Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Maine Focused Program Integrity Review

Final Report

November 2019

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Objective of the Review

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 assist 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 Maine Medicaid personal care services (PCS). The objective of the review was to assess the level of program integrity oversight of Medicaid PCS at the state level. A secondary objective of the review was to provide the state with useful feedback, discussions and technical assistance resources that may be used to enhance program integrity in the delivery of these services. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous program integrity review conducted in calendar year 2012.

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

Pursuant to the regulations found at 42 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 May 6-10, 2019, the CMS review team visited the Office of MaineCare Services (OMS). They 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/or 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/Consumer-Directed Services, Personal Care Services Provider Enrollment, Oversight of Personal Care Services Providers, and Electronic Visit Verification (EVV). The recommendations will be detailed further in the next section of the report.

Overview of Maine's Medicaid Personal Care Services

- As of March 1, 2018 Maine's Medicaid expenditures totaled approximately $2.9 billion, while the number of beneficiaries served via Medicaid totaled approximately 270,507 beneficiaries.
- In FFY18, Maine's Medicaid personal care services expenditures totaled approximately $203.6 million, while the number of beneficiaries receiving personal care services totaled approximately 11,079.
- In Maine PCS are authorized through both state plan and 1915 (c) waivers.
- All of Maine's PCS is reimbursed on a traditional fee-for-service methodology.

Overview of Maine's Administration of Personal Care Services

- The OMS is the state of Maine's designated single state agency with responsibility for administering the Medicaid Program.
- Both the Office of Aging and Disability Services (OADS) a sister agency and OMS have responsibility for the oversight of the PCS program
- The OMS PCS program does include self-directed options. Service Coordination Agencies (SCAs) are responsible for administrative functions relating to PCS self-directed services.

Summary of PCS in Maine

The OMS administers Medicaid PCS to eligible beneficiaries under the State Plan and 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. The Table 1 below provides details of the programs.

Table1.

Program Name /Federal Authority	Administered By	Description of the Program
State Plan- Section 12 - Consumer Directed Attendant Services[1]	OMS and OADS	Eligible members with disabilities can receive assistance with ADLs, instrumental ADLs, and health maintenance activities. Self – directed option: Yes- however PCS cannot be provided by a member of the recipient's family.
State Plan- Section 40 - Home Health Services[2]	OMS and OADS	Eligible members in need of Home Health Services must be required in conjunction with skilled nursing services, physical therapy or occupational therapy. Home Health Aide (HHA) services must be ordered by a physician with specified frequency and duration in the plan of care. The HHA can provide personal care services per the plan of care. All of the PCS provided to the member are non-skilled services. Self- directed option : No
State Plan- Section 96 - Private Duty Nursing and Personal Care Services[3]	OMS and OADS	Eligible members that meet the criteria to receive PCS in the home community. PCS may include: ADLs, instrumental ADLs, and medication administration services provided to a member by a HHA, certified nursing assistant personal support specialist (PSS), or certified residential medicine aide (CRMA) while competing tasks in accordance with an authorized plan of care. Self- directed option: Yes
State Plan- Section 97 - Private Non-Medical Institution Services[4]	OMS and OADS	Eligible members that meet the criteria to receive PCS in private non-medical institutions based upon a plan of care. Self-directed option : No

[1] 10-144-Chapter 101- MaineCare Benefits Manual- Chapter ll- Section12- Consumer-Directed Attendant Services – version 2/11/19.

[2] 10-144-Chapter 101- MaineCare Benefits Manual- Chapter ll- Section 40- Home Health Services – version 9/1/11

[3] 10-144-Chapter 101- MaineCare Benefits Manual- Chapter ll- Section 96- Private Duty Nursing and Personal Care Services – version 2/11/19

[4] 10-144-Chapter 101- MaineCare Benefits Manual- Chapter ll- Section 97- Private Non- Medical Institution Services – version 10/16/13

Program Name /Federal Authority	Administered By	Description of the Program
Section 1915(c)- Section 18 - HCBS Brain Injury (ME.1082) [5]	OADS	• Waiver began July 1, 2014 • Eligible members 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 • Provides care coordination, career planning, home support, community /work reintegration, assistive technology, employment specialist services. • Self-directed option: No
Section 1915 (c)- Section 19 - HCBS Elderly and Adults w/Disabilities (ME.0276)[6]	OADS	• Waiver began in 1995 and was merged with a prior waiver known as #88 in 2003. In 2013, the waiver was amended. • Eligible members from age 18 with physical disabilities • Provides care coordination, personal care, respite, financial management services, skills training, assistive technology, attendant services, etc • Self-directed option: Yes

Summary of PCS Expenditures and Beneficiary Data

Table 2.

