Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Oklahoma Focused Program Integrity Review

Oversight of Medicaid Personal Care Services

May 2025

Final Report

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I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services (CMS) conducted a focused program integrity review of Oklahoma's Medicaid Personal Care Services (PCS) program to assess the state's program integrity oversight efforts for Fiscal Years (FY) 2020 – 2022. This focused review specifically assessed the state's compliance with CMS regulatory PCS requirements within 42 CFR Parts 440 and 441. 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' 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 no findings that create a risk to the Oklahoma Medicaid program related to PCS program integrity oversight.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid PCS program. CMS identified **four** observations related to Oklahoma'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 Oklahoma to develop and implement procedures to improve communication and collaboration between the Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Human Services (OKDHS) to enhance program integrity activities and increase the number of PCS fraud, waste, and abuse referrals.

Electronic Visit Verification (EVV) for PCS

Observation #2: CMS encourages Oklahoma to provide PCS agencies with additional training and/or guidance to monitor and report potential EVV fraud.

State Oversight of Agency-Based PCS Providers

Observation #3: Consistent with CMS guidance,[1] CMS encourages Oklahoma to assign a unique identifier or national provider identifier (NPI) for agency-based PCAs. Unique identifiers or NPIs facilitate more efficient and transparent tracking of each PCS service rendered and reimbursed.

Observation #4: CMS encourages Oklahoma to consider implementing additional program integrity efforts, including data analytics, to increase the number of suspected fraud referrals to the Medicaid Fraud Control Unit (MFCU). In addition, Oklahoma should provide additional training to PCS provider agencies on the referral and reporting of suspected fraud, waste, and abuse as it pertains to issues relating to identified overpayments.

[1] https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/faqs-using-npis-for-medicaid-pcas.pdf

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[2] This plan encompasses 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 include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. 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 is 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 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.

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 statutes 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.

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

III. Overview of the Oklahoma Personal Care Services Program and the Focused Program Integrity Review

The Oklahoma Health Care Authority (OHCA) is the State Medicaid Agency (SMA) responsible for the administration of the Oklahoma Medicaid program, titled SoonerCare. The OHCA primarily administers and monitors the PCS program and delegates certain administrative and monitoring functions to its sister agency, the Oklahoma Department of Human Services (OKDHS) through an interagency agreement. Within OHCA, the Program Integrity Unit is tasked with oversight of program integrity-related functions.

Oklahoma administers Medicaid PCS to eligible beneficiaries under Section 1905(a) state plan authority, Section 1915(c) Home and Community-Based Services (HCBS) waiver authority, and a Money Follows the Person demonstration grant. The OHCA offers both agency-based and self-directed PCS options. Detailed descriptions of the Oklahoma Medicaid PCS programs and their applications can be found in Appendix C. Oklahoma has established PCS program participation and reporting requirements through state policy.

In FY 2022, Oklahoma's total Medicaid expenditures were approximately $8.3 billion,[3] providing coverage to approximately 1,130,866 beneficiaries.[4] Oklahoma's Medicaid expenditures for PCS totaled approximately $203 million and 23,362 beneficiaries received PCS. Appendix C provides enrollment and expenditure data for the PCS population in Oklahoma.

In September 2023, CMS conducted a focused program integrity review of Oklahoma's PCS program. This focused review assessed Oklahoma'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 state staff involved in the administration of PCS to validate the state's program integrity practices, as well as with key personnel within four PCS agencies. CMS also evaluated the status of Oklahoma's previous corrective action plan, developed by the state in response to a PCS-focused review conducted by CMS in 2018, the results of which can be found in Appendix A.

During this review, CMS identified a total of four 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 can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

[3] https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/
[4] https://www.kff.org/other/state-indicator/medicaid-and-chip-monthly-enrollment/

This review encompasses the six 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.

B. **Electronic Visit Verification (EVV) for PCS –** 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 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."

C. **Provider Enrollment and Screening –** CMS regulations at § 455.436 require that the SMA 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 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 re-enrollment, 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.

