

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Maine Focused Program Integrity Review

Medicaid Personal Care Services

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Final Report

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I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review of Maine's Medicaid Personal Care Services (PCS) program to assess the state's program integrity oversight efforts for Fiscal Years (FY) 2021 – 2023. This focused review specifically assessed the state's compliance with CMS regulatory PCS requirements within 42 CFR Parts 440, 441, and 455. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in the delivery of these services.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to the CMS PCS review tool provided at the initiation of the review, CMS also conducted in-depth interviews with the state Medicaid agency (SMA) and evaluated program integrity activities performed by selected agencies under contract to provide PCS to Medicaid beneficiaries.

This report includes CMS' findings and resulting recommendations, as well as observations, that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified one finding that creates risk to the Maine Medicaid program related to PCS program integrity oversight. Specifically, CMS found that Maine needs to fully implement Fingerprint-based Criminal Background Checks (FCBCs) as required by CMS effective July 1, 2018. In response to the finding, CMS identified **one** recommendation that will enable the state to come into compliance with federal and/or state Medicaid requirements related to PCS program integrity oversight. This recommendation is as following:

Provider Enrollment and Screening

Recommendation #1: Pursuant to § 455.434, CMS recommends Maine ensure the full implementation of the FCBCs as required by CMS effective July 1, 2018.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid PCS program. CMS identified **six** observations related to Maine’s PCS program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

State Oversight of PCS Program Integrity Activities and Expenditures

Observation #1: CMS encourages Maine to review and update their Memorandum of Understanding (MOU) between Office of MaineCare Services (OMS) and the Office of Aging and Disability Services (OADS), to include language related to Section 18, which covers the Home and Community-Based Services (HCBS) Brain Injury waiver.

Observation #2: CMS encourages Maine to establish program integrity policies and procedures for conducting post-payment reviews of PCS claims. These reviews should focus on identifying and investigating providers who may have an unusually high number of PCS visits that are manually entered or adjusted within the Electronic Visit Verification (EVV) system. Furthermore, CMS encourages Maine to leverage EVV data when performing data analytics to identify outliers and patterns in post-payment reviews, enhancing the detection of potential program abuses.

Provider Enrollment and Screening

Observation #3: CMS encourages Maine to require annual training for all PCS providers and require a program integrity component for initial and annual training. Annual training could include updates to PCS program rules and/or guidance, PCS billing requirements, and prevention, detection, investigation, referral, and reporting of fraud, waste, and abuse.

State Oversight of Self-Directed and Agency-Based Services

Observation #4: CMS encourages Maine to ensure that Medicaid Management Information System (MMIS) edits are active to detect overlapping claims with institutional care and to flag PCS claims exceeding 24 hours in a single day. Enabling these edits will strengthen program integrity and increase the identification and referral of potential fraud, waste, and abuse within PCS by allowing Maine to capture overlapping claims prior to the post-claims review process. Thereby, avoiding a “pay and chase” situation.

Observation #5: CMS encourages Maine to implement additional program integrity measures, such as placing providers with repeated billing errors on payment suspensions or corrective action plans requiring follow-up. These actions would enhance OMS’s ability to identify and address instances of fraud, waste, and abuse both at the agency level and by individual personal care attendants (PCAs).

Observation #6: CMS encourages the SMA to perform systematic audits to identify and address irregularities within self-directed PCS. The SMA's reliance on Service Coordination Agencies (SCAs) and Fiscal Intermediaries (FIs) for the identification of outliers and policy violations introduces a gap in oversight in self-directed PCS, as there is no systematic review of beneficiary records conducted directly by the SMA to identify potential outliers in PCS usage. Although the FI performs data mining using basic algorithms, this approach may lack the depth necessary for a robust fraud detection system. Without direct, systematic audits, the SMA may miss opportunities to proactively identify and address irregularities within self-directed PCS, potentially impacting program integrity and accountability.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for FYs 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.¹ The plan encompassed efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts focused program integrity reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and PCS. These reviews assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Personal Care Services

Medicaid PCS are services provided to eligible beneficiaries that help them to stay in their own homes and communities rather than live in institutional settings, such as nursing facilities. The PCS benefit is provided according to a state's approved plan, waiver, or demonstration and are optional Medicaid services, except when medically necessary for children eligible for early and periodic screening, diagnostic, and treatment (EPSDT) services. PCS are categorized as a range of assistance provided to persons with disabilities and chronic conditions to enable them to accomplish activities of daily living (ADLs) or instrumental activities of daily living (IADLs). An independent or agency-based personal care attendant (PCA) may provide ADL services, which include eating, bathing, dressing, ambulation, and transfers from one position to another, and IADL services, which include day-to-day tasks that allow an individual to live independently but are not considered necessary for fundamental daily functioning, such as meal preparation, hygiene, light housework, and shopping for food and clothing.

