Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Connecticut Focused Program Integrity Review

Final Report

October 2019

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) is committed to performing program integrity reviews with states in order to identify risks and vulnerabilities to the Medicaid program and assisting states with strengthening program integrity operations. The significance/value of performing onsite program integrity reviews include: (1) assess the effectiveness of the state's PI efforts, including compliance with certain Federal statutory and regulatory requirements, (2) identify risks and vulnerabilities to the Medicaid program and assist states to strengthen PI operations, (3) help inform CMS in developing future guidance to states and (4) help prepare states with the tools to improve PI operations and performance.

The CMS conducted a focused review of the Connecticut Medicaid personal care services (PCS). Personal Care Services in Connecticut are delivered as homemaker and companion services. References hereafter to PCS, and agency directed PCS providers are for non-medical homemaker-companion services rendered by homemaker-companion agencies. 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 may be used to enhance program integrity in the delivery of these services.

Medicaid PCS (sometimes referred to as 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 the personal care attendant (PCA) or cueing/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 42 C.F.R. § 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.

During the week of April 8, 2019, the CMS review team visited the Connecticut Department of Social Services (DSS). The CMS team conducted interviews with numerous state staff involved in program integrity and administration of PCS to validate the state's program integrity practices with regard to PCS.

Summary of Recommendations

The CMS review team identified a total of nine recommendations based upon the completed focused review modules and supporting documentation, as well as discussions and interviews with key stakeholders. The recommendations were in the following areas: Overview of the State's PCS, State Oversight of PCS Program Integrity Activities and Expenditures, State Oversight of Self-Directed Services, Agency-Based Personal Care Services Providers, and Electronic Visit Verification (EVV). The recommendations will be detailed further in the next section of the report.

Overview of the Connecticut Medicaid PCS

- In FFY 2018, Connecticut's total Medicaid expenditures were approximately $1.9 billion, and covered almost 847,899 beneficiaries.
- In FFY 2018, Connecticut's total Medicaid expenditures for PCS was approximately $341.45 million which provided PCS to 12,238 unduplicated beneficiaries.
- The Connecticut Personal Care Attendant Program (PCAP) provides PCS under the 1915(k) Community First Choice (CFC) and 1915 (c) Home and Community Based (HCBS) Waiver authorities. The HCBS programs are the Connecticut Home Care Program for Elders (CHCPE), and Acquired Brain Injury (ABI) II Waiver.
- In Connecticut, PCS are delivered as homemaker and companion services. References hereafter to PCS, and agency directed PCS providers are for non-medical homemaker-companion services rendered by homemaker-companion agencies.
- The state offers both agency-based and participant directed (self-directed) PCS options.

Overview of Connecticut's Administration of PCS

- The Connecticut Department of Social Services (DSS) is the single state agency designated in accordance with 42 C.F.R. § 431.10 to administer the Medicaid program in the state of Connecticut.
- The Connecticut Medical Assistance Program (CMAP) administered by DSS ensures that beneficiaries have access to Medicaid health services and benefits.
- The Community Options Unit at DSS is directly responsible for administering the CMAP PCS benefit.

Summary of PCS in Connecticut

Connecticut administers Medicaid PCS to eligible beneficiaries under the 1915(k) state plan authority, and 1915(c) 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. The Table 1 below provides details of the programs.

Table 1.

Program Name/Federal Authority	Administered By	Description of the Program
Community First Choice (CFC) 1915(k)	Connecticut Department of Social Services	The CFC program was implemented on July 1, 2015. The CFC program allows individuals to receive supports and services in their home. These services can include—but are not limited to—help preparing meals and doing household chores, and assistance with activities of daily living (bathing, dressing, transferring, etc.). The CFC is open to any Medicaid member that can self-direct services and meets Institutional Level of Care.
Connecticut Home Care Program for Elders (CHCPE) 1915(c)	Connecticut Department of Social Services	The CHCPE HCBS Waiver program was is a comprehensive home care program designed to enable older persons at risk of institutionalization to receive the support services they need to remain living at their home. The CHCPE provides a wide range of home health and non-medical services to persons age 65 and older who are institutionalized or at risk of institutionalization.
Acquired Brain Injury (ABI) II Waiver 1915(c)	Connecticut Department of Social Services	The ABI II Waiver program provides a broad range of services to persons with acquired brain injuries, and without services, would require the services provided in a nursing home, a sub-acute facility, and ICF/IID or a chronic disease hospital.

Summary of PCS Expenditures and Beneficiary Data

Table 2-A.

