C)(3)

We reviewed personnel records for the 186 personal care aides identified from the statistical sample to determine if the aide had obtained and maintained the required first aide certification. We found that 15 of these aides lacked the certification and 136 aides had a lapse in certification for a span of time.

Exception Test – Shared Recipients with Xcel

We examined 444 services and found 103 services rendered by an aide who lacked first aid certification on the date of service. These 103 errors are included in the improper payment of $14,279.86.

Exception Test – Shared Recipients with Imani

We found no instances of non-compliance.

Exception Test – Shared Recipients with Generations

We examined 159 services and found six services rendered by an aide who lacked first aid certification on the date of service. These six errors are included in the improper payment of $1,584.26.

[7] Per Section 323.10.70 of Am. Sub. H. B. 59 of the 130th General Assembly, the Legislative Services Commission renumbered the rules of the Office of Medical Assistance within the Department of Job and Family services to reflect its transfer to ODM. The renumbering became effective on October 1, 2013.

A. Provider Qualifications (Continued)

Personal Care Aide Sample

We examined 613 services and found 115 services rendered by an aide who lacked first aid certification on the date of service. These 115 errors are included in the projected improper payment of $1,630,122.

Recommendation:

Horizon should improve its internal controls to ensure all personnel meet applicable requirements prior to rendering direct care services. Horizon should address the identified issue to ensure compliance with Medicaid rules and avoid future findings.

B. Service Documentation

The MCRHHA must maintain documentation of home health services that includes, but is not limited to, clinical and time keeping records that indicate the date and time span of the service and the type of service provided. *See* Ohio Admin. Code § 5160-12-03 Waiver service providers must maintain and retain all required documentation including, but not limited to, details of tasks performed or not performed, service start and end times and the dated signatures of the provider and the recipient or authorized representative. *See* Ohio Admin. Code §§ 5160-45-10 and 5123:2-9-56(E)

During part of the examination period, providers of home health nursing and aide services received a base rate for any portion of the first 60 minutes of home health services delivered. After July 1, 2015, providers were required to render 35 to 60 minutes of services to receive the base rate. Ohio Admin. Code § 5160-12-05 (A)(1)(a-b)

We determined if service documentation was maintained, contained the in and out time of the covered service, if documented units matched units paid, contained a description of services rendered or included the tasks performed. For waiver services we also tested documentation for inclusion of the dated signatures of the rendering provider and recipient or their authorized representative. For errors where the number of units billed exceeded the documented duration, the improper payment was based on the unsupported units.

Exception Test – Shared Recipients with Xcel

We examined 444 services and found 41 services (9 percent) in which there was no documentation to support the Medicaid payment and one service in which the documentation did not include a description of the service rendered. These 42 errors are included in the improper payment of $14,279.86.

Exception Test – Shared Recipients with Imani

We examined 393 services and found 230 services (59 percent) in which there was no documentation to support the Medicaid payment and two services in which Horizon billed units that exceeded the documented service duration. These 232 errors are included in the improper payment of $10,474.88.

Exception Test – Shared Recipients with Generations

We examined 159 services and found 22 services (14 percent) in which there was no documentation to support the Medicaid payment. These 22 errors are included in the improper payment of $1,584.26.

B. Service Documentation (Continued)

Nursing Sample

We examined 548 services and identified the following errors:

- 34 services in which there was no documentation to support the Medicaid payment;
- 13 services (after July 1, 2015) in which the service rendered was less than 34 minutes and a base rate was billed;
- 13 services in which the number of units billed exceeded the documented service duration;
- 5 services in which the service was incorrectly modified resulting in a higher reimbursement;
- 4 services in which the documentation did not include a description of the service rendered; and
- 4 services in which a single shift was billed as two separate shifts resulting in a higher reimbursement.

These 73 errors are included in the projected improper payment of $841,104.

We also noted three services in which the time out was not recorded. On these dates of service, a base unit was reimbursed for any number of minutes up to 60; so we identified no improper payment.

Home Health Aide Sample

We examined 497 services and identified the following errors:

- 85 services (17 percent) in which there was no documentation to support the Medicaid payment; and
- 5 services in which a single shift was billed as two separate shifts resulting in a higher reimbursement.