¹ A more current plan exists, however, this was the plan during the timeframe of the audit:
<https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf>

States administer their Medicaid programs within broad federal rules and according to requirements of the specific authority approved by CMS. Pursuant to 42 CFR Part 440, states can choose to provide PCS for eligible beneficiaries through their state plan, a waiver, or a Section 1115 demonstration. Because PCS are typically an optional benefit, they can vary greatly by state and within states, depending on the Medicaid authority used to cover the benefit. Under federal statute and regulations, PCS must be approved by a physician or through some other authority recognized by the state. Beneficiaries receiving PCS 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 who have met certain training and enrollment requirements, as designated by each state.

Overview of the Maine Personal Care Services Program and the Focused Program Integrity Review

The Maine Department of Health and Human Services (DHHS), OMS is the agency responsible for the administration of the Maine Medicaid program, MaineCare. Within DHHS, the Program Integrity Unit (PIU) is the organizational unit tasked with oversight of program integrity-related functions, including those related to PCS. The PCS program is administered and monitored by the OMS and its sister agency, OADS, through an MOU agreement.

Maine administers Medicaid PCS to eligible beneficiaries under the Section 1905(a) state plan authority and Section 1915(c) Home and Community-Based Services (HCBS) waiver authority. PCS falls under HCBS, which are types of person-centered care delivered in the home and community. Detailed descriptions of the Maine Medicaid PCS Programs and their applications can be found in Appendix C.

In FY 2023, Maine's total Medicaid expenditures were approximately \$4.3 billion, providing coverage to approximately 367,783 beneficiaries. Maine's Medicaid expenditures for PCS totaled approximately \$331 million, and 12,646 beneficiaries received PCS. The OMS offers both agency-based and participant-directed PCS options. Appendix C provides enrollment and expenditure data for the PCS population in Maine.

In June 2024, CMS conducted a focused program integrity review of Maine's PCS program. This focused review assessed the state's compliance with regulatory requirements at 42 CFR Parts 440, 441, 455, and 456, as well as Sections 1905(a), 1915(c), and 1915(j) of the Social Security Act (the Act). As a part of this review, CMS conducted interviews with SMA staff involved in the administration of PCS to validate the state's program integrity practices, as well as with key personnel within three PCS agencies. CMS also evaluated the status of Maine's previous corrective action plan developed by the state in response to a PCS focused review conducted by CMS in 2019, the results of which can be found in Appendix A.

During this review, CMS identified a total of one recommendation and six observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to CMS' draft report (when forwarded) can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the three following areas:

- A. State Oversight of PCS Program Integrity Activities and Expenditures** – States share responsibility with CMS for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse. States must meet various statutory and regulatory requirements, such as program integrity safeguards in 42 CFR Parts 455 and 456, to maintain effective oversight of their Medicaid programs. In addition, pursuant to Section 12006(a) of the 21st Century Cures Act, all states were required to implement an Electronic Visit Verification (EVV) system for PCS by January 1, 2020. Failure to meet this requirement results in incremental Federal Medical Assistance Percentage (FMAP) reductions of up to 1 percent, unless the state has both made a “good faith effort” to comply and has encountered “unavoidable delays.”
- B. Provider Enrollment and Screening** – As defined by § 440.167, PCS must be provided by an individual who is qualified to provide such services, unless defined differently by a state agency for purposes of a waiver granted under part 441, subpart G.² In accordance with these standards, state law often requires PCS agency staff and attendants to be subject to enhanced screening and credentialing procedures at the date of hire and annually thereafter. CMS regulations at § 455.436 require that the SMA conduct database checks to determine the exclusion status of providers, persons with an ownership or control interest, and agents and managing employees on the 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 (NPPES) upon enrollment and reenrollment, and check the LEIE and SAM no less frequently than monthly. In accordance with § 455.434, PCS agencies or attendants that enroll in Medicaid as providers are also subject to federal screening requirements found at § 455.410.
- C. State Oversight of Self-Directed and Agency-Based Services** – States may elect to offer self-directed PCS through several pathways, including the state plan, Section 1915(c) waivers, and specific provisions under Sections 1915(j) and 1915(k). These options allow participants, or their authorized representatives, to exercise choice and control over the planning, budgeting, and purchase of self-directed PCS. CMS regulations at 42 CFR 441 Subpart J govern the use of self-direction under these options, outlining the requirements for oversight and support of participants’ control in managing their care. Self-directed PCS under the state plan and Section 1915(c) waivers enable beneficiaries to tailor their care according to their specific needs and preferences while maintaining autonomy. Alternatively, beneficiaries may receive agency-based PCS, where a personal care agency provides oversight, management, and supervision of their services. Agency-based PCS are available through either state plan or waiver authority. In accordance with §§ 441.302 and 441.570, the SMA must ensure that adequate safeguards are in place to