1915(k) State Plan Authority	FFY 2016	FFY 2017	FFY 2018
CFC	$40.09 Million	$60.8 Million	$84 Million
Total Expenditures	**$40.09 Million**	**$60.8 Million**	**$84 Million**

The CFC is the CMAP self-directed PCS program. The self-directed PCS program experienced more than a 100 percent increase in expenditures from FFY 2016 to FFY 2018. The program was implemented in FFY 2016, and rapidly expanded in a short period of time. The increase was attributed to significant growth in beneficiaries choosing to transfer from agency-directed PCS to self-directed PCS. Beneficiary enrollment under the self-directed program was consistent with the increase in expenditures from FFY 2017-2018.

Table 2-B.

1915(c) HCBS Waiver Authority	FFY 2016	FFY 2017	FFY 2018
CHCPE	$185 Million	$228 Million	$257 Million
ABI II	$66,634 Thousand	$164,326 Thousand	$455,419 Thousand
Total Expenditures	**$185.06 Million**	**$228.16 Million**	**$257.45 Million**

The CHCPE and ABI II Waivers provide PCS through agency-directed service delivery. Despite some gradual increase demonstrated, PCS expenditures overall remained consistent with the total unduplicated beneficiaries serviced during the three FFYs reviewed. The ABI II Program provides services to a small number of PCS beneficiaries in Connecticut, which results in less expenditures in comparison to the CHCPE program.

Table 3.

	FFY 2016	FFY 2017	FFY 2018
Total PCS Expenditures	$225.15 Million	$288.96 Million	$341.45 Million
% Agency-Directed PCS Expenditures	82.2%	79%	75%
% Self-Directed PCS Expenditures	17.8%	21%	25%

A significantly larger portion of PCS expenditures were allocated to agency directed services in Connecticut during the three FFYs reviewed. However, self-directed PCS is growing significantly in Connecticut. The percentage of expenditures attributed to each of the PCS delivery models demonstrated a noticeable variance during the time periods reviewed. Overall, PCS expenditures and the number of unduplicated beneficiaries receiving PCS services have increased during the three FFYs reviewed.

Table 4-A.

1915(c) HCBS Waiver Authority	FFY 2016	FFY 2017	FFY 2018
CHCPE	7,478	10,322	9,778
ABI II Waiver	26	25	45
Total Agency-directed Unduplicated Beneficiaries	**7,498**	**10,347**	**9,823**

*Unduplicated beneficiary count is the number of individuals receiving services, not units of service. Growth within the waivers occurred as more beneficiaries moved into assistive living.

The number of beneficiaries that receive agency-directed PCS have varied within the last three FFYs. There is an increase of beneficiaries transitioning to the self-directed PCS program, but the majority of PCS are rendered by agency-directed PCS providers. The ABI II Waiver requires beneficiaries to meet a higher level of need, in addition to other medical diagnoses to qualify for services. Therefore, a fewer number of beneficiaries are enrolled in the ABI Waiver because of these additional requirements.

Table 4-B.

1915(k) State Plan Authority	FFY 2016	FFY 2017	FFY 2018
CFC	**	1667	2415
Total Self-directed Unduplicated Beneficiaries	****	**1667**	**2415**

*Unduplicated beneficiary count is the number of individuals receiving services, not units of service.
**Connecticut was unable to provide the total number of unduplicated beneficiaries for FFY 2016.

Overall, PCS expenditures and the number of unduplicated beneficiaries receiving self-directed PCS services have increased. As noted above, more beneficiaries are opting to utilize self-directed PCS since the inception of the CFC program. The CMS review team noted that the self-directed program's growth is trending higher, with 50 percent growth in unduplicated beneficiaries from FFY 2017 to FFY 2018.

Results of the Review

The CMS team identified areas of concern with the state's PCS program integrity oversight, thereby creating risk of fraud, waste and abuse to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible. These issues and CMS' recommendations for improvement are 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.

Overview of the State's PCS

The CMAP PCS benefit is administered through the Community Options Unit at DSS. Connecticut has adopted a self-insured, managed fee-for-service (FFS) approach to Medicaid

service delivery. The DSS contracts with Administrative Service Organizations (ASOs) to provide a broad range of services, such as: health education, member services, utilization management, quality management, and health data analytics. The ASOs' mission is to improve care experiences, quality of service, and generate cost savings for the Medicaid program. The ASOs do not reimburse providers for services rendered. The DSS maintains full risk for all claims submitted for Medicaid reimbursement. Additionally, the DSS contracts with access agencies to conduct assessments for service eligibility and develop plans of care tailored to the needs of the beneficiary. Medicaid members and waiver participants can obtain PCS through the CFC State Plan option and direct their own care or through a homemaker-companion agency for agency-based PCS. Access agencies manage the prior authorization for delivery of PCS whether the PCS are provided through self-direction or a homemaker-companion agency.