Program Name/Federal Authority	**FFY 2016**	**FFY 2017**	**FFY 2018**
1915 (c) Waiver Services			
HCBS for Adults with Brain Injury	$226,603	$377,851	$354,491
HCBS for Elderly and Adults with Disabilities	$23,812,962	$27,491,398	$30,634,609

[5] Maine Waiver Fact Sheet. https://www.Medicaid.gov/medicaid/section1115-demo/demonstration-and-waiver-list retrieved July 3,2019
[6] Ibid

Program Name/Federal Authority	FFY 2016	FFY 2017	FFY 2018
HCBS for Elderly and Adults with Disabilities – Self-Directed	$11,424,107	$13,626,662	$15,289,787
HCBS for Adults with Other Related Conditions	$1,239,728	$1,238,756	$1,353,592
HCBS for Members with Intellectual Disabilities or Autism Spectrum Disorder	$11,795,027	$11,649,076	$11,931,909
Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder	$2,224,506	$3,072,251	$5,064,692
State Plan Services			
Consumer Directed Services	$3,614,226	$4,083,536	$4,529,235
Home Health Services	$90,123	$79,959	$90,356
Day Health Services	$224,545	$301,608	$476,446
Private Duty Nursing and Personal Care Services	$12,919,363	$14,969,470	$16,418,342
Private Duty Nursing and Personal Care Services – Self-Directed	$804,185	$744,850	$835,667
Private Non-Medical Institution Services	$102,767,260	$108,522,454	$116,703,144
Total Expenditures	**$171.1 million**	**$186.1 million**	**$203.6 million**

The PCS expenditures from FFY 16 to FFY 18 demonstrated an increase. The state indicated there was an increase in beneficiaries and an increase in the number of participating agencies.

Table 3.

	FFY 2016	FFY 2017	FFY 2018
Total PCS Expenditures	$171,142,641	$186,157,876	$203,682,277
% Agency-Directed PCS Expenditures	90.74%	90.09%	89.86%
% Self-Directed PCS Expenditures	09.26%	09.91%	10.14%

*****A larger portion of PCS expenditures were allocated to agency-directed services in the last three fiscal years reviewed.

Table 4-A.

1915(c) Waiver Authority Service/Program	FFY 2016	FFY 2017	FFY 2018
HCBS for Adults with Brain Injury	18	29	22
HCBS for Elderly and Adults with Disabilities	1,321	1,425	1,466
HCBS for Adults with Other Related Conditions	17	20	20
HCBS for Members with Intellectual Disabilities or Autism Spectrum Disorder	424	402	400
Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder	411	540	733
State Plan Services:			
Home Health Services	185	180	202
Day Health Services	50	79	81
Private Duty Nursing & Personal Care Services	2,227	2,223	2,197
Private Non-Medical Institutions	5,148	5,183	5,101
Total Agency-directed Unduplicated Beneficiaries	**9,475**	**9,727**	**9,892**

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

The trend for participating beneficiaries in the agency directed PCS programs increased slightly over the review period.

Table 4-B.

Program Name/Authority	FFY 2016	FFY 2017	FFY 2018
State Plan			
Consumer Directed Services	512	499	471
Private Duty Nursing and Personal Care Services	166	154	136
Waiver Services			
HCBS for Elderly and Adults with Disabilities	517	591	615
Total Self-directed Unduplicated Beneficiaries	**1,150**	**1,186**	**1,187**

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

Results of the Review

The CMS team identified areas of concern with Maine's PCS program integrity oversight, thereby creating a potential risk 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.

The State Plan and 1915(c) HCBS waivers administered by the OMS. Under these authorities, the PCS benefit is administered to eligible beneficiaries under a traditional fee-for-service (FFS) methodology for both the State Plan and HCBS waiver programs. The PCS program does include a self-directed option. Under the self-directed option the beneficiary is able to choose their own provider. The OADS is the state sister agency that is responsible for oversight of the PCS program. OMS has a memorandum of understanding (MOU) with OADS. The MOU does not clearly describe the oversight/administrative roles of OADS.