² The conditions of participation for home health aides participating in PCS programs are further detailed at § 484.80.

protect the health and welfare of individuals receiving PCS through these options and maintain financial accountability for all funds expended on PCS provided through waiver or state plan authority to uphold program integrity and compliance with federal standards.

III. Results of the Review

A. State Oversight of PCS Program Integrity Activities and Expenditures

States share responsibility with CMS for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse. States must meet various statutory and regulatory requirements, such as program integrity safeguards in 42 CFR Parts 455 and 456, to maintain effective oversight of their Medicaid programs. In Maine, these oversight and monitoring requirements were not met. This section addresses the lack of oversight and monitoring with a recommendation and observations noted at the end of this section.

As required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and beneficiaries. In addition, Section 1902(a)(30) of the Act and federal regulations at 42 CFR Part 456 require the state plan to provide for the establishment and implementation of a statewide surveillance and utilization control program that provides methods and procedures to safeguard against unnecessary or inappropriate utilization of care, services, and excess payments. States often meet these requirements through implementation of a surveillance and utilization review subsystem (SURS) within the Medicaid Management Information System (MMIS) and/or discrete SURS Units that are a part of larger program integrity efforts.

In Maine, OMS is responsible for Medicaid program integrity activities and OADS is responsible for monitoring and oversight of PCS agencies, SCAs, and FIs. However, the MOU between OMS and OADS does not include language specific to Section 18 – HCBS Brain Injury waiver.

The OMS has established PCS program participation and reporting requirements through state policy. OADS independently conducts programmatic audits to ensure compliance with established program guidelines. OADS identifies suspected fraud and abuse within the Medicaid program by reviewing paid claims history and conducting investigations. Each PCS agency is subject to an annual audit that includes, but is not limited to, reviews of personnel files, client records, and service billing records. The PCS agencies are potentially subject to recoupments and corrective action plans if programmatic deficiencies are discovered during the audit. According to Chapter I, Section 1 of the MaineCare Benefits Manual, the SMA is required to suspend payments to a provider upon a credible allegation of fraud for which an investigation is pending, unless a good cause exemption exists. Detailed information on post-payment actions taken as a result of PCS provider audits can be found in Appendix C.

In addition, Maine DHHS holds an MOU with the Maine MFCU, Office of the Attorney General, Healthcare Crimes Unit. The DHHS must promptly refer all cases of suspected provider fraud to the MFCU no later than the next business day after any payment suspension is enacted.

The MFCU and DHHS meet quarterly, or more often as necessary, to exchange information, update cases, and discuss issues of mutual concern.

States are also required to implement an EVV system to help oversee PCS providers. EVV is used to verify that PCS visits occurred and can be performed through a number of methods, including telephonic or GPS-enabled mobile applications. Pursuant to Section 12006(a) of the 21st Century Cures Act, all states were required to implement an EVV system for PCS by January 1, 2020. Failure to meet this requirement results in incremental FMAP reductions of up to 1 percent, unless the state has both made a “good faith effort” to comply and has encountered “unavoidable delays.”

Currently, Maine does utilize an EVV system for in-home scheduling, tracking, and billing for PCS providers. Maine contracts with Sandata Technologies, the vendor chosen for the Maine EVV system. A provider may use a third-party system other than Sandata if the third-party system fulfills the requirements of the 21st Century Cures Act and the system can transfer information to Sandata through system integration. All PCS agencies interviewed reported using Sandata. The Maine EVV system is a state-wide, open model system that has been in place since January 1, 2021, and is in compliance with Section 12006(a) of the 21st Century Cures Act.