Homemaker -companion agencies are required to register with the Department of Consumer Protection as a homemaker-companion agency. The DSS regulations require PCAs to be at least 18 years of age; able to understand and carry out directions given by the client; able to physically perform the duties on the plan of care; willing to receive training in the duties to be performed; able to handle emergencies; able to maintain an effective working relationship with the client, and operate any special equipment needed to help with activities of daily living. PCS aides are required to sit for, and pass a PCS training curriculum created by the Community Options Unit within DSS.

State Oversight of PCS Program Integrity Activities and Expenditures

The Special Investigations Division (SID) in the Office of Quality Assurance (OQA) is primarily responsible for the detection and prevention of fraud, waste, and abuse. The SID has three FTEs and is comprised of two units; provider investigations and provider enrollment. The OQA does not create an annual audit work plan that identifies areas of interest for oversight.

Recommendation #1: The OQA should consider creating annual audit work plans that identify areas of risk, as well as serve as guidance to providers and stakeholders on the state PCS oversight objectives and priorities.

Table 5.

Agency-Directed and Self-Directed Combined	**FFY 2016**	**FFY 2017**	**FFY 2018**
Identified Overpayments	$74,064.63	$0	$52,564.17
Recovered Overpayments	$0	$0	$0
Terminated Providers	0	0	0
Suspected Fraud Referrals	9	0	4
# of Fraud Referrals Made to MFCU	4	0	0

*Identified and recovered overpayments in FFY 2016-FFY 2018 only include identified credible allegations of fraud.

With limited resources and FTEs, SID has identified and referred an adequate amount of suspected PCS fraud to the Medicaid Fraud Control Unit (MFCU) in the last three FFYs. However, each suspected fraud referral and all identified overpayments involved individual aides that provide self-directed PCS to beneficiaries. The DSS has not taken any post payment actions to recoup overpayments when a credible allegation of fraud has been identified in the last three FFYs. The DSS was unable to provide any documented controls, or policies on recouping overpayments when overpayments have been identified.

The SID has not initiated any suspected fraud case referrals, nor identified suspected fraud overpayments for homemaker-companion agency providers in the last three FFYs. In FFY 2018, homemaker-companion agency providers accounted for approximately 75 percent of PCS expenditures. There is significant room for improvement to create strategies to identify and refer more substantive suspected fraud with homemaker-companion agencies. Subsequent recommendations listed in the report should be considered to assist with identifying agency-based PCS credible allegations of fraud The DSS advised CMS that law enforcement's failure to accept referrals, due to low amounts of monetary exposure, are the reasons why there are fewer accepted PCS referrals. The OQA utilizes Allied Community Resources (ACR), a financial management service (FMS), to regularly conduct homemaker-companion agency audits as part of their responsibilities listed in their statement of work. Approximately $57,000 in overpayments have been recouped in the last three FFYs as a result of the FMS' audit activities.

Recommendation #2: The DSS should create and implement post payment recovery policies when overpayments identified from a credible allegation of fraud has been identified.

According to 42 CFR 455.20, DSS is required to have a method for verifying with beneficiaries whether services billed by providers were received. The DSS has a process to verify services in accordance with the federal regulation. Explanation of Medical Benefit (EOMB) letters and a corresponding report are generated based on .25 percent of the beneficiaries that have paid claims for that month. However, PCS Agencies and ABI Waiver beneficiaries are excluded from the EOMB process. As mentioned above, there is a lack of oversight of homemaker-companion agency providers of PCS. Verifying services, as required in 42 CFR 455.20 enhances oversight and may identify suspected fraud with agency directed PCS providers.

Recommendation #3: The DSS should review policies, procedures, and internal processes to ensure compliance with 42 CFR 455.20.

Four suspected fraud PCS referrals from OQA were officially accepted by the MFCU, for further investigation, in the last three FFYs. Each of the referrals were for individual aides that provide PCS for self-directed program beneficiaries. The OQA did not initiate a payment suspension for any of the four referrals in the last three FFYs, in accordance with 42 CFR 455.23 after the MFCU accepted the referrals for further investigation. In the absence of a provider payment suspension, OQA was unable to provide a good cause exception for any of the four investigations referred to the MFCU in the last three FFYs. The OQA provided CMS with a MOU that cited provider payment suspension policies in accordance with 42 CFR 455.23 Suspension of payment in cases of fraud. Additional good cause exception criteria is listed in the MOU, consistent with the