D. **State Oversight of Self-Directed Services –** States may elect to cover self-directed PCS under a Section 1915(c) waiver, which allows participants or their representatives to exercise choice and control over the budget, planning, and purchase of self-directed PCS. CMS regulations at 42 CFR 441 Subpart J govern the use of this option.

E. **State Oversight of Agency-Based PCS Providers** – Beneficiaries may receive services through a personal care agency that oversees, manages, and supervises their care. Agency-based PCS are available under state plan or waiver authority. In accordance with §§ 441.302 and 441.570, the SMA must assure that certain necessary safeguards have been taken to protect the health and welfare of individuals furnished services under the program and assure the financial accountability for funds expended for PCS provided through waiver or state plan authority.

F. **PCS Agency Oversight of Staff and Attendants –** As defined by § 440.167, PCS services 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. The conditions of participation for home health aides participating in PCS programs are further detailed at § 484.80. 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. As part of this

review, CMS interviewed several PCS agencies to determine if they are exercising appropriate oversight of the quality and integrity of services provided to beneficiaries under the care of their agency, in accordance with state standards.

IV. 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.

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 the implementation of a surveillance and utilization review subsystem (SURS) within the Medicaid Management Information System (MMIS) and/or discrete SURS Units that are part of larger program integrity efforts.

In Oklahoma, these oversight and monitoring requirements are met. The OHCA is primarily responsible for Medicaid program integrity activities and collaborates with the OKDHS to conduct audits, oversight, and monitoring activities to ensure compliance with program guidelines. The OHCA Program Integrity Unit identifies fraud and abuse within the Medicaid program by reviewing claims data and conducting investigations, including those of PCS providers. These responsibilities are also delegated to the sister agency, OKDHS, which exercises programmatic and administrative authority over the PCS programs. While the OKDHS does not have a specific unit tasked with fraud investigations, it does complete quarterly and annual provider reviews to evaluate the performance of state case managers and contracted provider agencies, including reviews of personnel files, client records, and service billing records. The PCS agencies are subject to recoupments and corrective action plans if programmatic deficiencies are discovered during the audit. Detailed information on post-payment actions taken as a result of PCS provider audits can be found in Appendix C.

Every complaint of potential fraud or abuse received by OHCA goes through a preliminary investigation before determining if a full investigation is warranted. A preliminary investigation includes contact with the beneficiary and/or complainant to obtain details related to the complaint. Data is compiled based on beneficiary claims and additional data is then collected to compare the specific provider to its peers or similar provider types to identify potential aberrant billing patterns. The preliminary investigation is reviewed by the Case Selection Committee to

determine if a full investigation is warranted and, if so, the investigation continues by collecting documents and performing a comprehensive clinical audit of billed claims.

CMS noted that there appears to be room for improvement in communication between the OHCA and OKDHS, as there is currently a lack of understanding of the program integrity activities performed by the two units, which results in difficulty identifying and reporting PCS fraud, waste, and abuse in the Medicaid program.

Lastly, after completing a preliminary investigation, the OHCA is required to refer all cases of suspected provider fraud to the Medicaid Fraud Control Unit (MFCU). The OHCA holds a memorandum of understanding with the Office of the Attorney General MFCU that outlines the respective obligations and responsibilities to minimize duplication of effort. The OHCA meets monthly with the MFCU to discuss referrals and coordinate investigations or actions against providers.

> **Observation #1:** CMS encourages Oklahoma to develop and implement procedures to improve communication and collaboration between the OHCA and OKDHS to enhance program integrity activities and increase the number of PCS fraud, waste, and abuse referrals.

B. Electronic Visit Verification (EVV) for PCS

EVV is used to verify that PCS visits occurred and can be performed through a number of methods, including telephonic and GPS-enabled 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. Currently, Oklahoma utilizes an EVV system provided by the vendor AuthentiCare for in-home scheduling, tracking, and billing for PCS providers. The EVV system utilizes GPS to record the PCA's location at each clock-in/out.

The OKDHS Developmental Disabilities Services (DDS) Quality Assurance Unit audits EVV claims annually as part of their provider performance surveys. The State selects a random sample of EVV claims and compares billed charges to service delivery documentation to ensure providers are complying with EVV policies and procedures. A 60-day follow-up audit is then performed to ensure there are no other issues with claims and that the provider corrected the billing on the identified error(s).