These 90 errors are included in the projected improper payment of $1,184,257.

Personal Care Aide Sample

We examined 613 services and identified the following errors:

- 65 services (11 percent) in which there was no documentation to support the Medicaid payment;
- 23 services in which the documentation was not signed by the recipient or an authorized representative;
- 4 services in which the units billed exceeded the documented service duration; and
- 4 services in which a single shift was billed as two separate shifts resulting in a higher reimbursement.

These 96 errors are included in the projected improper payment of $1,630,122.

Recommendation:

Horizon should develop and implement procedures to ensure that all service documentation fully complies with requirements contained in Ohio Medicaid rules. In addition, Horizon should implement a quality review process to ensure that documentation is complete and accurate prior to submitting claims for reimbursement. Horizon should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

C. Authorization to Provide Services

Plans of Care

All home health providers are required by Ohio Admin. Code § 5160-12-03(B)(3)(b) to create a plan of care for recipients and the plan is required to be signed by the recipient's treating physician. Home health providers must obtain the completed, signed and dated plan of care prior to billing the ODM for the service.

All Services Plan

According to Ohio Admin. Code §§ 5160-12-01(E)(3), 5160-46-04(B)(5)(d), 5160-50-04(B)(5)(d) and 5123:2-9-56(D)(2), when a recipient is enrolled in home and community based waiver the home health services must be identified on the all services plan. In addition, providers of waiver services must render services in accordance with the recipients all services plan or individual service plan. *See* Ohio Admin. Code §§ 5160-45-10 and 5123:29-56(D)

We determined if the all services plans authorized both Horizon and personal care services. For services requiring a plan of care, we determined if plans of care were present, authorized both Horizon and the specific service and were signed by the physician prior to Horizon submitting a claim for payment.

Exception Test – Shared Recipients with Xcel

We examined the 313 nursing and home health aide services and found 130 services that were submitted for reimbursement prior to the date the physician signed the plan of care and three services in which there was no plan of care to cover the date of service.

We examined the 131 personal care aide services and found seven services in which Horizon was not identified on the all services plan.

These 140 errors are included in the improper payment of $14,279.86.

Exception Test – Shared Recipients with Imani

We examined the 284 nursing and home health aide services and found 122 services (43 percent) in which there was no plan of care to cover the date of service and 1 service that was submitted for reimbursement prior to the date the physician signed the plan of care.

We examined the 109 personal care aide services and found 103 services (94 percent) in which Horizon was not identified on the all services plan.

These 226 errors are included in the improper payment of $10,474.88.

Exception Test – Shared Recipients with Generations

We examined the 144 nursing and home health aide services and found 13 services in which there was no plan of care to cover the date of service. We examined the 15 personal care aide services and found Horizon was not identified on the all services plan for any of these 15 services. These 28 errors are included in the improper payment of $1,584.26.

C. Authorization to Provide Services (Continued)

Nursing Sample

We examined 548 services and found 157 services that were submitted for reimbursement prior to the date the physician signed the plan of care. These 157 errors are included in the projected improper payment of $841,104.

We also noted that the plans of care for services billed as private duty nursing authorized skilled nursing but not specifically private duty nursing. The reimbursement rates for home health nursing and private duty nursing are the same therefore no improper payment was identified for this issue. Ohio Admin. Code § 5160-12-02(A) states a private duty nursing visit is defined as a medically necessary visit that is more than four hours but less than or equal to twelve hours in length while Ohio Admin. Code § 5160-12-01(C) states home health nursing visits are not more than four hours. We determined that generally the plans of care for private duty nursing services authorized visits of more than four hours. We noted some services billed as private duty nursing were less than four hours in length and the plans of care generally authorized visits of not more than four hours.

Home Health Aide Sample

We examined 497 services and found the following errors:

- 116 services that were submitted for reimbursement prior to the date the physician signed the plan of care;
- 33 services in which there was no plan of care to cover the date of service;
- 4 services in which the plan of care did not include the frequency and duration; and
- 1 service in which the plan of care was not signed by physician.