Recommendation #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 fiscal intermediaries.

tate Oversight of PCS Program Integrity Activities and Expenditures

As previously mentioned, the OADS is responsible for PCS program oversight. The OMS and the Medicaid Fraud Control Unit (MFCU) have not provided any training to OADS in the last fiscal year on PCS FWA.

Recommendation #2

The state and the MFCU should consider providing quarterly training related to Medicaid FWA to OADS.

The Program Integrity unit performs post payment reviews and conducts data mining on PCS providers. However, there are no edits in the MMIS system to identify PCS overlap with an institutional claim. The state told the review team that this edit will be included in the next phase of duplicate editing corrections.

Also, the state does not have an edit to identify a provider billing in excess of twenty-four hours per day. At the time of the CMS review, the state reported that they were working with their MMIS vendor to design and develop an edit to capture billings in excess of 24 hours. The state intends to implement that edit upon completion.

Recommendation #3

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

There is frequent communication between the prior authorization staff and the provider relations unit and the program integrity unit to discuss differences between authorized services and audited services. In addition, the program integrity unit maintains regularly scheduled meetings with both the MFCU and from the Office of Inspector General (OIG). In addition to the regularly scheduled meetings, there are open lines of communication between program integrity unit staff, MFCU, and the Department of Justice staff on pending investigations. In addition to the fraud hotline, there is a general complaint

phone line for consumers or anyone else to register complaints about PCA agencies and individual PCS workers. Complaints can also come in through email and may be generated by concerns from the state sister agency or coordination units.

State Oversight of Self- Directed Services

The OMS PCS program does include a self-directed option. Self-directed PCS attendants are screened during the employment process in that they are subject to background checks. In addition, Service Coordination Agencies (SCA) are responsible for administrative functions relating to self-directed PCS. A primary administrative function includes coordination with the fiscal intermediary handling the payroll attendant. If a member wishes to utilize the self-directed option, they must first be assessed by the state's medical eligibility assessing agency. The assessment is reviewed by a SCA who will then outreach to the member to discuss the assessment and the self-directed option and the consumer's responsibilities. The SCA will perform a background check on the member. Once the background check is completed the member will be the employer of the PSS (Personal Support Specialist). The member will submit a Personal Care Services Application and upon approval the SCA will connect the member with their choice of a fiscal intermediary.

The fiscal intermediary has a contract with the OADS. CMS selected two fiscal intermediaries and three provider agencies for review. The two fiscal intermediaries and the three providers revealed that they never received training on PCS fraud, waste, and abuse. A review of the contract between OADS and the fiscal intermediaries found that it did not list a requirement for the fiscal intermediaries to receive training in fraud, waste, and abuse.

Recommendation #4

The state should ensure that the contract between OADS and the fiscal intermediates is amended to list a requirement that the fiscal intermediaries receives training on fraud, waste, and abuse.

Personal Care Services Provider Enrollment

The State Medicaid Agency enrolls all Medicaid providers, including PCS providers. The state requires all providers to complete an enrollment application and sign a provider agreement. There are approximately 25 staff in the Provider Enrollment unit. The Provider Enrollment Unit is currently doing a revalidation; there will be 13 revalidation cycles which will run through April 2020. Before each cycle starts, anyone who has not billed for one year is contacted and if they cannot be reached, they are terminated. PCAs work under the National Provider Identifier of the employing agency. They have two providers with an atypical provider identification (API) number. The state does not require PCS providers to be licensed, however there are direct care workers who have to obtain certification from the department in order to be eligible to provide services.

The State does not report to HHS-OIG adverse actions it takes on provider applications and MCOs do not always inform the State of adverse actions in MCO provider credentialing. The state indicated during an interview that if they deny a provider's enrollment due to a program integrity concern they do not notify Health and Human Services Office of Inspector General (HHS-OIG). The regulation at 42 CFR §1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The state has implemented all screening provisions with the exception of the criminal background check fingerprinting provision. The State is currently working towards full implementation of this requirement.

Recommendation #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

Recommendation #6

Pursuant to 42 CFR § 455.434, the state should ensure the full implementation of the Fingerprint-based Criminal Background Checks requirement as required by CMS effective July 1, 2018.

The three personal care agencies interviewed indicated that when they enroll a provider they check the List of Excluded Individuals and Entities (LEIE) and the Excluded Parties List System (EPLS). They are not checking the National Plan and Provider Enumeration Systems (NPPES) and the Social Security Death Master File (SSDMF) upon enrollment and reenrollment. The Federal regulation at 42 CFR § 455.436 states that the states must do the following.

(a) Confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of Federal databases.