aforementioned federal payment suspension policy. However, OQA was unable to provide procedures for enacting provider payment suspensions, or exercising good cause exceptions as described in 42 CFR 455.23 Suspension of payment in cases of fraud. The OQA advised CMS that PCS payment suspensions create union and legal obstacles, and OQA does not have resources (3 FTEs) to adequately address those obstacles. Further, the payment suspension for the individual aides are viewed by DSS as a suspension of consumer payments, rather than a suspension of payments for PCS services where a credible allegation of fraud has been established. As a result, a provider payment suspension has not been initiated for PCS aides or agencies when a credible allegation of fraud has been established. Failure to adequately review credible allegations of fraud, and consider federally mandated payment suspensions are a vulnerability to the Connecticut Medicaid program.

Recommendation #4: The DSS should revise their internal procedures to ensure the agency is in compliance with federal guidelines listed in 42 CFR 455.23.

42 CFR 455.436 requires that the state Medicaid agency check the exclusion status of the provider or persons with an ownership or control interest in the provider, and 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 Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly.

The DSS is responsible for credentialing and enrolling all CMAP Medicaid providers. The DSS delegates credentialing to ACR, and provider enrollment to DXC Technology. DXC Technology is responsible for conducting all federal database checks. The DSS provider agreement cites the requirements listed in the Regulations of Connecticut State Agencies for background and database checks, which is not inclusive of all required databases listed in 42 CFR 455.436 Federal database checks. The DSS does not have a written policy on database checks, but has internal procedures on database checks that does not include checking the SAM/EPLS database nor does it provide specifics on the frequency which databases are required to be checked. The failure of DSS to credential providers in accordance with CMS guidelines has been a repeated finding since FFY 2010.

Recommendation #5: The DSS should create a compliant 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 in its entirety.

Overview 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, but the state requires that any attendant meet the following standards: Be at least 16 years of age; have experience providing personal care; 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 excluded from being hired.

State Oversight of Self-Directed PCS

The DSS contracts with a FMS vendor, ACR, to assist with the administration of self-directed PCS. The FMS contract outlines 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. Any timesheet submitted that violates a system validation is rejected by the system and will not be paid without manual review and revision. These system validations are reviewed daily, and appropriately adjusted to ensure that employees are paid appropriately. ACR also conducts preliminary reviews to investigate complaints, and collaborates with OQA to identify suspected fraud.

The SID has identified a substantial amount of suspected fraud within self-directed PCS, even with limited resources and FTEs. The SID had thirteen suspected fraud investigations generated within the self–directed program that were referred to the MFCU (See Table 5). Four investigations were accepted by the MFCU for further, criminal investigation. Investigations are generally initiated based on system edits that identify activity when an aide has received a reimbursement for services during a time when reimbursement for services were not allowed. These instances overwhelmingly were when a beneficiary was hospitalized, and when confirmation was received that services were not rendered after reimbursements were provided.

Agency-Based Personal Care Services Providers

Providers of PCS deliver supports 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 state personnel, there were 192 homemaker-company agencies, providing PCS under the CHC and ABI II programs. Connecticut does not require PCAs to have unique identifiers, or state identifiers. The EVV system, managed separately by the state's FI, identifies PCAs by name and the last five digits of their social security number. In the last three FFYs, DSS has not identified or referred suspected fraud with homemaker-companion agencies to the MFCU. The DSS is reliant on the EVV and homemaker-companion agencies to provide the necessary oversight. However, DSS is limited in its ability to adequately review claims data to identify suspected homemaker-companion agency fraud because rendering PCAs are not identified on claims data. Having the ability to identify rendering PCAs on claims would provide more transparency on services provided, and allow DSS to adequately review claims data for aberrant trends.

In addition, the state does not regularly conduct, require, or delegate unannounced onsite visits to monitor PCAs or agency activities to further verify services. CMS was advised that the limited

amount of unannounced onsite visits conducted by DSS identified scenarios where the PCA was not in the beneficiary's home as scheduled, or as reported by EVV. Unannounced visits to further verify services is an effective tool to identify suspected fraud when PCA identifiers are not captured in claims data to identify aberrant trends for services provided by PCAs.

Recommendation #6: The state should consider assigning a unique identifier or NPI for CMAP PCAs. Unique identifiers, or NPIs facilitate tracking of each PCA beneficiary's case assignment.

Recommendation #7: The state should consider conducting, or delegating unannounced onsite visits to further monitor PCAs and/or agency activities.

Oversight of Homemaker-Companion Agencies Providing PCS

As part of the onsite review, CMS's review team selected four provider agencies to be interviewed. Those agencies were Caregivers Connecticut, Center for Transitional Living, Companions and Homemakers, and Liberty Home Care.

