Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

South Dakota Focused Program Integrity Review:

Oversight of Medicaid Personal Care Services

September 2023

Final Report

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I. EXECUTIVE SUMMARY

Objectives

The Centers for Medicare & Medicaid Services (CMS) conducted a focused program integrity review of South Dakota's Medicaid Personal Care Services (PCS) program for Fiscal Years (FYs) 2019-2021 to assess the state's program integrity oversight efforts. This focused review specifically assessed the state's compliance with CMS regulatory 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, and conducted in-depth interviews with the State Medicaid Agency (SMA), as well as 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 South Dakota Medicaid program related to PCS program integrity oversight. In response to the findings, 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 includes the following:

Provider Enrollment and Screening

> **Recommendation #1:** The SMA should ensure that PCS agencies screen PCS aides in accordance with § 455.436, to ensure consistency with screening across all PCS agencies.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid program. CMS identified **five** observations related to South Dakota'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 South Dakota to consider increasing the amount of monthly or regular unannounced site visits to strengthen the state's ongoing oversight of PCS.

Observation #2: CMS encourages South Dakota to consider strategies to boost program integrity activities and recoveries.

Observation #3: CMS encourages South Dakota to consider conducting more comprehensive claims reviews or preliminary investigations to boost the low level of program integrity activities.

State Oversight of Agency-Based PCS Providers

Observation #4: CMS encourages South Dakota to consider assigning a unique identifier or NPI for PCS aides because unique identifiers or NPIs facilitate more efficient and transparent tracking of each PCS service rendered and reimbursed. [1] This would allow South Dakota to identify aberrant trends from data mining and claims reviews.

PCS Agency Oversight of Staff and Attendants

Observation #5: CMS encourages South Dakota to consider including fraud, waste, and abuse training in the required training for PCAs to ensure they are consistently informed across the program.

[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 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.

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.

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

Overview of the South Dakota Personal Care Services Program and the Focused Program Integrity Review

South Dakota administers and monitors Medicaid PCS for eligible beneficiaries under the Section 1905(a) State plan authority and Section 1915(c) Home and Community-Based Services (HCBS) waiver authority, using the fee-for-service (FFS) reimbursement methodology. HCBS are types of person-centered care delivered in the home and community, including PCS. The state's PCS can be delivered through a provider managed service delivery model (agency-directed) and participant-directed. Detailed descriptions of the South Dakota Medicaid PCS programs and their applications can be found in Appendix C. In FY 2021, South Dakota's total Medicaid expenditures were approximately $1 billion,[3] providing coverage to 114,076 beneficiaries.[4] South Dakota's Medicaid expenditures for PCS totaled approximately $16 million, and 2,089 unduplicated[5] beneficiaries received PCS in FY 2021.

The Department of Social Services (DSS) is responsible for the administration of the Medicaid program in South Dakota. Within DSS, the Division of Medical Services (DMS) Program Integrity Unit (PIU) is the organizational unit tasked with oversight of program integrity-related functions, including those related to PCS. South Dakota's three Section 1915(c) waiver programs are administered by the Department of Human Services (DHS), with DSS guidance and oversight. The three waivers include the Home and Community-Based Options for Person Centered Excellence (HOPE) waiver, which is delivered through provider-managed services; the Family Support 360 (FS360) waiver, in which services are primarily participant-directed; and the Assistive Daily Living Services (ADLS) Waiver, in which services are also primarily participant-directed. As the SMA, DSS reviews and submits waiver applications, state plan amendments, and required CMS annual reporting for each Section 1915(c) waiver in coordination with DHS. SMA staff meets with DHS monthly to discuss claims, waiver and program updates, training, and issues affecting both agencies.

In August 2022, CMS conducted a Focused Program Integrity Review of South Dakota'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 program integrity and 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 South Dakota's previous corrective action plan, which was developed by the state in response to a PCS focused review conducted by CMS in 2017, the results of which can be found in Appendix A.

During this review, CMS identified a total of one recommendation and five 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

[3] https://www.kff.org/medicaid/state-indicator/total-medicaid-spending
[4] https://www.kff.org/other/state-indicator/medicaid-and-chip-monthly-enrollment
[5] Total unduplicated beneficiaries represent the count of unique individuals receiving PCS during a specified time period.

final report reflects changes CMS made based on the state's response.

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 HHS-OIG's LEIE; the 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.

D. **State Oversight of Self-Directed Services –** States may elect to cover self-directed PCS under a Section 1915(j) 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 wavier or state plan authority.

F. **PCS Agency Oversight of Staff and Attendants –** 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. The conditions of participation for home health aides participating in PCS programs are further detailed at § 484.36. 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.

