Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Oklahoma Personal Care Services

Focused Program Integrity Review

Final Report

January 2019

Table of Contents

Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of the Oklahoma Medicaid personal care services (PCS). The objective of the review was to assess the level of program integrity oversight of Medicaid PCS at the state level. A secondary objective of the review was to provide the state with useful feedback, discussions and technical assistance resources that maybe used to advance the program integrity in the delivery of these services.

Background

Medicaid PCS (sometimes referred to as personal attendant or personal assistance services) includes a range of assistance services provided to beneficiaries with disabilities and chronic conditions of all ages. Provision of these services in the beneficiary's home is intended to serve as an alternative to institutionalization. Assistance may either be in the form of direct provision of a task by the personal care attendant (PCA) or cuing/prompting by the PCA so that the beneficiary may perform the task. Such assistance most often involves activities of daily living (ADLs) such as eating, drinking, bathing, dressing, grooming, toileting, transferring, and mobility. Services offered under Medicaid PCS are an optional benefit, except when they are medically necessary for children who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment benefit that provides comprehensive and preventive health care services.

Pursuant to the regulations found at 42 CFR 440.167 PCS is a Medicaid benefit furnished to eligible beneficiaries according to an approved Medicaid state plan, waiver, or section 1115 demonstration. States administer their Medicaid programs within broad federal rules and according to requirements of the specific authority approved by CMS. Services must be approved by a physician, or some other authority recognized by the state. Personal care beneficiaries cannot be inpatients or residents of a hospital, nursing facility, intermediate care facility for the developmentally disabled or institution for mental disease. Services can only be rendered by qualified individuals, as designated by each state.

Methodology of the Review

In advance of the onsite visit, CMS requested the state complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. In addition, questionnaires and review guide modules were sent to PCS providers and/or provider agencies in order to gain an understanding of their role in program integrity. A four person review team has reviewed these responses and materials in advance of the onsite visit.

During the week of September 11-13, 2018, the CMS review team visited the Oklahoma Health Care Authority (OHCA). They conducted interviews with numerous state staff involved in program integrity and administration of PCS. In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the state's program integrity practices with regard to PCS.

Results of the Review

The CMS review team identified an area of concern with the state's PCS program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that the identified issue is satisfactorily resolved as soon as possible. The issue and CMS's recommendation for improvement is described in detail in this report. In addition, CMS has included technical assistance resources for the state to consider utilizing in its provision of PCS.

Section 1: Personal Care Services

Overview of the State's PCS

The OHCA administers Medicaid PCS to eligible beneficiaries under the state plan, section (1905(a)(24) of the Social Security Act, and section 1915(c) Home and Community Based Services (HCBS) waiver authorities. The OHCA administers five HCBS waivers through an interagency agreement with the Oklahoma Department of Human Services (OKDHS). The HCBS waivers consist of the ADvantage waiver, the Homeward Bound waiver, the Community waiver, the In-Home Supports Waiver for Adults (IHSW-A) and the In-Home Supports Waiver for Children (IHSW-C), which are depicted below in Table 1. The provision of PCS in the beneficiaries' homes or community settings is intended to serve as an alternative for individuals who would otherwise require institutional care. All PCS are prior authorized and operate under a fee-for-service delivery model.

Summary Information of the PCS State Plan Services and/or Waivers Reviewed

Table 1.

Program Name/ Year Implemented	State Plan or Waiver Type	Service or Program	Administered By
State Plan PCS Implemented approximately July 1, 1987	1905(a)(24) State Plan	State Plan PCS	OHCA
Medically Fragile Implemented July 1, 2010 **My Life My Choice (ML; MC)** – Implemented October 1, 2010, but this waiver program terminated December 1, 2015. **Sooner Seniors (SS**) – Implemented March 1, 2011; however, this waiver program terminated December 1, 2015. **Living Choice** – The Money Follows the Person demonstration grant, also known as *The Living Choice Project* was implemented January 1, 2007.	Section 1915(c) waiver	Medically Fragile waiver Living Choice Demonstration waiver	OHCA
HCBS waivers: **ADvantage waiver** Implemented in July 1, 1993 **DDS waivers –** **Homeward Bound waiver –** Implemented in July 1, 1987 **Community waiver –** Implemented in July 1, 1988 **In-Home Supports waiver** for Adults **(IHSW-A)** **In-Home Supports waiver** for children **(IHSW-C)** Implemented in July 1, 1999	Section 1915(c)	ADvantage waiver Homeward Bound waiver Community waiver IHSW-A IHSW-C	OKDHS
Participant-Directed Option **Medically Fragile** Implemented July 1, 2010 ***Living Choice*** **ADvantage waiver** **DDS waivers** - (Homeward Bound, Community, IHSW-A, & IHSW-C)	Section 1915(c)waiver	Medically Fragile waiver Living Choice Demonstration waiver	OHCA OKDHS