Although Maine’s EVV system complies with federal requirements, CMS identified issues with post-payment review policies. The state does not have a process in place and has not established policies and procedures for post-payment review of EVV data. Despite established EVV verification processes in place within the system, CMS noted that many PCS providers made excessive manual adjustments in the EVV system, with one provider logging over 7,000 adjustments in a three-month span in 2022, indicating potential oversight gaps.

Observation #1: CMS encourages Maine to review and update their MOU between OMS and OADS, to include language related to Section 18, which covers the HCBS Brain Injury waiver.

Observation #2: CMS encourages Maine to establish program integrity policies and procedures for conducting post-payment reviews of PCS claims. These reviews should focus on identifying and investigating providers who may have an unusually high number of PCS visits that are manually entered or adjusted within the EVV system. Furthermore, CMS encourages Maine to leverage EVV data when performing data analytics to identify outliers and patterns in post-payment reviews, enhancing the detection of potential program abuses.

B. Provider Enrollment and Screening

CMS regulations at § 455.436 require that the SMA conduct database checks to verify the exclusion status of the provider, persons with an ownership or control interest, and agents and managing employees on the HHS-OIG’s LEIE, SAM, SSA-DMF, and NPPES upon enrollment and reenrollment, and check the LEIE and SAM no less frequently than monthly.

For agency directed services available under the state plan and Section 1915(c) waiver

authorities, responsibility for compliance with § 455.436 is delegated to the agency. Compliance requirements for this regulation apply only to providers who are enrolled in Fee-For-Service Medicaid and are issued a Medicaid provider ID. CMS confirmed that OMS has a state policy in place addressing this requirement. For PCAs not enrolled with the state, federal database checks (e.g., LEIE or SAM) are not required under federal law for either traditional or managed care Medicaid, though states may impose their own requirements. General provider participation requirements applicable to all Medicaid providers are located in Chapter I, Section 1 of the MaineCare Benefits Manual.³ In addition, providers are subject to the requirements specific to the various sections of policy covering the service it is delivering. For self-directed services available under the state plan and waiver authorities, the FIs perform administrative support services on behalf of beneficiaries. Initially, every PCS provider (e.g., personal care agency, home health agency, waiver agency) must enroll as a Medicaid provider by completing an online enrollment application and an executed provider agreement. This agreement must be renewed at least every five years. The SMA contracts with fiscal agent Gainwell Technologies to perform enrollment credentialing functions including, but not limited to, verifying any required licenses and performing database checks on all providers at all risk levels; individuals with ownership or controlling interest of five percent or more in the disclosing entity; board members; managing employees; and rendering, non-billing, ordering, and prescribing providers. These screenings include an automated criminal history background check, federal exclusion database checks that include the LEIE, SAM, SSA-DMF, and the NPPES. These screenings are performed through automated database checks during the initial enrollment and monthly thereafter.

The Division of Licensing and Certification (DLC), PIU, and OADS have separate but sometimes overlapping responsibilities for provider oversight, including program integrity reviews, quality assurance reviews, ad hoc audits, and follow-up of any complaints. For providers who are licensed, the DLC performs annual licensing reviews to ensure background checks are conducted. The PIU also reviews credentials and background checks when conducting investigations or reviews. The state verifies compliance with requirements during enrollment, revalidation, and during post-payment or other reviews.

In accordance with § 455.410, PCS agencies or attendants that enroll in Medicaid as providers are subject to federal screening requirements found at § 455.450. As a condition of enrollment in Medicaid, SMAs must require high-risk providers to consent to Fingerprint-based Criminal Background Checks (FCBCs) when required to do so under state law or by the level of screening based on their fraud, waste, and abuse risk, as determined for that category of provider, in accordance with § 455.434. High-risk and moderate-risk providers are subject to enhanced screening.

Enrollment screening requirements apply to all applications (i.e., new enrollments, revalidations) and are based on categorical risk levels. In Maine, PCS agencies are generally classified as moderate risk, while newly enrolled home health agencies are designated as high risk. In accordance with 455.450 and supported by the MaineCare Benefits Manual policies and procedures⁴, providers classified as high-risk are required to consent to FCBCs, and those categorized as moderate or high-risk must undergo on-site inspections at their service locations.

