Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Alabama Focused Program Integrity Review

Final Report

December 2021

Table of Contents

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Executive Summary

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, the Centers for Medicare & Medicaid Services (CMS) set forth its strategy to safeguard the integrity of the Medicaid program.[1] State Medicaid programs are required to have a fraud detection and investigation program and oversight strategy that meet minimal federal standards. To ensure states are meeting these requirements, CMS conducts focused program integrity reviews on high-risk areas, such as managed care, new statutory and regulatory provisions, nonemergency medical transportation, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. The value of performing focused program integrity reviews include: (1) providing states with effective tools/strategies to improve program integrity operations and performance; (2) providing the opportunity for technical assistance related to program integrity trends; (3) assisting CMS in determining/identifying future guidance that would be beneficial to states; and (4) assisting with identifying and sharing promising practices related to program integrity.

CMS conducted a focused review of Alabama's Medicaid Personal Care Services (PCS) benefit. The primary 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 feedback, discussions, and technical assistance resources that may be used to enhance program integrity in the delivery of these services.

Medicaid PCS (sometimes referred to as a personal attendant or personal assistance services) includes a range of assistance services, provided to beneficiaries of all ages with disabilities and chronic conditions. 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 a personal care attendant (PCA), or cueing/prompting by a PCA so that the beneficiary may perform the task. Such assistance most often involves activities of daily living (ADLs) including, but not limited to eating, drinking, bathing, dressing, grooming, toileting, transferring, and mobility assistance. Services offered under Medicaid PCS are an optional benefit, except when medically necessary for children who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment benefit (EPSDT), which provides comprehensive and preventive health care services.

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

In March 2021, CMS conducted a virtual focused review of the Alabama Medicaid Agency (AMA). CMS conducted interviews with numerous state staff involved in program integrity and the administration of PCS to validate the state's program integrity practices regarding PCS. Three sister agencies and five PCS agencies were also interviewed as part of the review. CMS also evaluated the status of Alabama's previous corrective action plan, which was developed by the state in response to a PCS focused review conducted by CMS in 2016.

During this review, CMS identified a total of 11 recommendations based upon the completed focused review modules, supporting documentation, and discussions and/or interviews with key stakeholders and providers of PCS services. CMS also included technical assistance resources for the state to consider utilizing for its oversight of PCS. The review and recommendations encompass the following eight areas:

1. State oversight of PCS program integrity activities and expenditures
2. Payment suspensions based on credible allegations of fraud
3. Federal database checks
4. Screening levels for Medicaid providers
5. State oversight of self-directed services
6. Agency-based PCS providers
7. Oversight of PCS agency providers
8. Electronic Visit Verification (EVV)

Overview of Alabama Medicaid PCS

The AMA has several Memoranda of Understanding (MOU) with the sister agencies to provide a broad range of home and community-based services, which include PCS. The sister agencies are solely responsible for enrolling and managing the provider networks that provide Medicaid services, such as PCS, except for the Technology Assisted Waiver 0407. The PCS providers enrolled and managed by the sister agencies are not enrolled with AMA, except for Waiver 0407. The Alabama Department of Senior Services contracts with the Area Agencies on Aging (AAA). There are thirteen (13) Area Agencies on Aging in the state. The AAA's provide a broad range

[2] ADSS, ADRS, and ADMH will be further referenced as, "sister agencies".

of services to the community, which include case management, plan of care development, initial assessment for services, re-assessment of services, managing prior authorization(s) for PCS, and quality management. Medicaid beneficiaries can obtain PCS through PCS agency waiver providers enrolled with the sister agencies or self-direct their own care through the Personal Choices Program.

Summary of Medicaid PCS Programs in Alabama

Alabama administers Medicaid PCS to eligible beneficiaries under the Section 1915(j) authority and Section 1915(c) Home and Community Based Services (HCBS) Waiver authority. 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. Table 1 below provides details of Alabama's programs.