Oklahoma's State Medicaid Agency (SMA) currently administers PCS through its state plan authority under section 1905(a)(24) of the Social Security Act and operates under a fee-for-service delivery model. The state plan PCS are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental disease that are: 1) authorized for an individual by a physician in accordance with a plan of treatment or otherwise authorized for the individual in accordance with an individualized education plan; 2) provided by registered paraprofessionals who have completed training provided by the State Department of Education or personal care assistants, including licensed practical nurses who have completed on the job training specific to their duties and who is not a member of the individual's family (or legally responsible relative). Provision of these services allows clients with disabilities to function safely in their activities of daily living in the home and to safely attend school. Services include, but are not limited to: dressing, eating, bathing, assistance with transferring and toileting, positioning and instrumental activities of daily living such as preparing meals and managing medications. The PCS also includes assistance while riding a school bus to handle medical or physical emergencies. Services must be prior authorized.

A brief description of each of the HCBS waiver programs is provided as follows:

Medically Fragile

The Medically Fragile waiver is for Medicaid beneficiaries who have been diagnosed with a medically fragile condition who require a Hospital/Skilled Nursing Facility (H/SNF) level of care (LOC) and whose needs could not otherwise be met through another Oklahoma waiver. A medically fragile condition is defined as a chronic physical condition, which results in prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following:

(1) There is a life threatening condition characterized by reasonably frequent periods of acute exacerbation which requires frequent medical supervision, and/or physician consultation and which in the absence of such supervision or consultation would require hospitalization.

(2) The individual requires frequent time consuming administration of specialized treatments which are medically necessary.

(3) The individual is dependent on medical technology such that without the technology a reasonable level of health could not be maintained. Examples include but are not limited to dependence on ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen.

The goal of this program is to provide services which allow Medicaid beneficiaries who need H/SNF LOC to remain at home or in the residential setting of their choosing while receiving the necessary care. The Medically Fragile waiver program is a HCBS alternative to placement in an H/SNF to receive Medicaid-funded assistance for care. This waiver also incorporates self-direction opportunities for a specified group of services such as advanced supportive restorative assistance, personal care and respite care as a service delivery mechanism.

My Life; My Choice (ML; MC) and Sooner Seniors (SS)
Termination of the waivers (Dec 2015):

The OHCA administers and operates two nursing facility LOC 1915(c) HCBS waivers; ML; MC and SS. In developing these waivers, the OHCA utilized the ADvantage waiver operated by the OKDHS as a model to structure the ML; MC and SS waivers. All three waivers shared the same LOC eligibility criteria and predominately the same providers and services.

The ML; MC and SS waivers were terminated in December of 2015. The termination of the OHCA operated waivers and absorption of beneficiaries into the ADvantage waiver resulted in numerous efficiencies, for example the change reduced the redundant administrative activities related to provider enrollment, monitoring, records management, reporting, financial tracking, and other functions. In addition, streamlining simplified member choice and allowed for easier access to waiver services. Beneficiaries have the same access to services in the amount, scope and duration that they had prior to transition. Services currently provided as a part of the ML; MC and SS waivers are also being provided in the ADvantage waiver.

Living Choice – (Money Follows the Person Demonstration Grant)

The Living Choice waiver promotes community-based services instead of institutional services. This waiver authorizes the OHCA to facilitate the transition of 826 individuals (19 years or older with disabilities or long-term illnesses) from institutional settings to their own homes in the community under the Money Follows the Person Rebalancing Demonstration. Staff from the OHCA have partnered with staff from each of the following organizations to facilitate these transitions and to rebalance Oklahoma's long-term care system:

- Oklahoma Department of Human Services – Aging Services Division (ASD)
- Oklahoma Department of Human Services – Developmental Disabilities Services (DDS)
- Ability Resources
- Oklahomans for Independent Living
- University of Oklahoma College of Nursing
- And other partners as well.

The OHCA HCBS waiver operated by OKDHS Aging Division are as follows:

ADvantage Waiver Program

The ADvantage waiver program permits Oklahoma to furnish an array of HCBS that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The SMA has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The SMA delegated administration for ADvantage waiver to the OKDHS, who contracted with the Long Term Care Authority of Tulsa for program administration. Program administration continued under this arrangement until October 2008, when direct administration for the ADvantage waiver program was assumed by OKDHS.

Managed by the ASD, the goal of this program is to provide services which allow Medicaid eligible persons who need nursing facility LOC to remain at home or in the residential setting of their choosing while receiving the necessary care. The ADvantage waiver program is a home and community-based alternative to placement in a nursing facility to receive Medicaid-funded assistance for care. The program uses agency and individual self-direction methods of service delivery. The ADvantage waiver incorporates self-direction opportunities as a service delivery mechanism statewide. The program is cost effective, in that Medicaid expenditures for services under the ADvantage waiver program must be less than the Medicaid-funded institutional services would have been had the individuals been served in a nursing facility.