These 154 errors are included in the projected improper payment of $1,184,257.

Personal Care Aide Sample

We did not examine authorization to provide services in this sample.

Recommendation:

Horizon should establish a system to ensure the signed plans of care are obtained prior to submitting claim for services to the ODM. Horizon should also ensure the plans of care specifically authorize private duty nursing when appropriate. In addition, prior to rendering waiver services, Horizon should ensure it is identified on the all services plan. Horizon should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Official Response

Horizon submitted an official response to the results of this examination which is presented in **Appendix IV**. Horizon disputes the identified results and indicates that some of the errors are attributable to another agency. We did not examine the Provider's response and, accordingly, we express no opinion on it.

Auditor of State Conclusion

This examination included only services paid to Horizon and the improper payments identified are based solely on Horizon's documentation. We sent Horizon a detailed explanation of all non-compliance identified in the examination and it had that information prior to the date of the official response. All additional documentation submitted by Horizon was reviewed by the Auditor of State's office and incorporated into the final results. During the examination, auditors did observe a records room and determined that records in the file cabinets were not relevant to the examination period.

APPENDIX I

Summary of Nursing Services Sample

POPULATION
The population is all paid Medicaid home health nursing services (procedure code G0154) and private duty nursing services (procedure code T1000), less certain excluded services, net of any adjustments with dates of service during the examination period.

SAMPLING FRAME
The sampling frame was paid and processed claims from Medicaid Information Technology System (MITS).

SAMPLE UNIT
The sampling unit was an RDOS.

SAMPLE DESIGN
We used a stratified random sample.

Description	Results
Number of Population RDOS Provided	26,992
Number of Population RDOS Sampled	411
Number of Population RDOS Sampled with Errors	164
Number of Population Services Provided	33,095
Number of Population Services Sampled	548
Number of Population Services Sampled with Errors	217
Total Medicaid Amount Paid for Population	$2,624,168.21
Amount Paid for Population Services Sampled	$63,723.94
Estimated Overpayment (Point Estimate)	$944,860
Precision of Overpayment Estimate at 95% Confidence Level	$123,633 (13.08%)
Precision of Overpayment Estimate at 90% Confidence Level	$103,756 (10.98%)
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (calculated by subtracting the 90 percent overpayment precision from the point estimate) (equivalent to the estimate used for Medicare audits)	$841,104

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

APPENDIX II

Summary of Home Health Aide Sample

POPULATION
The population is all paid Medicaid home health aide services (procedure code G0156), less certain excluded services, net of any adjustments with dates of service during the examination period.

SAMPLING FRAME
The sampling frame was paid and processed claims from Medicaid Information Technology System (MITS).

SAMPLE UNIT
The sampling unit was an RDOS.

SAMPLE DESIGN
We used a stratified random sample.

Description	Results
Number of Population RDOS Provided	104,398
Number of Population RDOS Sampled	454
Number of Population RDOS Sampled with Errors	187
Number of Population Services Provided	106,154
Number of Population Services Sampled	497
Number of Population Services Sampled with Errors	198
Total Medicaid Amount Paid for Population	$4,214,959.45
Amount Paid for Population Services Sampled	$20,614.03
Projected Population Overpayment Amount	$1,302,194
Precision of Overpayment Estimate at 95% Confidence Level	$140,531 (10.79%)
Precision of Overpayment Estimate at 90% Confidence Level	$117,938 (9.06%)
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (calculated by subtracting the 90% overpayment precision from the point estimate) (equivalent to the estimate used for Medicare Audits)	$1,184,257

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

APPENDIX III

Summary of Personal Care Aide Sample

POPULATION
The population is all paid non-exception Medicaid personal care aide services (procedure code T1019), less certain excluded services, net of any adjustments with dates of service during the examination period.

SAMPLING FRAME
The sampling frame was paid and processed claims from Medicaid Information Technology System (MITS).

SAMPLE UNIT
The sampling unit was an RDOS.

SAMPLE DESIGN
We used a stratified random sample.