Table 1. Alabama Medicaid PCS Programs

Program Name/Federal Authority	Administered By	Description of the Program
Personal Choices Program Section 1915(j)	ADSS, ADRS	The Personal Choices Program has been operational since 2007. The program serves all beneficiaries that receive PCS, and allows them the option to self-direct PCS at their discretion.
Technology Assist (TA) Waiver for Adults/Section 1915(c)	AMA	The TA Waiver has been operational since 2003. The TA Waiver serves adults with complex skilled medical conditions who are ventilator dependent or who have tracheostomies, and who receive private duty nursing and meet the nursing facility level of care. Private Duty Nursing providers render services that may include PCS. PCS providers enroll directly with AMA, and targeted case management is provided by ADSS.

Program Name/Federal Authority	Administered By	Description of the Program
Elderly and Disabled Waiver (E&D)/Section 1915(c)	ADSS	The E&D Waiver has been operational since 1982. The E&D Waiver is designed to provide services to allow elderly and/or disabled individuals who would otherwise require care in a nursing facility to live in the community.
Alabama Community Transition (ACT) Waiver/Section 1915(c)	ADSS	The ACT Waiver has been operational since 2011. The ACT Waiver provides services to individuals with disabilities or long-term illnesses who currently reside in an institution and desire to transition to a home or community-based setting.
State of Alabama Independent Living (SAIL) Waiver/Section 1915(c)	ADRS	The SAIL Waiver became operational in 1992. The SAIL Waiver serves individuals meeting the nursing facility level of care. Services are provided to individuals with the following or certain other diagnoses: Quadriplegia, Traumatic Brain Injury, Amyotrophic Lateral Sclerosis, Multiple Sclerosis, Muscular Dystrophy, Spinal Muscular atrophy, Severe Cerebral Palsy, Stroke, and other substantial neurological impairments, severely debilitating disease or rare genetic diseases.
Living at Home (LAH) Waiver/Section 1915(c)	ADMH	The LAH Waiver has been operational since 2002. The LAH Waiver provides services to adults and children 3 years or older who have a diagnosis of intellectual disabilities who would otherwise qualify for care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
Intellectual Disabilities (ID) Waiver/Section 1915(c)	ADMH	The ID Waiver has been operational since 1981. The ID Waiver serves individuals with a diagnosis of intellectual disabilities (ID), and/or individuals meeting an ICF/IID level of care**.**
HIV/AIDS Waiver	ADSS	The HIV/AIDS Waiver was discontinued in September 2017. The Waiver provided case management, homemaker, personal care, respite, companion, skilled nursing for beneficiaries with a diagnosis of HIV/AIDS or related illnesses.

Summary of PCS Expenditures and Beneficiary Data

In FY 2019, Alabama's total Medicaid expenditures were approximately $6.98 billion, and the Alabama Medicaid program covered almost 1.03 million beneficiaries. Alabama's total Medicaid expenditures for PCS was approximately $50.6 million, and 10,046 unduplicated beneficiaries[3] received PCS.

[3] The unduplicated beneficiary count is the number of individuals receiving services in a specified time period, not units of service.

The Personal Choices program is the self-directed PCS program. The self-directed PCS program experienced a 348 percent increase in expenditures from FY 2017 to FY 2019. The increase was attributed to significant growth in beneficiaries choosing to transfer from agency-directed PCS to self-directed PCS for the ability to select a PCA that may be known to the beneficiary, and access to a savings and health account that can be utilized to purchase medical supplies and goods not otherwise covered by Medicaid. Beneficiary enrollment under the self-directed program was consistent with the increase in expenditures. Table 2-A below provides details of the Personal Choices program's expenditures.