³ [Chapter 101, Ch. I - Section 1 of the Department of Health and Human Services \(Maine\)](#)

⁴ [Chapter 101 of the Department of Health and Human Services \(Maine\)](#)

All PCS agencies must comply with the enhanced screening requirements outlined in 455.450.

During the review period, the SMA did not conduct FCBCs on Medicaid PCS providers or other home health agency providers. Although Maine's legislature has authorized fingerprint checks, annual delays in finalizing regulations and accessing the national criminal database have impeded compliance with federal screening requirements.

In accordance with State regulations, PCS agency staff and attendants are subject to enhanced screening and credentialing procedures at the date of hire and periodically thereafter. Maine does not require PCAs providing agency-directed services to be licensed or enrolled in MaineCare, therefore it is the responsibility of the employing agency to perform the appropriate background checks according to the specific state plan and waiver requirements. In Maine, PCS may be provided by a home health aide, certified nursing assistant, personal support specialist (PSS), or certified residential medication aide. Chapter II, Section 96 of the MaineCare Benefits Manual requires that the PSS be employed by or acting under a contractual relationship with a licensed home health agency, registered personal care agency, or licensed assisted living agency under contract with OADS, among other requirements. PCS providers are to use the Maine Background Check Center (MBCC) to perform a comprehensive background check of applicants across multiple registries (e.g., Maine Registry of Certified Nursing Assistants and Direct Care Workers, Maine Excluded Providers, LEIE, Maine State Criminal History check). All PCAs hired by employers are automatically enrolled in criminal record rap back monitoring as a function of the MBCC search for five years.

Each PCS agency must assure that PCAs meet specific training, competency, and other regulatory requirements. An individual without the required training may be hired and reimbursed for PCS delivery if they enroll in a certified training program within 60 days of hire and complete both the training and examination requirements within nine months of employment. All other requirements must also be met. If the individual fails to pass the examination within nine months, reimbursement for their services must stop until such time as the training and examination requirements are met. In addition, a newly hired PSS must receive an agency orientation and must obtain certification from the DLC in order to be eligible to provide services. While initial training is required upon hire, PCS providers are not required to participate in annual training, including fraud prevention training. Documentation of background checks and required training must be maintained by the provider for all staff and will be reviewed during the agency's annual evaluations.

As part of the CMS review, three PCS agencies—Comfort Home Care, In Home Senior Services, and R & C Home Care/In Home Care—were selected for interviews. The purpose was to assess whether these agencies maintain appropriate oversight of service quality and integrity for beneficiaries in accordance with state standards. Each agency utilized the MBCC to perform required background checks for new hires and conducted these checks annually thereafter.

CMS determined that Maine has not met one federal screening requirement.

Recommendation #1: Pursuant to § 455.434, CMS recommends Maine ensure the full implementation of the FCBCs as required by CMS effective July 1, 2018.

Observation #3: CMS encourages Maine to require annual training for all PCS providers and require a program integrity component for initial and annual training. Annual training could include updates to PCS program rules and/or guidance, PCS billing requirements, and prevention, detection, investigation, referral, and reporting of fraud, waste, and abuse.

C. State Oversight of Self-Directed and Agency-Based Services

A self-directed PCS state option allows beneficiaries or their representatives, if applicable, to exercise decision-making authority in identifying, accessing, managing, and purchasing their PCS. A state offering a self-directed option must assure that certain necessary safeguards have been taken to protect the health and welfare of individuals furnishing services under the program and assure the financial accountability for funds expended for self-directed services in accordance with § 441.464. These safeguards must include prevention against the premature depletion of the beneficiary directed budget, as well as identification of potential service delivery problems that might be associated with budget underutilization.

MaineCare offers self-directed PCS through two state plan options (Sections 12 and 96) and two 1915(c) waivers (Section 19 and 29). For self-directed PCS, the beneficiary is the employer of record and employs the PCA. The beneficiary is responsible for hiring, firing, training, and scheduling PCAs. Maine ensures these requirements are met through the utilization of FIs⁵, or SCAs, that provide care coordination, skills training, administrative functions, including but not limited to, maintaining beneficiary records, submitting claims, conducting internal utilization and quality assurance activities, documenting investigation and resolution of complaints, conducting required background checks and processing payroll, withholdings, filings and payment of applicable taxes and insurances. The FI supplies the state with quarterly reporting on complaints and complaint resolutions, annual satisfaction survey report, etc.