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 standards 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 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 South Dakota, the Division of Medical Services PIU within DSS is primarily responsible for Medicaid program integrity activities. The PIU identifies fraud and abuse within the Medicaid program through reviewing claims history and conducting field reviews to determine provider abuse, deliberate misuse, and suspicion of fraud. The PIU and IWRC, both within DSS, conduct annual and quarterly reviews of the three HCBS waiver programs, respectively. Quarterly program integrity reviews include a sample of paid claims and review of policy and procedures. The SMA confirmed that DSS evaluates program integrity performance measures during annual onsite waiver program reviews, using a standardized tool that tracks system changes, operational enhancements, provider education, and follow-up activities. The PIU also conducts focused reviews with a sample of waiver providers to verify services were rendered as billed, payments were correct, and the service was properly documented. CMS observed that the state does not have an official annual audit work plan; however, DSS created written guidance with areas of interest for provider management and oversight.

DSS, as the SMA, is responsible for maintaining oversight of DHS, which administers and manages PCS delivery for the state's waiver programs. South Dakota's memorandum of understanding (MOU) indicates that "…the prevention, detection, and elimination of abuse, neglect, and improper practices in provider facilities receiving Medicaid funding under the

Medicaid waivers operated by the DHS is the responsibility of DHS." The primary means of monitoring PCS is through provider onsite visits and audits conducted by DHS, with the DSS PIU providing annual desk review support for HOPE waiver services.

DHS performs annual onsite reviews of PCS agencies providing services under the State Plan or HOPE waiver, as required by DSS to monitor program compliance. This annual onsite review includes, but is not limited to, personnel files, client records, and service billing records review. DHS develops standard onsite provider review protocol and procedures for documenting provider audits. DHS then reports to the PIU on any corrective action plans or areas of noncompliance. DHS staff are also responsible for conducting and/or reviewing annual claims audits and certification reviews for the FS360 and ADLS waivers, as required by each program. Findings are reported to DHS and DSS. While CMS found South Dakota to be compliant with required PCS program integrity safeguards, more frequent site visits and provider audits may boost the state's low level of program integrity-related findings and recoveries.

The MOU between the DSS, DHS, South Dakota Department of Health (DOH), and the Medicaid Fraud Control Unit (MFCU) lists objectives, responsibilities, reporting, and lines of communication that outline a general framework for oversight. The SMA also has PIU operational documents that provide goals and strategies for identifying suspected fraud, including medical record and claims reviews. DHS does not have standalone program integrity units that conduct investigations for suspected fraud or conduct data mining to detect aberrant trends. The DSS PIU has five full-time equivalent employees (FTEs), including one payment control officer and three investigators. Two DHS Service Coordinators monitor service plans, provide case management, ensure services are provided, and receive complaints for the ADLS waiver. Fifty-two LTSS Case Management Specialists monitor service plans, provide case management, ensure services are provided, and receive complaints for the HOPE Waiver. Additionally, the DHS Provider Operations Manager and the Provider Quality Assurance Coordinator oversee HOPE waiver provider processes and compliance. Coordinators for the FS360 waivers are employed through contracted providers, and participants are responsible for monitoring service delivery.

The state conducted PCS provider reviews in FYs 2019 and 2021, but no reviews were conducted in FY 2020 due to the COVID-19 public health emergency. The PCS agencies are subject to recoupments and corrective actions plans if programmatic deficiencies are discovered during the audit. DSS reported that there were no recoveries or corrective action plans as a result of provider review findings. In FY 2021, DHS identified a programmatic overpayment with an ADLS provider due to missing participant signatures. The SMA recovered the funds through offsetting the provider's claims and directed DHS to conduct provider education and a follow-up review. There were no reported recoupments or program integrity-related findings for State Plan PCS, HOPE waiver services, or FS360 services during the review period. Information on post-payment actions taken as a result of PCS provider audits in South Dakota can be found in Appendix C.

CMS found South Dakota to be compliant with federal regulations regarding suspected fraud referrals and payment suspensions. South Dakota's MOU includes provisions by which the SMA

will "…formally notify MFCU of any determinations of credible allegations of fraud." Item 19 of the MOU directs "… [the SMA] and MFCU [to] make and handle referrals using the standards stated in *CMS Performance Standard for Referrals of Suspected Fraud from a State Agency to a MFCU*." The SMA provided written policies and procedures for payment suspensions and good cause exceptions in accordance with § 455.23; these provisions are also included in item 17 of the SMA's MOU with the MFCU.