Table 2-A. PCS Expenditures for Section 1915(j) Waiver Programs (in millions)

1915(j) Waiver Plan Authority	FY 2017	FY 2018	FY 2019
Personal Choices	$6.2	$16.5	$27.8
Total Expenditures	**$6.2**	**$16.5**	**$27.8**

Table 2-B. The PCS Expenditures by Section 1915(c) HCBS Waiver(s) (in millions)

Section 1915(c) HCBS Waiver Authority	FY 2017	FY 2018	FY 2019
TA Waiver	$0.156	$0.139	$0.122
E&D Waiver	$12.3	$10.7	$9.7
ACT Waiver	$0.718	$0.752	$0.838
SAIL Waiver	$2.3	$3.3	$2.3
LAH Waiver	$0.897	$0.817	$0.663
ID Waiver	$9.9	$9.3	$9.1
HIV/AIDS Waiver	$0.598	$0.48	$0
Total Expenditures	**$26.4**	**$25.1**	**$22.7**

A significantly larger proportion of PCS expenditures were allocated to agency-directed services than self-directed PCS in Alabama during the first FY reviewed. However, self-directed PCS expenditures increased by 21 percent in FY 2018, and by FY 2019, self-directed PCS became the leading service delivery expenditure for PCS. Table 3 below provides information on PCS expenditures by type.

Table 3. PCS Expenditure by Type (in millions)

	FY 2017	FY 2018	FY 2019
Total PCS Expenditures	$32.6	$41.6	$50.6
% Agency-Directed PCS Expenditures	81%	60%	45%
% Self-Directed PCS Expenditures	19%	40%	55%

Overall, PCS expenditures and the number of unduplicated beneficiaries receiving PCS services remained constant with some gradual changes during the three FYs reviewed. The HIV/AIDS Waiver was discontinued in September 2017, which accounts for the lack of beneficiaries for the program in FFY 2019. Table 4-A provides additional information by waiver for agency-directed unduplicated beneficiaries.

Table 4-A. Agency-directed Unduplicated Beneficiaries

1915(c) HCBS Waiver Authority	FY 2017	FY 2018	FY 2019
TA Waiver	26	22	24
E&D Waiver	5,108	6,146	5,755
ACT Waiver	140	190	196
SAIL Waiver	318	500	395
LAH Waiver	104	97	84
ID Waiver	561	573	575
HIV/AIDS Waiver	31	17	0
Total Agency-directed Unduplicated Beneficiaries	**6,288**	**7,545**	**7,029**

In the analysis of the number of beneficiaries that received self-directed PCS, the expenditures were significantly higher in comparison to agency-directed PCS expenditures. Specifically, in FY 2019, there were approximately 133 percent more agency-directed PCS beneficiaries than self-directed PCS beneficiaries. However, self-directed PCS expenditures accounted for 55 percent of all PCS expenditures. Table 4-B provides additional information for self-directed unduplicated beneficiaries.

Table 4-B. Self-directed Unduplicated Beneficiaries

1915(j) Waiver Plan Authority	FY 2017	FY 2018	FY 2019
Personal Choices	941	1,960	3,017
Total Self-directed Unduplicated Beneficiaries	**941**	**1,960**	**3,017**

Results of the Review

CMS evaluated the following eight areas of Alabama's PCS program:

1. State oversight of PCS program integrity activities and expenditures
2. Payment suspensions based on credible allegations of fraud
3. Federal database checks
4. Screening levels for Medicaid providers
5. State oversight of self-directed PCS
6. Agency-based PCS providers
7. Oversight of PCS agency providers
8. Electronic Visit Verification

CMS identified 7 areas of concern with Alabama's PCS program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all the identified issues are satisfactorily resolved as soon as possible through implementation of a corrective action plan. These areas of concern and CMS' recommendations for improvement are described in detail below.