The SMA does not conduct regular audits of self-directed beneficiary records to identify potential outliers. Alternatively, the state relies, in part, on the SCAs and FIs to identify policy violations and potential fraud, waste, and abuse. The FI conducts data mining through basic algorithms, such as checking the number of hours billed per day or number of units used against the authorization. The SCAs meet regularly with staff from OADS to discuss matters, including PCS. In addition, OADS has quarterly long-term care system meetings that may include PCS providers, case management agencies, the FIs, and the state's assessing services agency depending on the topics discussed. The SMA relies on SCAs and FIs to identify outliers and policy violations in self-directed PCS; this introduces a gap in oversight, as there is no systematic review of beneficiary records conducted directly by the SMA to identify potential outliers in PCS usage.

Beneficiaries in Maine can also elect to have their care overseen, managed, and supervised by a personal care agency. Agency-based PCS is available under state plan/waiver authority. In accordance with §§ 441.302 and 441.570, the SMA must ensure that certain safeguards are in

⁵ During the review period the three FIs were SeniorsPlus LLC, Attendant Services Maine, and GT Independence,

place to protect the health and welfare of individuals furnishing services under the program and to maintain the financial accountability for agency-based PCS expenditures. Maine meets these requirements through prior authorization of PCS based on each beneficiary's needs, identified through a person-centered service planning process. This care plan is updated as required based on ongoing assessments of the beneficiary's progress and needs. Claim edits are in place in the MMIS to deny any claim where the number of billed units exceed the number of allowed units on an approved care plan.

Additionally, PCS agencies are subject to audits, reviews, and data mining by the OMS PIU to identify aberrant billing patterns, etc. This unit conducts post payment reviews and data mining to identify potential errors at the provider agency level including reviewing PCS claims submitted after a beneficiary's date of death and claims for services billed during a beneficiary's inpatient or nursing facility stay. However, there were no operational pre-payment edits in place in the MMIS system to identify PCS overlap with an institutional claim or billing in excess of 24 hours. Implementing additional program integrity measures, such as reviewing supporting documentation for claims, could help prevent and detect improper billing. When documentation is not submitted promptly, the PIU could consider corrective and/or administrative actions such as payment suspension, placing providers on corrective action plans, or referring cases to the MFCU. Claims data analysis over multiple years could also be used to identify trends and providers with recurrent billing issues, supporting OMS in detecting fraud, waste, and abuse at the agency and individual PCA levels.

Maine reported that its fiscal agent, Gainwell, conducts monthly beneficiary verifications using a random sample of MaineCare beneficiaries to confirm that services were received as billed. While this approach meets the federal requirement under § 455.20, CMS notes that the process could be further strengthened through more clearly documented verification methodologies, standardized tracking elements (e.g., provider type, service type, delivery model), and enhanced controls to support ongoing monitoring, reporting, and program oversight. CMS determined that Maine has met federal monitoring requirements; however, CMS encourages the state to ensure certain MMIS edits are active, implement additional program integrity controls and policies and procedures, to help OMS identify fraud, waste, and abuse, and take a more proactive approach in identifying outliers and policy violations within self-directed PCS.

Observation #4: CMS encourages Maine to ensure that MMIS edits are active to detect overlapping claims with institutional care and to flag PCS claims exceeding 24 hours in a single day. Enabling these edits will strengthen program integrity and increase the identification and referral of potential fraud, waste, and abuse within PCS.

Observation #5: CMS encourages Maine to implement additional program integrity measures, such as placing providers with repeated billing errors on payment suspensions or corrective action plans requiring follow-up. These actions would enhance OMS's ability to identify and address instances of fraud, waste, and abuse both at the agency level and by individual PCAs.

Observation #6: CMS encourages the SMA to perform systematic audits to identify and

address irregularities within self-directed PCS. The SMA's reliance on SCAs and FIs for the identification of outliers and policy violations introduces a gap in oversight in self-directed PCS, as there is no systematic review of beneficiary records conducted directly by the SMA to identify potential outliers in PCS usage. Although the FI performs data mining using basic algorithms, this approach may lack the depth necessary for a robust fraud detection system. Without direct, systematic audits, the SMA may miss opportunities to proactively identify and address irregularities within self-directed PCS, potentially impacting program integrity and accountability.