The services provided by the ADvantage waiver program includes:

- Case Management Services
- Personal Care
- Respite Care
- Adult Day Health Care with Personal Care and Therapy Enhancements
- Environmental Modifications
- Specialized Medical Equipment and Supplies
- Advanced Supportive/Restorative Assistance
- Nursing
- Prescription Drugs
- Home-Delivered Meals
- Therapy Services: Physical, Occupational, Speech & Language
- Hospice Care
- Personal Emergency Response System
- Institution Transition Services
- Consumer-Directed Personal Assistance Services and Supports
- Assisted Living Services
- Skilled Nursing

The DDS division of the OKDHS, through an interagency agreement with the OHCA, operates the following waivers:

The Homeward Bound Waiver

The Homeward Bound waiver is intended to better meet the HCBS needs of beneficiaries representing the Plaintiff Class in Homeward Bound et al v. The Hissom Memorial Center et al, United States District Court, Northern District of Oklahoma, Case No. 85-C-437-e. The purpose of the Homeward Bound waiver is to assist class beneficiaries to lead healthy, independent, and productive lives to the fullest extent possible; promote the full exercise of their rights as citizens of their community, state, and country; and promote the integrity and well-being of their families. Services are provided with the goal of promoting independence through the strengthening of the member's capacity for self-care and self- sufficiency.

The Homeward Bound waiver program is a service system centered on the needs and preferences of the class beneficiaries and supports the integration of participants within their communities.

The Homeward Bound waiver serves to provide residential and comprehensive supports for class beneficiaries. It provides services and payment for those services that are not otherwise covered through Oklahoma's Medicaid program (referred to as SoonerCare). Homeward Bound waiver services, when used in conjunction with non-waiver SoonerCare services, and other generic services and natural supports, provide for the health and developmental needs of persons who otherwise would not be able to live in a home and community-based setting. The waiver is operated on a statewide basis. Employees of OKDHS provide case management services. Case managers are located in offices throughout the state. Case managers assure that individual needs are assessed and identified and coordinate the personal support team for each individual class member.

The Community Waiver

The purpose of the Community waiver program is to assist beneficiaries to lead healthy, independent and productive lives to the fullest extent possible; promote the full exercise of their rights as citizens of their community, state, and country; and promote the integrity and well-being of their families. Services are provided with the goal of promoting independence through the strengthening of the member's capacity for self-care and self-sufficiency. The Community waiver is a service system centered on the needs and preferences of the member and supports the integration of beneficiaries within their communities. The Community waiver provides an ongoing opportunity for beneficiaries to transition from intermediate care facilities for individuals with intellectual disabilities and to provide residential, comprehensive supports for beneficiaries with complex needs.

The In-Home Supports Waiver for Adults (IHSW-A) and In-Home Supports Waiver for children (IHSW-C)

The IHSW-A and IHSW-C provides participants, or their representatives, the opportunity to exercise choice and control over services. Beneficiaries are afforded the decision-making authority to recruit, hire, train and supervise the individuals who furnish their services under self-directed care models. Beneficiaries may also have decision-making authority over how the Medicaid funds in their service budget are spent.

Medicaid and PCS Expenditure Information

Oklahoma's total Medicaid expenditures in federal fiscal year (FFY) 2017 were approximately $4.96 billion and covered approximately 783,143 beneficiaries. Oklahoma's total Medicaid expenditures for PCS in FFY 2017 were approximately $189 million, which are depicted below in Table 2. The unduplicated number of beneficiaries who received agency-directed and self-directed PCS in FFY 2017 was approximately 25,147. Total unduplicated beneficiaries represents the count of unique individuals receiving PCS during a specified time period. The number of PCS providers enrolled in FFY 2017 was approximately 1,299.

Table 2.

State Plan and 1915(c) Waiver Authority Service/Program	FFY 2015	FFY 2016	FFY 2017
State plan	$8.6 million	$9.8 million	$10.2 million
Medically Fragile waiver	$.8 million	$1.1 million	$1.1 million
Living Choice waiver	$.07 million	$.05 million	$.7 million
ADvantage waiver	$58.3 million	$74.7 million	$77.6 million
DDS waivers - (Homeward Bound and Community waivers, IHSW-A, & IHSW-C)	$78.9 million	$100.7 million	$99.6 million
Total Expenditures	**$146.7 million**	**$186.4 million**	**$189.2 million**

The overall PCS expenditure trend is slightly increasing for the Medicaid PCS program in Oklahoma. The upward trend appears standard across all state plan and waiver programs.

Table 3.