(b) Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/ Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe.

(c) (1) Consult appropriate databases to confirm identity upon enrollment and reenrollment; and

(2) Check the LEIE and EPLS no less frequently than monthly.

Although (PCAs) are not mandated by this regulation to conduct exclusion searches of the network providers they enroll, CMS considers the requirements under this regulation to be program safeguards that would be prudent in personal care settings. States may delegate these requirements to their PCA's through their contracts with their PCAs.

Recommendation #7
Pursuant to 42 CFR § 455.436, the state should ensure the PCS provider agencies complete the necessary federal database checks upon enrollment and on a monthly basis thereafter.

Oversight of 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.

As part of the onsite review, CMS's review team selected three PCS agencies and two fiscal intermediaries and conducted interviews. During the interviews with the PCS agencies and the fiscal intermediaries; they all disclosed that they have not received training related to Medicaid FWA and/or updated PCS policies and procedures and regulations from OADS.

Recommendation #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 FWA identification, and referral and reporting requirements.

Table 5.

Agency-Directed and Self-Directed Combined	**FFY** 20162016	**FFY** 20172017	**FFY** 20182018
Identified Overpayments	$187	$21,125.28	$647,259.97
Recovered Overpayments	$187	$1,838	$11,864
Terminated Providers	11	7	16
Suspected Fraud Referrals Received *	39	59	72
# of Fraud Referrals Made to MFCU	3	3	2

*The numbers reflect the total number of complaints received by the Program Integrity Unit – which includes non-fraud complaints. The state reported that they did not keep track of what overpayments identified or recovered were fraudulent or non-fraudulent. **Overpayments identified and recovered in FFY 20162016, FFY 20172017, and FFY 20182018 include fraud, waste, and abuse. *** In FFY 18 there was one sizable overpayment for one provider for $421,000.00. The state cannot recover the funds until all appeals are exhausted. The provider has been terminated but they are appealing. The MFCU and the Department of Justice are still investigating.

Overall, Maine's activity regarding post payment actions taken seems low when compared to expenditures. There were only eight fraud referrals made in the last three FFYs to law enforcement. During FFYs 16, 17, and 18, there were overpayments identified and recovered.

Electronic Visit Verification (EVV)

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

Specifically, The EVV system should verify the date of service, location of service, individual providing the service, type of service, individual receiving the service, and the time the service begins/ends. Some of the benefits of utilizing an EVV system include ensuring quality of care and monitoring cost expenditures.

Currently, OMS does not utilize an EVV system for in-home scheduling, tracking, and billing. The state already has a contracted vendor, SanData, for its EVV system. The state is moving towards full implementation of the requirement for EVV, effective January 1, 2020 for PCS providers as required by the federal statute.

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.

Recommendation #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 of Corrective Action Plan from Year 2012 Review

Maine's last CMS program integrity review was in January, 2012, and the report for that review was issued in August 2012. The report contained six recommendations relative to implementation of the state not implementing the new provisions of the regulation to suspend payment in cases of creditable allegations of fraud, not capturing all ownership and control disclosure from disclosing entities, not capturing criminal conviction disclosures from providers or contractors, not conducting complete searches for individuals and entities excluded from participating in Medicaid, enrollment application not capturing criminal conviction information on enrollment application, not conducting complete searches for individuals and entities excluded from Medicaid. During the onsite review in May 2019, the CMS review team conducted a thorough review of the corrective actions taken by Maine to address all issues reported in calendar year 2012. The findings from the 2012 review have been satisfied by the state.

Risk Areas-

1. **A risk was identified in the state not implementing the new provisions of the regulation to suspend payments in cases of creditable allegations of fraud**.

   Status of the time of the review: Corrected

2. **A risk was identified in the state not capturing all required ownership and disclosure from disclosing entities.**

   Status of the time of the review: Corrected

3. **A risk was identified in the state not capturing criminal conviction disclosures from providers or contractors**.

   Status of the time of the review: Corrected

4. **A risk was identified that the state does not conduct complete searches for individuals and entities excluded from participating in Medicaid**.

   Status of the time of the review: Corrected

5. **A risk was identified in not capturing criminal conviction disclosures from contracted PCA providers**.

   Status of the time of the review: Corrected

6. **A risk was identified in not capturing complete searches for individuals and entities from participating in Medicaid**.

   Status of the time of the review: Corrected

Technical Assistance Resources

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

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

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations 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 final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies 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 CAP should identify those corrections as well.

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