Companions & Homemakers is a privately owned, Connecticut based company that has been providing hourly and live-in personal care services since 1990. In FFY 2018, the agency generated $10.5 million in revenue from providing services to Medicaid beneficiaries under the Eldercare waiver. Medicaid represents approximately 35 percent of the agency's total revenue, with the remaining revenue attributable to private pay clients. In FFY 2018, Companions & Homemakers served 603 Medicaid beneficiaries and employed a total of 1,602 attendants.

The agency is the state's largest Medicaid PCS provider, measured by total reimbursements and beneficiaries serviced in the last three FFYs. Companions & Homemakers does not have defined policies, nor a Compliance Officer, to serve as a single point of contact for regulatory and suspected fraud concerns. The agency divides compliance activities amongst various departments. Compliance and operational issues are discussed at bi-weekly management meetings. Of note, the provider agency representative advised the CMS review team that he believes PCS poses limited fraud risk.

The DSS relies on EVV and homemaker-companion agencies to identify fraud and abuse. However, the DSS has not received any suspected fraud referrals from agency providers in the last three FFYs. Since homemaker-companion agencies are expected to play a significant role in oversight of PCS, DSS should consider creating guidance on basic requirements for homemaker-companion agency providers regarding compliance program structure to ensure continuity and appropriate oversight of the Medicaid PCS program.

Recommendation #8: The state should establish guidance on the basic requirements for all PCS providers regarding compliance program structure to ensure continuity within its Medicaid PCS program.

Liberty Homecare Options (Liberty) is privately-owned, and has been providing in-home personal care services to the elderly and disabled populations for the state since May 2014. Liberty has a comprehensive compliance program facilitated by their compliance officer, who

also serves as their Human Resources manager. Liberty has a robust compliance program, and has enacted safeguards that surpass minimum standards required by DSS. When Liberty receives a complaint of suspected fraud, the PCA is placed on probation or suspended from work while an internal investigation is conducted. In instances of timesheet fraud, PCAs were terminated "almost immediately." Adequate records are stored and provided to the Department of Labor that indicate the employee was terminated for fraudulent conduct. This record ensures that unemployment is not collected if the employee attempts to access unemployment compensation and benefits. The Department of Labor may have an unofficial record of PCAs that have been identified for suspected fraud. Liberty does not notify DSS when an employee is terminated for suspected fraud, and DSS 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 homemaker-companion agencies providing PCS.

The DSS has not adopted compliant language, policies, and procedures for identifying and reporting adverse provider terminations. The Medicaid Provider Enrollment Compendium (MPEC)[1] states for-cause adverse terminations may include, but is not limited to, termination for reasons based upon fraud, integrity, or quality. The MPEC provides guidance on identifying and mandatory reporting of for cause terminations.

Recommendation #9: The DSS should: 1) Develop adverse termination criteria consistent with guidance listed in the MPEC, including prompt notification requirements for advertise terminations. 2) Develop policies and procedures for implementing, reporting, and investigating adverse terminations. 3) Amend the provider agreement to communicate the criteria and requirements to providers.

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, Connecticut does utilize an EVV system for in-home scheduling, tracking and billing for agency-directed PCS providers. Connecticut has utilized EVV for agency providers for several years before the 21st Century Cures Act required states to implement EVV. The DSS is currently in the process of piloting EVV with the self-directed program, and in process of fully implementing EVV for self-directed aides. The DSS projects EVV will be fully implemented for self-directed aides by December 2020. Pursuant to Section 12006 of the 21st Century Cures Act, all states are required to implement an EVV system for PCS by January 1, 2020. The DSS advised CMS that they are in the process of requesting an extension from CMS to accommodate the required full implementation of EVV.

[1] https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf

Status of Corrective Action Plan from Year 2018 Review

Connecticut's last CMS program integrity review was in September 2015 and the report for that review was issued in May 2016. The report contained nine vulnerabilities. CMS completed a desk review of the corrective action plan in April 2018. The desk review indicated that the findings from the 2015 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 Connecticut 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. 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
- Review the Medicaid and CHIP FAQs document titled "Allowability of Using National Provider Identifiers (NPIs) for Medicaid Personal Care Attendants (PCAs)." This document can be accessed at the following link https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/FAQs-Using-NPIs-for-Medicaid-PCAs.pdf
- 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.

Conclusion

The CMS supports Connecticut efforts and encourages the state to look for additional opportunities to improve overall program integrity. The CMS focused review identified areas 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 state Medicaid agency is responsible for correcting 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 taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

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