	FFY 2015	FFY 2016	FFY 2017
Total PCS Expenditures	$146.7 million	$186.4 million	$189.2 million
% Agency-Directed PCS Expenditures	94%	94%	94%
% Self-Directed PCS Expenditures	6%	6%	6%

The ratio between the percentage of agency-directed and self-directed expenditures remained constant at a 94 to 6 percent ratio over the review period. This reflects the PCS expenditures have remained consistent within Oklahoma's SMA and self-directed PCS programs.

Table 4-A.

1905(a)(24) State Plan and 1915(c) Waiver Authority Service/Program	FFY 2015	FFY 2016	FFY 2017
State plan	3,542	3,536	3,506
Medically Fragile waiver	46	49	48
Living Choice waiver	152	29	31
ADvantage waiver	16,610	17,524	17,510
DDS waivers - (Homeward Bound and Community waivers, IHSW-A, & IHSW-C)	5,771	5,928	5,943
Total Agency-directed Unduplicated Beneficiaries	22,582	23,529	23,488

*Unduplicated beneficiary count is the number of individuals receiving services, not units of service.

The amount of agency-directed unduplicated beneficiaries has remained relatively constant over the review period. This is an indication of stability within the Medicaid PCS program relative to its agency-directed beneficiary population.

Table 4-B.

1915(c) Waiver Authority Service/Program	FFY 2015	FFY 2016	FFY 2017
Medical Fragile	12	16	17
Living Choice	18	1	0
ADvantage	1,307	1,485	1,507
DDS waivers - (Homeward Bound, Community, IHSW-A, & IHSW-C)	130	132	135
Total Self-directed Unduplicated Beneficiaries	1,467	1,634	1,659

*Unduplicated beneficiary count is the number of individuals receiving services, not units of service.

The number of self-directed beneficiaries has seen some growth since the first year of the review period and balancing out across the last year from FFY 2016 to FFY 2017. This indicates that the self-directed beneficiary population may be leveling out and should begin to see more moderate increases to its beneficiary population.

State Oversight of PCS Program Integrity Activities and Expenditures

The OHCA delegates certain administrative functions for PCS to OKDHS through their interagency agreement. The community services division provides technical assistance to service beneficiaries, providers, and OKDHS. The OHCA program integrity unit also maintains a Surveillance Utilization Review Subsystem (SURS) section and conducts post-payment reviews of claims submitted by health care providers participating in Oklahoma's publicly funded health care programs, including PCS providers. The OHCA maintains an audit work plan that includes PCS providers and/or self-directed services, based upon the risk assessment of the provider.

Table 5.

Agency-Directed and Self-Directed Combined	FFY 2015	FFY 2016	FFY 2017
Identified Overpayments*	$0.00	$15,439.16	$7,701.10
Recovered Overpayments*	$0.00	$15,360.76	$7,701.10
Terminated Providers	0	1	0
Suspected Fraud Referrals	0	6	11
# of Fraud Referrals Made to MFCU	0	4	10

*Overpayments identified and recovered in FFY 2015, FFY 2016, and FFY 2017 include fraud, waste, and abuse.

Table 5 shows the program integrity activities for the review period of FFYs 2015-2017. The number of fraud referrals (suspected and referred to the MFCU) has increased during the review period. The OHCA proactively recovers all overpayments identified primarily by offsetting future payments to providers until the overpayment is satisfied. The state does not have the level of fraud, waste, abuse in PCS that is typical of this service type in other states. The state does not terminate a high volume of providers and only had one termination for the review period.

Section 2: Self-Directed / Participant-Directed Care Services

Overview of Self-Directed Care Services

Oklahoma has the authority to operate a self-directed program for PCS and does so under the HCBS waivers: The Medically Fragile and Living Choice waivers operated by OHCA, as well as the waivers delegated to OKDHS that consist of the ADvantage waiver and the DDS waivers - (HBW, CW, IHSW-A, & IHSW-C), which are depicted in Table 1.

For the Medically Fragile waiver and Living Choice waiver, PCS are monitored by the Quality Assurance and Community Living Services (QA/CLS) operations unit. For all waivers operated by the sister agency OKDHS, monitoring is conducted through those agencies and the SMA provides oversight.

For the ADvantage waiver at the member level, the consumer direction model recognizes the service recipient as the "employer of record." As such, the service recipient is responsible for direct supervision of the personal services provider. The SMA provides oversight as through: the provision of case management services, including routine member monitoring to ensure the health and welfare needs of the member can be met through waiver services; completing background checks according to waiver requirements; and addressing issues of abuse, neglect and exploitation.