IV. Conclusion

CMS supports Maine's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified one recommendation and six observations that require the state's attention.

We require the state to provide a corrective action plan for the one recommendation within 30 calendar days from the date of issuance of the final report. The corrective action plan should explain how the state will ensure that the recommendation has 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 SMA 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 acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

The state is not required to develop a corrective action plan for the six observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

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

V. Appendices

Appendix A: Results of the Prior Review

Maine's last CMS program integrity review was in May 2019, and the report for that review was issued in November 2019. The report contained nine recommendations. During the virtual review in June 2024, CMS conducted a thorough review of the corrective actions taken by Maine to address all recommendations reported in calendar year 2019. The findings from the 2019 Maine focused program integrity review report have not all been corrected by the state, as noted below.

Findings

1. *The state should consider updating the current MOU between OMS and OADS. The MOU should clearly describe OADS monitoring and PCS oversight of the personal care agencies and FIs.*

Status at time of the review: Corrected

2. *The state and the MFCU should consider providing quarterly training related to Medicaid fraud, waste, and abuse to OADS.*

Status at time of the review: Corrected

3. *The state should ensure that the MMIS edits proposed for overlap with institutional claims and billing in excess of 24 hours are operational.*

Status at time of the review: Not Corrected

Maine indicated there were no operational pre-payment edits in place in the MMIS system to identify PCS overlap with an institutional claim and PCS claims billed in excess of 24 hours.

4. *The state should ensure that the contract between OADS and the FIs is amended to list a requirement that the FIs receive training on fraud, waste, and abuse.*

Status at time of the review: Corrected

5. *The state should develop a provider enrollment policy pursuant to 42 CFR § 1002.3(b) that requires reporting to HHS-OIG any adverse actions the state takes on provider applications for participation in the program. If a provider is denied participation in the program HHS-OIG will be notified.*

Status at time of the review: Corrected

6. *Pursuant to 42 CFR § 455.434, the state should ensure the full implementation of the FCBCs requirement as required by CMS effective July 1, 2018.*

Status at time of the review: Not Corrected

Maine indicated that due to extensive delays in approval of state regulations and access to the national criminal database, the state has not yet implemented FCBCs as required by §

455.434

7. Pursuant to 42 CFR § 455.436, the state should ensure the PCS agencies complete the necessary federal database checks upon enrollment and on a monthly basis thereafter.
Status at time of the review: Corrected

8. The state should consider providing regular training opportunities for PCS providers related to topics (including but not limited to) updates related to PCS program rules and/or guidance, PCS billing requirements, PCS fraud, waste, and abuse identification, and referral and reporting requirements.
Status at time of the review: Partially Corrected

Maine indicated that newly enrolling personal care agencies are required to perform training prior to enrolling; however, there does not appear to be a program integrity component in initial training and annual training is not required.

9. The state should ensure that the implementation of the EVV system for PCS with the current contractor, Sandata is effective by January 1, 2020.
Status at time of the review: Corrected

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access the Resources for State Medicaid Agencies website at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs> to address techniques for collaborating with MFCUs.
- Access the CMS frequently asked questions document, Allowability of Using National Provider Identifiers (NPIs) for Medicaid Personal Care Attendants (PCAs), at <https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/faqs-using-npis-for-medicaid-pcas.pdf>
- Access Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services at <https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/vulnerabilities-mitigation-strategies.pdf>
- Access the Preventing Medicaid Improper Payments for Personal Care Services fact sheet and booklet at <https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/pcs-prevent-improperpayment-factsheet.pdf> and <https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/pcs-prevent-improperpayment-booklet.pdf>
- Access the Medicaid Payment Suspension Toolkit at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf>, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts.
- 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>
- 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.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at <https://www.cms.gov/hfpp>.