Despite the established verification processes in place, CMS determined during the focused program integrity review interviews that many agencies are frequently detecting potential issues with EVV by their employees.

> **Observation #2:** CMS encourages Oklahoma to provide PCS agencies with additional training and/or guidance to monitor and report potential EVV fraud.

C. Provider Enrollment and Screening

In accordance with § 455.434, PCS agencies or attendants that enroll in Medicaid as providers are subject to federal screening requirements found at § 455.410. SMAs must require providers, as a condition of enrollment in Medicaid, 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 fraud, waste, and abuse risk as determined for that category of provider, in accordance with § 455.450. High-risk and moderate-risk providers are subject to enhanced screening.

In addition, 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 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 re-enrollment, and to check the LEIE and SAM no less frequently than monthly. In addition, under § 455.104, entities must disclose individuals or entities having five percent or more direct or indirect ownership of or controlling interest in the agency.

For agency-directed services available under the state plan and Section 1915(c) waiver authorities, responsibility for compliance with § 455.436 is delegated to OHCA. CMS confirmed that the OHCA has a state policy in place addressing this requirement. For self-directed services available under the Section 1915(c) waiver authority, the Financial Management Services Agency (FMSA) performs the provider enrollment and screenings which are submitted to the SMA for review and approval.

Pursuant to state policy,[5] provider agencies must have an approved provider agreement on file with OHCA. This agreement must be renewed at least every five years. Reimbursement for personal care is made only to agencies that are certified as home care agency providers by the Oklahoma State Department of Health and are certified by the OKDHS ADvantage Administration as meeting applicable federal, state, and local laws, rules, and regulations. The OKDHS/DDS reviews supporting documentation for licensure and background checks during quarterly and annual provider reviews.

CMS determined that the OHCA has met federal screening requirements and screens PCS providers at the highest level.

CMS did not identify any findings or observations related to these requirements.

D. State Oversight of Self-Directed 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. For self-directed PCS, the beneficiary is the employer of record and employs the PCA. The

[5] Oklahoma Administrative Code 317:30-3-2 and 317:30-5-950

beneficiary may designate an adult family member or friend, who is not a PCA, as an authorized representative to assist in executing the employer functions. The beneficiary is responsible, with assistance from the FMSA, for recruiting, hiring, supervising, and ensuring sufficient instruction and training of the individuals who furnish their services under self-directed care. The beneficiary also determines where and how the PCA works, hours of work, what is to be accomplished, and within individual budget allocation limits, wages to be paid for the work.

A state offering a self-directed option must assure that certain necessary safeguards have been taken to protect the health and welfare of individuals furnished 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.

Oklahoma ensures these requirements are met through the FMSA, which provides each beneficiary with a case manager to monitor the participant's expenditures. This case manager is tasked with advising the beneficiary on care choices and reporting significant budget variances that may indicate potential fraud or abuse to the SMA. The SMA and OKDHS work together with the FMSA and have established oversight, reporting structure, lines of communication, and responsibilities in the pursuit of PCS objectives. Acumen is the contracted FMSA vendor responsible for the financial management of self-directed services for the Living Choice Program and Medically Fragile Waiver beneficiaries. The OKDHS/DDS serves as the FMSA for the Homeward Bound Waiver, Community Waiver, and In-Home Support for Adults/Children Waivers.

The FMSA completes the criminal background checks to determine worker appropriateness, which are submitted to the SMA for review and approval prior to hiring. Workers are enrolled with the SMA and have a specific personal identification (ID) number to utilize the EVV system. Assigned case managers monitor beneficiaries monthly to ensure services are delivered by PCAs according to the service plan.

The OKDHS/DDS Quality Assurance Unit completes a review of self-directed services annually and written summaries are prepared to inform the employer of record of any deficiency. The OKDHS/DDS Case Management Unit provides additional oversight and review. The Advantage Program Manager reviews a random sampling of the information provided for accuracy by ensuring billings correspond with documented dates of service. Acumen ensures the maximum weekly authorizations are in line with the total units authorized and prepares a utilization report each month.