For the DDS waivers, agencies do not provide or arrange services for self-directed PCS. The OKDHS/DDS serves as a Financial Management Service (FMS) in a Government Fiscal Employer Agent (FEA) model and also operates as an Organized Health Care Delivery System (OHCDS) using a subagent. The OKDHS/DDS reviews reports, invoices or other valid indications of performance to assure all contract terms and conditions of contract with the subagent are met. The subagent is required to be bonded and/or have sufficient liability insurance to protect beneficiaries and the SMA against loss of funds, fraud or mismanagement. The subagent is required to provide an annual audit as well as monthly reports. Entities responsible for monitoring of the subagent are OKDHS/DDS, Oklahoma Department of Central

Services and OHCA. The OHCA randomly reviews plans of care through several authorities within the SMA, such as Program Integrity and Accountability, Quality Assurance/Improvement and Claims/Coding and Integrity units. Subagent performance is assessed monthly and more frequently upon request.

For the IHSW-A and IHSW-C, the regulation at 42 CFR 441.450 provides participants, or their representatives, the opportunity to exercise choice and control over services. Beneficiaries are afforded the decision-making authority to recruit, hire, train and supervise the individuals who furnish their services under self-directed care models. Beneficiaries may also have decision-making authority over how the Medicaid funds in their service budget are spent.

State Oversight of Self-Directed Services

Monitoring OHCA's self-directed PCS (Medically Fragile and Living Choice waiver) is the responsibility of the QA/CLS unit. On a monthly basis the spending reports and other administrative activity reports submitted by the FMS are reviewed to ensure contractual compliance with program qualifications to include, utilization reports, background checks, providers enrolled, and payroll's processed.

For all waivers operated by the sister agency DHS, monitoring is conducted through those agencies and the SMA provides oversight.

For the ADvantage waiver, the FMS provider is required to deliver reporting and access to their software systems that allows the SMA to review and ensure PCS payments. Monitoring is routine, and could be performed as often as daily. A contract monitor is assigned to oversee the functions of the FMS and ensure adherence to programmatic requirements and performance monitoring. The contract monitor for the FMS is the Consumer Directed Personal Services and Supports Program Manager.

For the DDS waivers, the Quality Assurance Unit performs audits of self-directed PCS if they are part of the random survey and area surveys are completed quarterly. Per the FMS contract with OHCA, member spending reports are due to the QA/CLS unit coordinator by the 15th of each month. The QA/CLS staff reviews each report to ensure utilization is within the approved limits as outlined in the member's individual service plan. The information from the spending report is compared with the prior authorization details in the MMIS to ensure there are no discrepancies found. During this review process any discrepancies are communicated with the FMS for verification and or correction. Over utilization is also discussed with the member case manager and adjustments made to ensure that the remaining budget is sufficient to complete the plan year. In the event the member has a change in condition the case manager will work with the member to request an approval for additional units.

Data mining is completed through review of monthly reports in regard to service utilization in comparison with service authorization. Analytics are conducted at the attendant level. The OHCA's contracted entity sent out a total of 75 EOMBs (69 personal care and six advanced restorative) in the last three federal fiscal years. In this time, the OHCA has received no complaints or concerns of paid services not being rendered. For these beneficiaries, the

responsibility lies with the beneficiary, as they are accountable for receiving their services and validating those services prior to payment being made for their selected personal care assistant.

Section 3: PCS Provider Enrollment

Overview of PCS Provider Enrollment

Identifying and recovering overpayments may be resource intensive and take considerable time. Preventing ineligible entities and individuals from initially enrolling as providers allows the program to avoid the necessity to identify and recover overpayments. Provider screening enables states to identify such parties before they are able to enroll and begin billing.

Oklahoma Medicaid providers are screened according to their level of risk. The Oklahoma enrollment process complies with 42 CFR Part 455 Subparts B and E. The enrollment process complies with all state and federal database exclusion check requirements. The applicable federal database checks are completed for new-enrollment, re-enrollment, and revalidation applications as well as for existing-enrollment on a monthly basis.

ADvantage PCS agencies must have an OSDH license for each branch office in which they conduct business. The PCS agencies are required to have provided PC services for a minimum of two years before they are eligible to be certified as a service provider. All compliance must be documented and OHCA verifies these requirements on an annual basis. Agencies must be enrolled as an ADvantage provider before they can be a provider for the other waiver services provided by OHCA. The SMA does not require individual PCS providers to be licensed.

State Oversight of PCS Provider Enrollment

As required by 42 CFR 455.450, the SMA has implemented the screening level provisions, including fingerprinting, based on the assigned level of risk for directly enrolled PCS providers. The SMA conducts complete database searches for individuals and entities participating in Medicaid. The SMA checks the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the Social Security Administration Death Master File, the National Plan and the Provider Enumeration System upon enrollment and reenrollment and the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE) and the Excluded Parties List System on the System for Award Management (SAM) monthly after enrollment/reenrollment as required at 42 CFR 455.436).

Annual audits are conducted on each PCS provider agency to ensure compliance with state and federal laws and regulations, contractual documents, etc. The provider, using the aide's social security number, also checks the Community Service Worker Registry, prior to hiring the aide. The OKDHS/DDS operates the Community Service Worker Registry and sends notification to associated providers, should the aide be added to the registry at any time.