Appendix C: Program Information

Table C-1 provides detailed information on the PCS programs available in Maine at the time of the audit.⁶

Table C-1. Maine Medicaid PCS Programs

Program Name/Federal Authority	Administered By	Description of the Program
<i>State Plan Authorities</i>		
Section 12 - Consumer Directed Attendant Services	OMS and OADS	Section 12 provides PCS for adults 18 years or older with a disability who have functional impairments that interfere with self-care and ADLs but have the cognitive capacity to competently direct and manage PCS.
Section 26 - Day Health Services	OMS and OADS	Section 26 provides health services, including PCS, outside of the beneficiary's home to those who meet MaineCare eligibility requirements.
Section 40 - Home Health Services		Section 40 provides home health aide services which may include PCS to the beneficiary to maintain health, or to facilitate treatment of the beneficiary's illness.
Section 96 - Private Duty Nursing and Personal Care Services	OMS and OADS	Section 96 provides services, including PCS, to people of any age who meet MaineCare requirements.
Section 97 - Private Non-Medical Institution (PNMI) Services	OMS and OADS	Section 97 provides services, including PCS, to eligible beneficiaries that meet the criteria to receive care in a PNMI.
<i>Section 1915(c) HCBS Waiver Authorities</i>		
Section 18 - HCBS for Members with Brain Injury (ME.1082)	OADS	Section 18 provides services, including PCS, to adults with a diagnosis of acquired brain injury who are 18 or older, meet criteria for care in an intermediate care facility or nursing facility and choose to live in the community with the support of this waiver.
Section 19 - HCBS Elderly and Adults with Disabilities (ME.0276)	OADS	Section 19 provides services, including PCS, to individuals ages 65 or older and individuals with physical disabilities ages 18 or older who meet a hospital or nursing facility level of care.
Section 20 - HCBS for Adults with Other Related Conditions (ME.0995)	OADS	Section 20 provides services, including PCS, for beneficiaries aged 21 years and older with cerebral palsy, epilepsy, or any other condition other than mental illness that requires treatment similar to beneficiaries with intellectual disabilities. Beneficiaries must meet the criteria to receive services from an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
Section 21 - HCBS for Adults	OADS	Section 21 provides services, including PCS, to

⁶ For PCS state policies by program, see specific sections in the [10-144-Chapter 101 - MaineCare Benefits Manual](#)

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Program Name/Federal Authority	Administered By	Description of the Program
with Intellectual Disabilities or Autism Spectrum Disorder (ME.0159)		individuals with autism or intellectual disabilities ages 18 or older who meet an ICF/IID level of care.
Section 29 - Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder (ME.0467)	OADS	Section 29 provides services, including PCS, to adults with intellectual disabilities or autism spectrum disorder ages 18 or older who meet an ICF/IID level of care.

Table C-2. Maine PCS Enrollment by Authority

	FY 2021	FY 2022	FY 2023
State Plan Authority	8,082	8,167	8,463
1915(c) HCBS Waiver Authority	3,933	3,978	4,183

Table C-3. Summary of Maine PCS Expenditures by Authority

	FY 2021	FY 2022	FY 2023
State Plan Authority	\$167,668,864	\$176,890,923	\$190,005,934
1915(c) HCBS Waiver Authority	\$101,942,253	\$117,555,220	\$141,839,614

Note: During the past three FFYs, the Maine State Legislature has directed rate increases for various services, including PCS.

Table C-4. Waiver Authority Expenditures by Type

1915(c) HCBS Waiver Authority	FY 2021	FY 2022	FY 2023
Section 18 - HCBS for Members with Brain Injury (ME.1082)	\$148,946	\$177,926	\$136,990
Section 19 – HCBS Elderly and Adults with Disabilities (ME.0276)	\$78,806,343	\$93,345,171	\$115,142,026
Section 20 - HCBS for Adults with Other Related Conditions (ME.0995)	\$2,360,025	\$2,324,646	\$2,546,508
Section 21 – HCBS for Adults with Intellectual Disabilities or Autism Spectrum Disorder (ME.0159)	\$14,365,999	\$15,257,998	\$16,111,617
Section 29 - Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder (ME.0467)	\$6,260,940	\$6,449,479	\$7,902,473

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

Agency-Directed and Self-Directed Combined	FY 2021	FY 2022	FY 2023
Identified Overpayments	\$2,369,036	\$1,348,356	\$1,929,856
Recovered Overpayments	\$59,814	\$245,030	\$328,721
Terminated Providers	0	0	0
Suspected Fraud Referrals	28	46	90
Number of Fraud Referrals Made to MFCU	2	2	1

Appendix D: State Program Integrity Review Response

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an “X” in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
Recommendation #1	Pursuant to § 455.434, CMS recommends Maine ensure the full implementation of the Fingerprint-based Criminal Background Checks (FCBCs) as required by CMS effective July 1, 2018.	X	

Acknowledged by:

William Logan, Associate Director of Compliance, Office of MaineCare Services

February 2, 2026