Description	Results
Number of Population RDOS	60,410
Number of Population RDOS Sampled	433
Number of Population RDOS Sampled with Errors	155
Number of Population Services Provided	80,271
Number of Population Services Sampled	613
Number of Population Services Sampled with Errors	205
Total Medicaid Amount Paid for Population	$5,622,168.73
Amount Paid for Population Services Sampled	$45,932.61
Estimated Overpayment (Point Estimate)	$1,838,732
Precision of Overpayment Estimate at 95% Confidence Level	$248,574 (13.52%)
Precision of Overpayment Estimate at 90% Confidence Level	$208,610 (11.35%)
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (calculated by subtracting the 90 percent overpayment precision from the point estimate) (equivalent to the estimate used for Medicare audits)	$1,630,122

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

Legal Counsel.

DINSMORE & SHOHL LLP
191 West Nationwide Boulevard ^ Suite 300
Columbus, OH 43215
www.dinsmore.com

Sydney N. Pahren
(614) 628-6971 (direct) ^ (614) 628-6890 (fax)
sydney.pahren@dinsmore.com

January 31, 2019

VIA EMAIL & U.S. MAIL (crcouts@ohioauditor.gov)

Cherie Couts
Senior Audit Manager
Medicaid/Contract Audit Section
Ohio State Auditor
88 East Broad Street
Columbus, Ohio 43215

Re: Horizon Health Services, LLC; Medicaid Provider No. 2533726
Response to Draft Compliance Examination Report

Dear Senior Audit Manager Couts,

This law firm represents Horizon Health Services, LLC ("Horizon"), a home health care agency located at 13001 Cedar Road, Cleveland Heights, Ohio 44118. On January 3, [2019], Horizon received a letter from you stating that you completed your examination of selected services rendered by Horizon during the period July 1, 2013 to June 30, 2016. The letter alleges instances of noncompliance and states that Horizon could submit an official response to the draft examination report. This letter serves as the official response on behalf of Horizon.

Horizon believes that many of the allegations are incorrect and will provide documentation enclosed with this letter showing that fact. However, many of the allegations are unclear and not specific enough for Horizon to provide the necessary documentation to refute the allegations. As such, Horizon is respectfully requesting an additional draft audit report that gives more detailed information and outlines the specific allegations and lists each employee, services, and alleged non-compliance so Horizon can properly defend itself. Once Horizon has received more information, they will provide additional documentation regarding those allegations. In addition, Horizon is requesting the opportunity to meet with you and your colleagues to discuss the draft examination report.

First, page 1 of the draft examination report provides that there was no documentation to support the Medicaid payments to Horizon for 582 of the 2,654 selected services and no required authorization for 255 out of 1,932 selected services. Thus, you allege you were unable to sufficiently rely on the documentation to determine Horizon's compliance. Horizon staff provided all documentation that was requested. Any documentation that was "missing", if requested by the auditors, was located during the audit and provided to the auditors. Horizon

utilizes electronic records and many documents were available in the eChart system, which was available to the auditor. Horizon states that much of the time spent by the auditors initially seemed to be used to scan the contents of consumer charts and employee first aid certificates. After the scanned data was reviewed off-site, missing documents were identified by the auditors and noted in the report. Horizon staff had no opportunity to locate and produce many of the documents noted as missing.

Next, page 4 of the draft examination report provides that there were links between Horizon and three other home health agencies: Xcel Healthcare Providers, Inc. ("Xcel"); Imani Home Health Care, LLC ("Imani"); and Generations Health Services, LLC ("Generations"). We do not represent those other agencies for purposes of this audit and do not know why they are mentioned in the examination report. There is no common ownership between Horizon and those other agencies. Our client finds it difficult to differentiate what allegations pertain to Horizon and what allegations pertain to the other agencies mentioned. Four agencies are being tied together into one report and it has caused our client much confusion, making it impossible to properly respond to the report. We respectfully request another audit report that only focuses on the compliance of Horizon.

Again, on page 6 of the draft examination report, the auditors claim that Horizon did provide all of the requested documentation but referenced additional records being kept at another location. Horizon representatives provided all consumer charts that were requested by the initial review scope letter and any charts or documentation requested during the onsite review. Jacqueline Tate, Director of Home Health Services, allowed the reviewers to inspect the storage area where records were kept but the auditors did not inspect the contents of any of the file cabinets or charts stored there, nor was a request made to do so or to return. Photographs of the storage area are enclosed.