Section 4: Personal Care Service Providers

Overview of the State's Personal Care Service Providers

Providers of PCS deliver the services to Medicaid eligible beneficiaries in their own home or communities who would otherwise require care in a medical institution. These non-medical services assist beneficiaries with ADLs, relative to beneficiaries who have limited ability to care for themselves because of physical, developmental, or intellectual disabilities or conditions.

Oversight of PCS Providers

Healthcare Innovations Private Services

Healthcare Innovations Private Services (HCIPS) is the largest provider of Medicaid home healthcare services and case management in the state of Oklahoma. The organization provides PCS to eligible participants of Oklahoma's ADvantage Program and state Medicaid Program and has been providing services since 1999. The HCIPS has personal care branches covering all 77 counties in the state of Oklahoma. In 2013, HCIPS was acquired by Jordan Health Services and provides home health services to patients throughout the state of Missouri, Oklahoma, and Texas. During FFY 2017, HCIPS provided PCS to approximately 10,972 participants, and employed approximately 417 PCA staff, including approximately 28 field supervisors/staff schedulers and eight Administrators.

The HCIPS compliance department is managed by the Chief Compliance Officer and the compliance committee, who consists of at least one designee from the Human Resources, IT, Billing, Accounting, Legal, Operations (one from each business line), and Marketing departments. The compliance committee advises the Chief Compliance Officer and, at a minimum, reviews the compliance program for enhancements and prepares reports for the Board. The compliance committee also monitors internal and external audits and investigations to identify deficiencies and implement appropriate corrective actions.

To ensure that PCAs are managing time and tasks efficiently, HCIPS employs field supervisors who conduct daily and weekly service calls and onsite visits to monitor services being delivered by the attendant. On an annual basis an in home evaluation is also completed.

As a condition of employment, all employees are required to complete orientation, within 14 days of hire. In addition to orientation, employees, regardless of title or position, receive code of conduct as well as compliance program training. Annually, employees are required to complete continued education and in-service training for such topics such as compliance with Medicare and Medicaid requirements, documentation, kickbacks, clients/patients' rights, and the duty to report misconduct. During orientation, the attendant must pass an in home assessment where the nurse will provide training on each task that must be completed while in the home. Copies for all training, regardless of format, are maintained in the personnel file. The department administrator attests to training for all employees within each area annually.

All employees and independent contractors are verified prior to hire and monthly thereafter for participation and exclusion status. Providers are screened initially and then annually during re-credentialing. In addition to checking the HHS-OIG LEIE as well as the SAM databases, the SMA also reviews the Community Service Worker Registry, The National Sex Offender

Registry, Nurse Aid Registry, Sex offender Registry, Violent Registry and the Social Security Number Verification system.

The HCIPS currently utilizes the state's EVV system, Authenticare, which tracks PCS and timesheets through claims processing. While Authenticare does not verify that timesheets or service logs have been signed off on by the beneficiary, the system does have a mechanism for randomly selecting beneficiary records to audit. When selected, follow up calls are made to the beneficiary to verify that PCS were received, including shift start and shift end accuracy. In place since 2016, the Authenticare system requires PCAs to enter an assigned employee number directly from the beneficiary's phone. In instances where timesheets are utilized, they are reviewed for accuracy by the Field Supervisor for shift dates, times, tasks and to ensure the appropriate signatures have been obtained from the beneficiary and the PCA.

ResCare, Inc. (ResCare)

ResCare is a nationally based health and human services provider agency that services patients in 42 states. They are the largest diversified health and human services provider in the US, with over 45,000 employees providing homecare, residential, workforce, youth and pharmacy services. In FFY 2017, Medicaid PCS represented $1.26 million, or 54 percent, of the national agency's revenue; 79 percent of PCS provided in FFY 2017 were to Medicaid beneficiaries. ResCare provides Medicaid PCS in 22 states and has been a PCS provider in Oklahoma since 2007. The Oklahoma branch of the PCS agency, Oklahoma ResCare HomeCare Services (OKRHS), served 571 beneficiaries with 233 attendants during FFY 2017. The OKRHS provides PCS services to eligible beneficiaries under the state plan and HCBS waiver (ADvantage) authority through offices in Del City and Tulsa, Oklahoma.

ResCare, Inc. has a nationally based compliance program overseen by the Chief Compliance Officer. ResCare has a national compliance department that is primarily responsible for the daily operations of the compliance plan, including; employee compliance training, policy development, investigations and response to compliance and policy regulations. The compliance department is comprised of six FTEs; four residential compliance staff members, one workforce services compliance staff member and one clinician devoted to the home care line of business. ResCare's board of directors also provides oversight of compliance activities through the quality and compliance committee. This committee meets quarterly, approximately two weeks prior to the general board of directors meeting, to discuss relevant compliance and program integrity issues that should be addressed. The ResCare compliance unit also reviews the results of audits conducted by the internal audit services and clinical quality departments to evaluate the effectiveness of internal controls and to identify potential risk areas.