1. State Oversight of PCS Program Integrity Activities and Expenditures

Federal regulations require the State Plan for Medical Assistance to provide for the establishment and implementation of a statewide surveillance and utilization control program that safeguards

against unnecessary or inappropriate utilization of care, services, and excess payments. The AMA has designated the Program Integrity Division through its Provider Review, Recipient Review, and Investigations Units to perform this function. These units are responsible for detecting fraud and abuse within the Medicaid Program through reviewing paid claims history and conducting field reviews and investigations to determine provider/recipient abuse, deliberate misuse, and suspicion of fraud. In addition, these units are utilized to aid in program management and system improvement. The Program Integrity Division is responsible for planning, developing, and directing Agency efforts to identify, prevent, and prosecute fraud, abuse, and/or misuse in the Medicaid Program. This includes verifying that medical services are appropriate and rendered as billed, services are provided by qualified providers to eligible recipients, payments for those services are correct, and all funds identified for collection are pursued.

The Quality Assurance (QA) Division at the AMA is primarily responsible for auditing and oversight of the sister state agencies. The sister state agencies are primarily responsible for the detection and prevention of fraud, waste, and abuse within the Waiver programs. The MOUs indicate that each sister state agency is "solely responsible for the accuracy and authenticity of said electronic claims submitted" and must "certify[y] that the service described on the electronic media claim was rendered by the provider of service in accordance with program requirements." Each sister state agency submits a claim to the AMA for reimbursement. The sister state agency is listed as the billing provider, and the PCS agency provider is listed as the rendering provider in the claims field.

The Division of Program Integrity does not conduct audits or investigations of PCS providers. The AMA relies on the sister agencies for the programmatic and administrative authority of the Waiver programs. The Waiver programs are the only programs that have Medicaid PCS providers. The sister agencies do not have program integrity units that conduct investigations for suspected fraud or conduct data mining to detect aberrant trends. The sister agencies utilize nurses and support staff to conduct provider audits to assess compliance with programmatic guidelines. Also, the sister agencies and ASOs conduct reviews and audits of timesheets prior to claims submission for reimbursement.

The AMA, as the State Medicaid Agency, retains ultimate administrative authority and responsibility for the operation of the Waiver programs by exercising oversight of the performance of Waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities. The QA Division does have policies and procedures for conducting audits of Waiver providers. However, the QA Division did not conduct any audits of Medicaid PCS agencies from FY 2017-2019. Further, the QA Division does not create an annual audit work plan that identifies areas of interest for oversight. **The AMA has relied on the sister agencies for the auditing and review of Medicaid PCS providers and the administration of PCS. The AMA should consider taking a more active role in PCS oversight and HCBS Waiver implementation to ensure more robust program integrity measures are in place.**

Table 5. Program Integrity Post-Payment Actions Taken – PCS Providers

Agency-Directed and Self-Directed Combined	FFY 2017	FFY 2018	FFY 2019
Identified Overpayments	$0	$0	$0
Recovered Overpayments	$0	$0	$0

Agency-Directed and Self-Directed Combined	FFY 2017	FFY 2018	FFY 2019
Terminated Providers	0	0	0
Suspected Fraud Referrals	0	0	0
Number of Fraud Referrals Made to MFCU	0	0	0

*Identified and recovered overpayments in FY 2017-FY 2019 only include identified credible allegations of fraud.

Recommendation #1: The QA Division and the Division of Program Integrity should consider creating annual audit work plans that may identify areas of risk. The audit work plan may serve as guidance to providers and stakeholders on state PCS oversight objectives and priorities.

Recommendation #2: The AMA should develop contractual requirement(s) for the sister agencies to implement and maintain procedures that are designed to detect and prevent fraud, waste, and abuse.

Recommendation #3: The AMA and sister agencies should create and implement post-payment recovery policies to address overpayments identified from a credible allegation of fraud.