CMS did not identify any findings or observations related to these requirements.

E. State Oversight of Agency-Based PCS Providers

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

been taken to protect the health and welfare of those individuals and to assure the financial accountability for funds expended for agency-based PCS. Oklahoma ensures these requirements are met through prior authorization of PCS services, which is based on the individual beneficiary's needs identified through a person-centered service planning process. The OKDHS/DDS Case Management Unit provides oversight and acts as the lead in monitoring the care plan. The care plan is updated as needed through ongoing assessments of progress and needs. Claim edits are in place in the MMIS to deny any claim in which the number of billed units exceeds the number of allowed units on an approved care plan.

The PCS provider agency submits claims for services performed under their business name and a valid ID number (e.g., National Provider Identifier (NPI), Medicaid provider ID number). Accordingly, the PCS provider agency is responsible for ensuring the qualifications and standards of behavior for employees delivering services. While self-directed PCS providers are required to enroll and obtain a Medicaid provider ID number through the SMA, agency-based PCAs are not assigned a Medicaid provider ID number nor directly enrolled with or paid by the OHCA. As a result, the OHCA is limited in its ability to use claims data to identify individual PCA fraud.

Additionally, provider agencies are subject to audits, reviews, and data mining conducted by OHCA to identify any aberrant billing patterns. The OHCA Data Analytics Division performs an annual review using data mining to identify potential errors at the provider agency level. For example, this division reviews PCS claims billed and paid for after the beneficiary's date of death, as well as claims for when a beneficiary was an inpatient or resident of a hospital or nursing facility during the same time period.[6] All potential errors are identified and flagged as a possible overpayment and opened for review, as they could represent an instance in which a PCA documented seeing the beneficiary and clocked in/out of the EVV system when the beneficiary did not receive PCS. During the review period, the OHCA did not refer any cases of suspected PCS fraud to the MFCU from these annual reviews but instead only requested recoupments for potential errors. The OHCA may increase the number of case referrals from these reviews if additional program integrity efforts are implemented in addition to requesting recoupment. Program integrity efforts could include documentation review, claims data monitoring over multiple years, and/or development of provider corrective action plans, especially for providers with repeated billing errors. These additional efforts could help the OHCA identify fraud, waste, and abuse at the agency level and by individual PCAs.

In addition, the OHCA Provider Audits Unit conducts ongoing monitoring of services to ensure Medicaid guidelines are followed. Any indication that Medicaid guidelines are not being met would lead to an investigation that may result in the recoupment of payments made to the provider. The OKDHS/DDS Quality Assurance Unit completes quarterly Area Surveys to evaluate the performance of case managers and Provider Performance Surveys to evaluate the performance of contracted provider agencies. The Area Survey monitoring process is a review of OKDHS/DDS case manager records for monitoring the health and welfare of beneficiaries, assuring case managers conduct face-to-face visits as required, address issues that could put the

[6] In the annual review, OHCA excludes claims from their analysis for dates the beneficiaries were admitted to the inpatient facility and the dates they were discharged.

beneficiary's health or welfare at risk, and provide follow-up on issues identified in incident reports. The Performance Survey is an annual monitoring site visit in which all provider agencies participate by providing data based on an aggregated statistically significant sample of beneficiaries receiving waiver services and provider agency staff. OKDHS/DDS requires that all identified barriers to performance consistent with the expectation of regulatory policy and contracts are resolved no later than 60 days following the completion of the annual performance survey.

CMS noted during the review that provider agencies are voluntarily returning overpayments to the OHCA for PCS fraud; however, the current process in place appears to be confusing for the provider to report or refer suspected fraud, waste, and abuse. One provider agency interviewed made referrals of suspected fraud to the MFCU and submitted an electronic Critical Incident Report to the OKDHS Medicaid Services Unit. However, the agency was not required to notify the OHCA of the suspected fraud and instead required the agency to return the overpayment. Currently, the number of fraud referrals by the OHCA, OKDHS, FMSA, and PCS provider agencies is very low. With proper guidance and established reporting procedures, the SMA will better understand the magnitude of PCS fraud, waste, and abuse and should see an increase in the number of case referrals to the SMA and MFCU.