ResCare compliance staff conducts on site audits of their local branches as part of their regular activities. These audits are performed every three years and as needed to address billing, human resources issues, Health Insurance Portability and Accountability Act of 1996 compliance and the reporting of pending investigations and critical incidents to the national level. ResCare provided the most recent assessment of OKRHS, which determined that there were critical areas that did not meet national ResCare standards and needed improvement. No formalized audit activities are performed at the local level. However, OKRHS office staff does conduct routine monitoring of processes and systems to ensure compliance with billing and documentation

requirements. This monitoring includes review of beneficiary charts, regular direct contact with beneficiaries and consistent tracking of document expirations as they pertain to state waiver plan documents, state homecare license documents, and ResCare required documents. Furthermore, the local staff performs daily and weekly comparisons of the ResCare point of care billing system to the Authenticare EVV system using reports from each system to verify the systems reconcile the total hours worked for a client during a set period of time.

ResCare requires that employees have obtained a minimum of a high school diploma or general education development or high school equivalency certificate; this document is included in their employee file. New attendants are also required to submit to a background check administered through a ResCare vendor, First Advantage, and to be queried in the Oklahoma screen system. The First Advantage search verifies social security number and checks the Fraud and Abuse Control Information System (level 2), which includes Federal exclusion information taken by the LEIE and SAM, as well as Motor Vehicle Records and the National Sex Offender database. In addition, PCS providers are checked against the Oklahoma Child Care Restricted Registry, Oklahoma Nurse Aide and Non-Technical Service Worker Abuse Registry, Oklahoma On-Demand Court Records, and the Arkansas Nurse Aide Registry. All employees are checked against the LEIE and SAM databases on a monthly basis by the ResCare corporate office.

ResCare has mandatory fraud, waste, and abuse trainings at the point of hire and annually thereafter. This training includes a review of the company code of conduct, the internal compliance structure, monitoring and auditing processes, disciplinary actions, and the incident and concern reporting process. ResCare performs on site nurse visits every six months and as needed to ensure that care is being delivered and documented appropriately. The PCA is present at the time of the visits so that care delivery can be properly evaluated. Case managers independent of ResCare are in contact with beneficiaries on a weekly basis and do on site visits monthly. ResCare is in direct, regular contact with both the beneficiary and the case manager.

ResCare utilizes the state mandated EVV system, Authenticare, to track PCA services and timesheets. Authenticare does not verify that timesheets or service logs have been signed off on by the beneficiary. However, the Authenticare system does randomly select clients for follow up calls to verify PCA attendance and clock in and clock out times are correct. This system has been in effect for two years prior to the review and requires attendants to enter an individualized employee number from a client phone.

Excel

Excel has been providing PCS in Oklahoma since 2009 as Excel Private Care Service. As of November 1, 2017, Excel was acquired by The Ensign Group, Incorporated and has continued to provide services. It should be noted that Excel is not a national plan and only provides service in Oklahoma. Excel has approximately 140-160 PCAs.

Excel has been unable to report the number of Medicaid beneficiaries and the amount of Medicaid overpayments identified and recovered in the last three FFYs due to the acquisition and system change.

The quality assurance and compliance committee adopted a charter outlining the responsibilities of management, including the Chief Compliance Officer, for maintaining ethical business standards. Responsibility for managing the compliance and ethics program is assigned to the Chief Compliance Officer. The Chief Compliance Officer reports on significant compliance efforts and identified compliance issues to the quality assurance and compliance committee.

Section 5: Electronic Visit Verification (EVV)

Overview of the State's Electronic Visit Verification (EVV) System

An EVV system is a telephonic and computer-based in-home scheduling, tracking, and billing system. Specifically, the EVV system documents the precise time and type of care provided by caregivers' right at the point of care. Some of the benefits of utilizing an EVV system include ensuring quality of care and monitoring costs expenditures.

Oklahoma currently uses an electronic visit verification (EVV) system in-home scheduling, tracking and billing system. All in-home service providers are required to use an EVV system for tracking and billing purposes. The Oklahoma EVV system is a state-wide system that has been in place since 2010 and is compliant with the 21st Century Cures Act. After piloting the system in 2009, the decision was made by program administration to implement the EVV system statewide. This system allowed the SMA to quickly initiate processes to reduce fraud/inappropriate billing and ensure the health and safety of those served by the program. The OHCA uses a single vendor system and all in-home service providers are required to check in/check out using a telephonic system that identifies the service delivery provided.

The EVV system supports scheduling of home care visits consistent with individual beneficiaries' service plans. This scheduling system generates alerts to inform when home care visits are not kept thereby informing on the health and welfare of program beneficiaries. According to the SMA, the EVV system works well and has provided them with proven results such as a significant decrease in expenditures for PCS. Reportable outcomes focus on: (1) Provider adherence to maintaining scheduled visits for program beneficiaries; and (2) Appropriateness of billing based on actual services provided.