2. Payment Suspensions Based on Credible Allegations of Fraud

CMS regulations at 42 CFR 455.23(a) require that when the State Medicaid agency determines that there is a credible allegation of fraud, it must suspend all Medicaid payments to a provider, unless the agency has good cause not to suspend payments or to suspend payment only in part. There were no suspected fraud PCS referrals from the Division of Program Integrity referred to, or accepted by, the MFCU for further investigation in the last three FYs. As a result, the AMA did not initiate a PCS payment suspension in the last three FFYs. The AMA advised CMS that they would impose a payment suspension on a provider based on credible allegation of fraud, waste, or abuse. A provider's risk remains "high" for 10 years beyond the date of the payment suspension. The AMA did provide policies or procedures for enacting provider payment suspensions or exercising good cause exceptions as described in 42 CFR 455.23.

3. Federal Database Checks

CMS regulations at 42 CFR 455.436 require that the state Medicaid agency check the exclusion status of the provider or persons with an ownership or control interest in the provider, agents, and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); and the National Plan and Provider Enumeration System upon enrollment and reenrollment, and check the LEIE and SAM no less frequently than monthly.

The ADSS, ADRS, and ADMH are responsible for managing their provider networks. Gainwell Technologies, a fiscal agent of AMA, is responsible for conducting the required screening and enrollment process for PCS agency providers. Allied and Morning Sun also conduct the required screening based on AMA policies and guidelines. Statewide background checks are required for all employees hired, and must be performed prior to the date of hire. Employees are not allowed to provide services until after the results of the background check have been received. PCS agencies are responsible for initial and then monthly checks of employees against the Medicaid

Exclusion List. In addition to the background check, employers must also check the State of Alabama Nurse Aide Registry, National Sex Offender public registry, and previous employer references. **The listing of screening and database checks are not inclusive of all required databases listed in 42 CFR 455.436. The SAM database is a required screening tool in accordance with the federal regulation but is not required by the AMA. The SSA-DMF is also a required screening tool in accordance with 42 CFR 455.436 but is not required by the AMA. Some PCS agencies interviewed reported not checking the SSA-DMF. Addus Healthcare, an agency that is operational in multiple states, was the only PCS agency interviewed that conducted SAM database checks and had a policy in compliance with 42 CFR 455.436**.

Recommendation #4: The AMA should create a compliance policy on required federal database checks, amend current internal federal database check procedures, and amend the provider agreement as necessary in accordance with 42 CFR 455.436, to ensure compliance.

4. Screening Levels for Medicaid Providers

High- and moderate-risk providers are subject to enhanced screening that may include onsite visits, Federal Bureau of Investigation background checks and fingerprinting. The AMA has identified high-and moderate-risk providers in accordance with 42 CFR 455.450. **However, the AMA does not enroll PCS providers, and they were not considered when assigning risk for provider types. The sister agencies advised CMS that Waiver providers are enrolled utilizing uniform standards and the providers do not have a risk designation assigned by the AMA or the sister agencies. The SMA is required to assign Medicaid-only categories of providers to an appropriate risk level.**

Recommendation #5: The AMA should ensure all Medicaid providers have been considered for risk designation, in accordance with 42 CFR 455.450.

5. State Oversight of Self-Directed PCS

Beneficiaries that receive self-directed PCS have the authority to define the qualifications for his or her attendant. Although an individual may set the qualifications for his or her attendant, it is the state's recommendation that any attendant be at least 18 years of age and possess a high school diploma or General Educational Development Equivalent. The AMA permits beneficiaries to hire legally liable relatives as paid providers of the PCS identified in the service plan and budget. All attendant applicants must undergo a national and statewide background check, which includes Department of Motor Vehicles and Sex Offender Registry Check, drug screen, and TB skin test prior to beginning employment. The PCAs must be able to follow written or verbal instructions given by the individual or the individual's representative or designee; be physically able to perform the services required; and receive and follow instructions given by the beneficiary or the beneficiary's designee. Spouses and parental caregivers are not excluded from being hired.