Observation #3: Consistent with CMS guidance,[7] CMS encourages Oklahoma to assign a unique identifier or national provider identifier (NPI) for agency-based PCAs. Unique identifiers or NPIs facilitate more efficient and transparent tracking of each PCS service rendered and reimbursed.

Observation #4: CMS encourages Oklahoma to consider implementing additional program integrity efforts, including data analytics, to increase the number of suspected fraud referrals to the MFCU. In addition, Oklahoma should provide additional training to PCS provider agencies on the referral and reporting of suspected fraud, waste, and abuse as it pertains to issues relating to identified overpayments.

F. PCS Agency Oversight of Staff and Attendants

In accordance with state law, PCS agency staff and attendants are subject to enhanced screening and credentialing procedures at the date of hire and annually thereafter. The SMA does not require PCAs providing agency-directed services to be licensed or enrolled in Oklahoma Medicaid; therefore, it is the responsibility of the employing agency to perform the appropriate background screenings according to the specific waiver requirements.

Prior to placing a PCA in the beneficiary's home, the provider agency must request the Oklahoma State Bureau of Investigation to conduct a criminal history background check pursuant to the provisions of the Long-Term Care Security Act and Oklahoma Statute § 63-1-1950.1. Providers are to use the Oklahoma Screening and Registry Employee Evaluation Network (OKSCREEN) web portal to perform fingerprint-based national background screenings

[7] https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/faqs-using-npis-for-medicaid-pcas.pdf

of applicants across multiple registries (e.g., HHS-OIG's LEIE, Community Services Worker Registry, National and Oklahoma Sex Offender registries, Nurse Aide Registry) and obtain authorizations for fingerprinting and determinations of employment eligibility from the Oklahoma State Department of Health. New hires have a continuously monitored criminal history and do not require re-fingerprinting when changing employers within the industry. Documentation of background screenings must be maintained by the provider for all staff who qualify for screenings and will be requested for review by OKDHS/DDS during annual provider reviews to ensure all required employment background checks have been obtained and all required training has taken place.

As part of the review, CMS selected four provider agencies to be interviewed: Complete Home Services[8], Elara Caring, Mays Plus, and We Care LLC. CMS reviewed each of the agency's documentation provided to support compliance with the screening and credentialing requirements.

CMS did not identify any findings or observations related to these requirements.

V. Conclusion

CMS supports Oklahoma's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified four observations that require the state's attention. The state is not required to develop a corrective action plan for any 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 Oklahoma to build an effective and strengthened program integrity function.

[8] Complete Home Services, d/b/a CompleteOK

VI. Appendices

Appendix A:

Oklahoma's last CMS program integrity review was in September 2018, and the report for that review was issued in January 2019. The report contained one recommendation. During the virtual review in September 2023, CMS conducted a thorough review of the corrective action taken by Oklahoma to address the recommendation reported in calendar year 2019. The finding from the 2019 Oklahoma focused program integrity review report has not been corrected by the state as noted below.

Finding

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

   Status at time of the review: Not Corrected

   Oklahoma indicated that they thought they were making referrals, but instead, an incident report was being created and sent to the Office of Client Advocacy (OCA) regardless of the source of the potential fraud, waste, abuse, or exploitation. The OCA started referring provider issues to the MFCU in 2023, but the OHCA has since agreed that all referrals would be directed to the OHCA.

Appendix B:
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. https://www.riss.net/
- Continue to take advantage of courses and training 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:

Table C-1 provides detailed information on the PCS programs available in Oklahoma.