Page 6 of the draft examination report provides that 444 services were examined associated with 4 recipients that also received services from Xcel. The report claims that Horizon lacked supporting documentation for 44 of these Medicaid payments. The report claims that the paid services for those recipients show that one agency provided nursing and the other aide services but both agencies billed for nursing assessment, indicating a possible over utilization of services. That allegation does not specify which agency billed for which services. Again, the report lumps different agencies together that have nothing to do with one another. Xcel has no common ownership with Horizon. Moreover, patients may access services from multiple agencies at one time. Horizon would not be privy to the services provided by Xcel, or any other provider. Horizon is only responsible for their billing; not other providers. All providers are entitled to bill for nursing assessments and there is no provision prohibiting another provider from also billing for their assessment.

Page 6 of the draft examination report also claims that there were 393 services associated with 22 recipients that also received services from Imani. The report claims that Horizon lacked supporting documentation for 230 of the Medicaid payments. The report provides that these agencies billed the same code on the same date of service but often one or the other agency lacked documentation to support the Medicaid payment. Again, the report fails to acknowledge

which agency lacked the documentation. The phrase "one or the other agency lacked documentation" is unclear and makes it difficult for Horizon to properly respond to these allegations.

As for the double billing attempts, it was well known within the industry that the MITS billing systems caused double billing. For example, (1) Biller signs in for Agency 1, conducts billing; (2) Biller signs out of Agency 1, signs in using the credentials of Agency 2; and (3) Biller does not notice that despite using new credentials, Agency 1 was not closed by MITS for new claims processing and payment.

Horizon was not aware of the possibility of incorrect payments until it received the draft report. Horizon used the following system to eliminate the possibility of incorrect payments: (1) Incoming remittance data is processed by a separate person for best practices; (2) This second staff member signs in and confirms payment through the MITS website by searching payments on a consumer-by-consumer basis, NOT by accessing the remittance advices; (3) However, by using this process, payments made for consumers not on Horizon's census were not uncovered; and (4) Claims for which payment appeared not to have been received by Horizon, (possibly because the services were billed by and paid to another agency), were not found as paid, and then noted as skipped by Horizon remittance staff and slated to be "re" billed because no payment had been received as expected. In this way, Horizon did not realize that any claim was billed by both agencies unless they received notification. Once the MITS website glitch was realized, the practice of verifying payments consumer-by-consumer was discontinued, and the use of the remittance advices has been instituted to reveal any aberrant payment or non-agency consumer. If noted, the claim would have immediately been reversed or voided, and the payment returned.

Then, page 7 of the draft examination report provides that 159 services were examined with 7 recipients that also received services from Generations. The claim again states that there was no documentation and that both agencies billed on the same dates of services. Yet again, the allegation is unclear. It states that "one of the agencies that billed had no supporting documentation" but does not specify which agency. The only agency that should be at issue here is Horizon. Additionally, the allegations states that for one recipient one agency billed nursing and the other billed aide services on the exact same dates of service. Two agencies providing services to a single recipient on the same date is not unusual. In fact, if one was providing nursing and the other aide services, as suggested in the report, it would make sense that those agencies billed for those respective services on the same date.

The allegations on page 7 of the examination report include nursing sample, home health aide sample, and personal care sample. The report claims that there were several errors and overpayments but fails to specifically identify Horizon and the details of the allegations. Horizon cannot properly respond to these allegations because they are vague and not detailed. There is no mention of Horizon or a specific other agency and there is no mention of the details of the errors.

The allegations relating to provider qualifications claim that 21 aides lacked the required first aide certification and that 116 aides had a lapse in the certification for a span of time. Several missing certifications were present in the employee files and have been located by

Horizon staff. Although there are lapses in many of the certifications, in most cases that employee was no longer a Horizon employee at the time of the lapse. In other cases, during the lapse period the employee was not providing services.