The AMA maintains administrative oversight responsibilities for the quality management of the self-directed PCS program. The sister state agencies are responsible for the day-to-day

management of quality activities in the quality management plan. The sister state agencies contract with Financial Management Services (FMS) vendors to assist with the administration of self-directed PCS. The ADSS and ADMH contract with Allied Community Resources (Allied), and the ADRS contracts with Morning Sun as the FMS vendors of record. The FMS contract(s) outline the requirements of the FMS to act as agent for the employer/participant in gathering and maintaining relevant employee information; maintaining employer and employee files with necessary tax, IRS, and payroll information; and provide a system for payment and verification of services provided. The contracts indicate each FMS is "solely responsible for the accuracy and authenticity of said electronic claims submitted" and must "certify[y] that the service described on the electronic media claim was rendered by the provider of service, in accordance with program requirements." The Personal Choices Program also provides beneficiaries with an added benefit of a $1,000 health savings account that can be used to purchase medical equipment and supplies, not otherwise eligible for Medicaid reimbursement. Both FMS vendors conduct some level of timesheet reviews to ensure proper reimbursement and adherence to the approved plan of care. Both FMS also have the ability to conduct programmatic audits and investigate reported complaints. The FMS vendors reported approximately $15,000 in audit overpayments recovered in the last three FYs.

There have not been any instances of suspected fraud identified or reported by the FMS vendors, the sister agencies, or AMA in the last three FYs. Morning Sun and Allied did not report any suspected fraud overpayments in the last three FYs. Self-Directed PCS expenditures accounted for 55 percent of all PCS expenditures in FY 2019, even though 70 percent of PCS beneficiaries utilize agency directed PCS instead of self-directed PCS. Because the majority of the PCS exposure lies in the Personal Choices Program, the AMA should ensure that there is adequate attention and oversight of the program. A lack of any identified suspected fraud referrals may indicate more oversight efforts are necessary to ensure adequate program integrity.

Recommendation #6: The AMA should consider reviewing and revising self-directed PCS oversight efforts by initiating regular programmatic audits and investigations of self-directed PCS.

6. Agency-Based Personal Care Services Providers

As previously mentioned, providers of PCS deliver support 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 who have limited ability to care for themselves because of physical, developmental, or intellectual disabilities or conditions. These non-medical services assist beneficiaries with ADLs.

According to information provided by the sister agencies, there were a total of 238 PCS agencies, providing PCS under the Waiver programs in FY 2019. Alabama does not require PCAs to have unique identifiers or other state identifiers. **In the last three FYs, neither AMA nor**

the sister agencies have identified or referred suspected PCS fraud to the MFCU. Also, the sister agencies are reliant on the EVV, case management vendor, and PCS agencies to identify and report suspected fraud. All agencies and vendors are limited in their ability to adequately review claims data to identify suspected PCS agency fraud due to rendering PCAs not identified on claims data. Having the ability to identify rendering PCAs on claims would provide more transparency on the services provided and allow AMA and the sister agencies to adequately review claims data for aberrant trends. **In addition, neither AMA nor the sister agencies regularly conduct, require, or delegate unannounced onsite visits to further monitor PCA or agency activity.** Unannounced visits to further verify services performed is an effective tool to identify suspected fraud when PCA identifiers are not captured in claims data or ultimately PCAs are not identified through aberrant trend data analysis.

The ADRS did perform a standard audit, identified suspected fraud, and terminated the provider from the network for-cause. The provider was enrolled with at least one other sister agency, and the sister agencies regularly share their findings with the AMA and the other sister agencies. The AMA does not mandate that the sister agencies terminate providers. Each agency has discretion on whether to terminate the provider from their network or take additional actions, such as investigating the allegations. The notification process is informal, with no policies or guidelines on how to proceed with terminated providers. The AMA advised CMS that it did not take any additional action against the provider, and does not have a process in place to notify CMS of such for cause terminations because the providers are under the purview of the sister agencies.