Recommendations for Improvement

- The state should consider modifying its policies and procedures regarding the disposition of cases referred to the MFCU by the sister agency to ensure its program integrity unit maintains visibility and oversight of all cases referred to the MFCU by the sister agency. The OHCA should refer its sister agency to CMS' 2008 guidance on "Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units, in order to better manage the PCS cases of suspected fraud, waste, and abuse referred directed by the sister agency. Otherwise, OHCA might request the sister agency refer suspected fraud, waste, and abuse directly to OHCA and subsequently the OHCA would then be responsible for referring all cases of suspected fraud, waste, and abuse to the MFCU.

Section 6: Status of Corrective Action Plan

Oklahoma's last CMS program integrity review was in February 2011, and the report for this review was issued in August 2011. The report contained four findings and five vulnerabilities. During the onsite review in September 2018, the CMS review team conducted a thorough review of the corrective actions taken by Oklahoma to address all issues reported in calendar year 2011. The findings of this review are described below.

Findings -

1. ***The State does not capture all required ownership, control, and relationship information from FFS providers.***

   Status at time of the review: Corrected

   Oklahoma reported to the CMS review team that all provider enrollment disclosure forms were modified to capture all the required ownership, control, and disclosure information.

2. ***The State does not require all providers to submit business transaction information upon request from the NEMT broker and PACE provider.***

   Status at time of the review: Corrected

   Oklahoma reported to the CMS review team that they modified the contracts with the NEMT broker and the PACE provider to meet the requirements of 42 CFR § 455.105(b).

3. ***The State does not request health care-related criminal convictions from all required parties in the FFS, NEMT and PACE programs.***

   Status at time of the review: Corrected

   Oklahoma reported to the CMS review team that they modified the FFS paper and electronic provider enrollment forms and the State's contracts with the NEMT broker and PACE provider to meet the requirements of 42 CFR 455.106.

4. ***The State is not notifying all required parties when it initiates an exclusion of a FFS provider.***

Status at time of the review: Corrected

Oklahoma reported to the CMS review team that they developed and implemented policies and procedures to ensure that all parties identified by the regulation are notified of a State-initiated exclusion.

5. ***Not capturing managing employee information on FFS, NEMT, and PACE provider enrollment forms.***

   Status at time of the review: Corrected

   Oklahoma reported to the CMS review team that they developed and implemented policies to ensure that FFS, PACE, and NEMT subcontractor forms solicit and collect managing employee information during subcontracting and on all enrollment forms or in some manner on attachments to those forms. In addition, this information is captured in the application database for comparison during the enrollment process and routinely thereafter.

6. ***Not collecting all required ownership and control disclosures from NEMT subcontractors.***

   Status at time of the review: Corrected

   Oklahoma reported to the CMS review team that they modified and amended the NEMT contracts to require the collection of ownership, control, and relationship information from NEMT subcontractors.

7. ***Not requiring NEMT subcontractors to disclose business transaction information upon request.***

   Status at time of the review: Corrected

   Oklahoma reported to the CMS review team that they revised the contract with the NEMT broker and developed and implemented policies and procedures to ensure that NEMT subcontractors disclose business transaction information upon request to meet the requirements of 42 CFR § 455.105(b).

8. ***Not requiring the disclosure of health care-related criminal conviction information from NEMT subcontractors.***

   Status at time of the review: Corrected

   Oklahoma reported to the CMS review team that they developed and do enforce NEMT subcontractor contract provisions mandating the appropriate collection and reporting of required health care-related criminal conviction disclosures.

9. ***Not conducting complete searches for individuals and entities excluded from participating in Medicaid.***

Status at time of the review: Corrected

Oklahoma reported to the CMS review team that the state has developed policies and procedures to ensure for the collection and maintenance of disclosure information about disclosing entities, persons with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity.

Technical Assistance Resources

Technical Resources should be specific to areas identified during the onsite review as a finding, vulnerability, or risk. Choose any of the following. This list is not all inclusive.

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for OklahomaOklahoma to consider utilizing:

- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute, which can help, address the risk areas identified in this report. Courses that may be helpful to OklahomaOklahoma are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Review the document titled "Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services". This document can be accessed at the following link https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Visit and utilize the information found on the CMS' Medicaid Program Integrity Education site. More information can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html.
- Consult with other states that have PCS programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of staff in program integrity issues.

Conclusion

CMS supports Oklahoma efforts and encourages it to look for to additional opportunities to improve overall program integrity. The CMS focused review identified an area of concern which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the weaknesses will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the SMA is responsible for corrected the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already take action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

CMS looks forward to working with Oklahoma to build an effective and strengthened program integrity function.