Table C-1. Oklahoma Medicaid PCS Programs

Program Name/Federal Authority	Administered By	Description of the Program
Section 1905(a) Personal Care Services Program	OHCA	The state plan Personal Care Program is available to assist Medicaid eligible individuals to perform ADLs and IADLs.
Section 1915(c) HCBS Waiver Authorities		
Medically Fragile Waiver	OHCA	The Medically Fragile Waiver provides services to individuals who are medically fragile or who are technology dependent ages 19 or older who meet a hospital or nursing facility level of care.
ADvantage Waiver	OKDHS	The ADvantage Waiver serves elderly individuals age 65 or older and adults age 19-64 who meet a nursing level of care.
Homeward Bound Waiver	OKDHS	The Homeward Bound Waiver for Adults serves individuals who are 21 years of age and older who have intellectual disabilities and certain persons with related conditions who would otherwise require placement in an intermediate care facility for individuals with intellectual disability (ICF/IID).
Community Waiver	OKDHS	The Community Waiver serves individuals who are three years of age and older who have intellectual disabilities and certain persons with related conditions who would otherwise require placement in an intermediate care facility for individuals with intellectual disabilities.
In-Home Supports for Adults Waiver	OKDHS	The In-Home Supports Waiver for adults serves the needs of individuals 18 years of age and older with intellectual disabilities who would otherwise require placement in an ICF/IID.
In-Home Supports for Children Waiver	OKDHS	The In-Home Supports Waiver for children serves the needs of children ages three through 17 years with intellectual disabilities who would otherwise require placement in an ICF/IID.
Demonstration Grant		
Living Choice Program (Money Follows the Person Demonstration Grant)	OHCA	The Living Choice Program, also known as the Money Follows the Person Demonstration Grant offers services to individuals with physical disabilities aged 19-64, individuals with chronic illnesses aged 65 and older, and individuals with intellectual disabilities aged 19 and older.

Table C-2. Oklahoma PCS Enrollment by Authority

	FY 2020	FY 2021	FY 2022
1905(a) State Plan Authority	3,012	2,818	2,368
1915(c) OHCA Admin Waiver	39	38	33
1915(c) HCBS Waiver Authority	21,186	20,706	20,932
Demonstration Grant	19	17	29

Note: Beneficiaries can be enrolled in multiple waivers.

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

	FY 2020	FY 2021	FY 2022
1905(a) State Plan Authority	$8,877,333	$8,604,821	$7,766,437
1915(c) OHCA Admin Waiver	$881,730	$913,281	$881,863
1915(c) HCBS Waiver Authority**	$198,822,218	$195,902,578	$194,283,997
Demonstration Grant*	$19,513	$30,480	$226,935

* The SMA reported the Demonstration Grant expenditures increased from 2021 and 2022 possibly due to policy change or increased outreach resulting in an increase in enrollment and reimbursements.
** These figures include an immaterial amount of non-federal medical expenditures not reflected in Table C-4.

Table C-4. Waiver Authority Expenditures by Type

1915(c) OHCA Admin Waiver	**FY 2020**	**FY 2021**	**FY 2022**
Medically Fragile Waiver	$881,730	$913,281	$881,863
1915(c) HCBS Waiver	**FY 2020**	**FY 2021**	**FY 2022**
ADvantage Waiver	$72,128,414	$72,766,650	$71,208,896
Homeward Bound Waiver	$42,269,477	$40,769,316	$38,717,073
Community Waiver	$62,922,015	$60,557,523	$60,727,048
In-Home Supports for Adults Waiver	$20,411,370	$20,979,862	$22,681,961
In-Home Supports for Children Waiver	$805,833	$574,671	$690,392
Demonstration Grant	**FY 2020**	**FY 2021**	**FY 2022**
Living Choice Program	$19,513	$30,480	$226,935

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

Agency-Directed and Self-Directed Combined	**FY 2020**	**FY 2021**	**FY 2022**
Identified Overpayments	$10,362	$20,619	$13,775
Recovered Overpayments	$8,670	$19,271	$11,017
Terminated Providers	1	1	0
Suspected Fraud Referrals	2	0	1
Number of Fraud Referrals Made to MFCU	0	30	2

Note: The source of the referrals to the MFCU was Acumen, the contracted FMSA provider.

Appendix D:

State PI Review Response Form

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
N/A	No recommendations are included in this report.	**X**	

Acknowledged by:

C. Foss
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Christina Foss, Chief of Staff/State Medicaid Director

6/30/2025