The AMA has not adopted compliant language, policies, and procedures for identifying and reporting adverse provider terminations. CMS guidance indicates "for cause" adverse terminations may include, but is not limited to, termination for reasons based upon fraud, integrity, or quality.[4] Section 6501 of the Affordable Care Act mandates that state Medicaid agencies effectively terminate providers that have been terminated "for cause." State Medicaid agencies are required to notify CMS of "for cause" terminations, which require other Medicaid programs to initiate termination procedures for the provider if they are enrolled in another State Medicaid program. These measures help to ensure adequate safeguards as a consequence for provider outlier behavior. Without proper notification procedures in place, the provider may be eligible and free to enroll as a Medicaid provider in another state.

Recommendation #7: The state should consider assigning a unique identifier or National Provider Identifier (NPI) for PCAs. Unique identifiers, or NPIs,[5] facilitate more efficient and transparent tracking of each PCS service rendered and reimbursed.

Recommendation #8: The AMA and sister agencies should consider conducting, or delegating regular unannounced onsite visits, to further monitor PCAs and/or agency activities.

Recommendation #9: The AMA should: 1) Develop adverse termination criteria consistent with Section 6501 of the Affordable Care Act, including prompt notification requirements for adverse

[4] https://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/6501-Term.pdf
[5] https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/FAQs-Using-NPIs-for-Medicaid-PCAs.pdf

terminations; 2) Amend the provider agreement to communicate the criteria and requirements to providers; 3) Develop processes to ensure timely reporting of adverse terminations to CMS.

7. Oversight of PCS Agency Providers

As part of the review, CMS selected five provider agencies to be interviewed. Those agencies were Addus Healthcare, Magnolia Wood Lodge, Three Folds LLC, Capital City Home Health, and Help at Home. Each of the agencies advised CMS that they have encountered several circumstances where they terminated a PCS aide for suspected time sheet fraud. In each instance, there was no notification to the AMA or the MFCU of the suspected fraud. **None of these agencies have a policy or process for notifying the AMA when an employee is terminated for suspected fraud. The AMA has not provided guidance on case referrals for employees terminated for fraudulent conduct.** Identifying and properly adjudicating PCA suspected fraud referrals will help to ensure that PCAs that engage in suspected fraud activity are identified and not recycled to other PCS agencies, in the Alabama Medicaid Program.

Recommendation #10: The AMA should establish guidance on the basic requirements for all PCS providers regarding compliance program structure, and reporting suspected fraud to ensure continuity within its Medicaid PCS program.

Recommendation #11: The AMA should establish guidance for PCS agencies on referring credible allegations of suspected fraud, regarding individual PCS attendants, to the AMA and/or the MFCU.

8. Electronic Visit Verification (EVV)

An EVV system is a telephonic and computer-based in-home scheduling, tracking, and billing system. Specifically, EVV 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.

Currently, Alabama does utilize an EVV system for in-home scheduling, tracking, and billing for agency-directed PCS providers. Alabama has utilized EVV for agency providers for several years before the 21st Century Cures Act required states to implement EVV. Pursuant to Section 12006 of the 21st Century Cures Act, all states were required to implement an EVV system for PCS by January 1, 2020.

CMS did not identify any recommendations regarding Alabama's EVV system.

Status of Alabama's 2016 Corrective Action Plan

Alabama's previous focused program integrity review was in July 2016, and the final report was issued in July 2017. The report contained five vulnerabilities. CMS completed a desk review of the corrective action plan in April 2018, which indicated that the findings from the 2016 review have all been satisfied by the state.

Technical Assistance Resources

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

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
  - Risk Assessment Template (XLSX) July 2021:
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute.
- Access Personal Care Services resource documents at the following link: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Personal-Care-Services
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- 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.

Conclusion

CMS supports Alabama's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified twelve areas of concern that should be addressed as soon as possible.

We require the state to provide a corrective action plan for each of the recommendations within 30 calendar days from the date of issuance of the final report. The corrective action plan should address all specific risk areas identified in this report and explain how the state will ensure that the weaknesses have been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, 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 issuance of the final report. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

CMS looks forward to working with Alabama to enhance and strengthen its program integrity function.