The exception test allegations on page 8 of the draft examination report seem to relate to shared recipients with Xcel and Generations. The report claims that there was an aide who rendered services without the proper first aid certification for the exception tests for both Xcel and Generation. Horizon does not know if that aide is a Horizon aide or the personnel of one of the other agencies. Horizon is not responsible for Xcel or Generation employees and their alleged lack of certification.

Additionally, Horizon is diligent about ensuring that all direct care employees have the required training and certification. Horizon maintains that all of the files reviewed contained the required information and certification. In fact, Horizon employs 2 full time employees whose sole job description is to ensure that all employees are compliant with their training and certifications.

On page 9 of the draft examination report, there are exception tests with Xcel, Imani, and Generations. Horizon does not know why these other agencies are included throughout this report as there is no common ownership between those agencies. Further, the claim that there is no documentation to support the Medicaid payment does not specify which agency allegedly did not have documentation. Horizon is not responsible for any improper payments to those other agencies.

The allegations on page 10 of the draft examination report involving the nursing sample, home health aide sample, and personal care aide sample mention several alleged billing and documentation errors. Horizon is unsure whether this includes Imani, Xcel, and Generations errors since those agencies have been incorrectly tied together throughout the report. Any alleged "missing" documentation from Horizon was likely in the eChart or may have been missed by the reviewers due to the sheer volume of the charts reviewed. Horizon employs 3 full time employees whose only task is to review and record documentation and ensure that each visit billed has the requisite visit documentation. As such, Horizon is confident that they had the necessary documentation.

Further, the allegations on page 11 pertaining to the shared recipient's exception tests with Xcel, Imani, and Generations relates to reimbursement and plan of care issues. Once more, Horizon does not know whether these allegations pertain to Horizon or to the other agencies mentioned. The All Services Plan (ASP) identifies any Ohio providers that are working with the patient. It does not imply that providers are connected in any way. Horizon is unsure why a connection is being drawn between Xcel, Imani, and Generations. The fact that the other agencies may have reimbursement or plan of care issues has no bearing on Horizon's performance or compliance.

Finally, the allegation on page 12 of the draft examination report provides that 153 of the 548 services examined in the nursing sample were submitted for reimbursement prior to the date

the physician signed the plan of care and for 24 services there was no plan of care. Moreover, in the home heath aide sample, the report claims that 107 services were submitted for reimbursement prior to the date the physician signed the plan of care; that 68 services did not have a plan of care; and that 4 services did not have the frequency and duration included in their plan of care. Horizon nursing staff is trained to call the attending physician and receive verbal orders to ensure that there is no lapse in physician authorizations. Please see enclosed redacted sample of a standard Horizon Plan of Care. Horizon believes that the reviewers missed the nurse-signed verbal authorization noted on each plan of care.

Horizon respectfully requests more detailed information regarding the claim and allegations brought against it in the examination report. There are several allegations in which it is unclear whether the reviewers are addressing concerns with Horizon or with the other 3 home health companies that are, for some unknown reason, included in the examination report. Horizon maintains that there is no common ownership between Horizon and Xcel, Imani, or Generations. Horizon is not sure why they are included in the examination report. Their inclusion only causes confusion about which claims are being attached to Horizon and makes it difficult for Horizon to fully respond to the allegations. Horizon maintains that all of the requested information was provided or available to the reviewers but that due to the sheer volume of documents some items may have been missed.

Some of the documentation refuting these claims is enclosed with this letter but Horizon will provide additional documentation once they know the details of each allegation. As such, Horizon respectfully requests another draft audit report that clearly outlines each allegation as it pertains to Horizon and requests a meeting to discuss the draft audit report and verify its findings.

Should you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

Sydney N. Pahren

SNP:cls

cc: Thomas W. Hess

14438497v1

OHIO AUDITOR OF STATE
KEITH FABER

HORIZON HEALTH SERVICES, LLC

CUYAHOGA COUNTY

CLERK'S CERTIFICATION

This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
MARCH 14, 2019

88 East Broad Street, Columbus, Ohio 43215
Phone: 614-466-4514 or 800-282-0370
www.ohioauditor.gov