However, South Dakota's reported post-payment activities performed during the review period were low. The PIU referred zero cases of suspected PCS fraud to the MFCU, and all four PCS agencies interviewed did not refer any cases of suspected fraud to the SMA during the review period. As a result, the SMA did not initiate any PCS payment suspensions for the review period. During the review, the PIU informed CMS the low level of post-payment activity was due to preliminary investigations of complaints finding poor quality of service, not provider fraud. The state reported that some PCS agencies make their own direct referrals to the MFCU; however, the selected PCS provider agencies reported that they refer any suspected fraud, waste, or abuse to the SMA.

During the review, the PIU informed CMS that there is more onus on the provider to self-correct any overbillings found in self-audits. Circle of Life KOLA reported one programmatic overpayment due to duplicate payments in FY 2019 that was resolved by the agency. The SMA was able to articulate procedures to identify overpayments, including claims reviews, Payment Error Rate Measurement audits, and provider self-audits. The MOU directs the DSS Office of Recoveries and Fraud Investigations to supervise recovery efforts for any fraud, waste, and abuse-related overpayments identified by the State agencies; however, no state-initiated recoupments were pursued during the review period. In addition, the state has a practice of off-setting identified overpayments, which can circumvent the fraud referral process.

> **Observation #1:** CMS encourages South Dakota to consider increasing the amount of monthly or regular unannounced site visits to strengthen the state's ongoing oversight of PCS.
>
> **Observation #2:** CMS encourages South Dakota to consider strategies to boost program integrity activities and recoveries.
>
> **Observation #3:** CMS encourages South Dakota to consider conducting more comprehensive claims reviews or preliminary investigations to boost the low level of program integrity activities.

B. Electronic Visit Verification (EVV) for PCS

EVV is a technology used to verify that PCS visits occurred, and systems include telephonic verification, verification through a fixed or mobile device in the home, verification through a GPS-enabled mobile application, or a combination of these. 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." South Dakota had a good faith exemption for implementing EVV that expired on January 1, 2021.[6]

South Dakota implemented their current EVV in January 2021 and is compliant with Section 12006(a) of the 21st Century Cures Act. The state currently utilizes a combination EVV model, where providers can use either the state-provided system or an approved vendor of their choice. PCS providers use EVV for in-home scheduling, tracking, and billing. South Dakota contracts with vendors FOCOS Innovations and Therap to provide EVV services. Alternative EVV systems must be approved by DHS and linked to the SMA's centralized claims payment system (MMIS). The SMA reported that signatures are not required for PCS provided through the State Plan, FS360 waiver, and HOPE waiver due to the state's active Appendix K Emergency Preparedness amendment;[7] however, timecards and supporting EVV documentation are regularly reviewed by SMA staff.

Prairie Lakes Home Health, Sanford Home Health, and HomeCare Services reported using either the State-provided EVV or an approved alternative during the review period. However, Circle of Life KOLA, which primarily serves beneficiaries in rural areas, indicated there were GPS connectivity issues while implementing EVV. The agency reported they are researching EVV-compliant landline options to resolve this issue and are using unannounced visits, weekly paper timesheets, and beneficiary verifications via phone call as a compensating control.

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

C. Provider Enrollment and Screening

CMS regulations at § 455.436 require that the SMA verify 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 HHS-OIG's LEIE; SAM; SSA-DMF; NPPES upon enrollment and re-enrollment; and check the LEIE and SAM no less frequently than monthly.

For all PCS, including agency-directed and self-directed services, available under the State Plan and Section 1915(c) waiver authorities, the SMA is the entity responsible for compliance with § 455.436. After the review concluded, the DSS provided CMS with provider screening and enrollment policies that are consistent with § 455.436. The SMA's Provider Enrollment section is responsible for enrolling providers into Medicaid through an online application process. Provider Enrollment reviews and processes new applications, modifies existing providers, and confirms with DHS for the PCS waiver programs, as appropriate. The state runs database checks against the Medicare Provider Enrollment, Chain, and Ownership System (PECOS), the CMS Data Exchange (which includes the SSA-DMF), NPPES, SAM, and LEIE upon initial provider enrollment. DSS also contracts with an external vendor, IBM, to produce provider screening reports.

[6] https://www.medicaid.gov/sites/default/files/2019-12/sd-evv-gfe-appvl-ltr.pdf
[7] https://www.medicaid.gov/state-resource-center/downloads/sd-0189-appendix-k-appvl.pdf

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. South Dakota has a process for risk-based screening and FCBCs for PCS agencies and waiver providers. All PCS providers in South Dakota are categorized as moderate risk. Moderate and high-risk providers are required to undergo a joint onsite visit by DHS and DSS staff. The state's Medicaid Provider Agreement also includes language that directs providers to "acknowledge and grant access… for unannounced site visits for the purposed of meeting requirements of § 455.432," and submit FCBCs "pursuant to 42 CFR Part 455."

All PCS entities enrolling in South Dakota Medicaid are required to conduct fingerprinting and employee background checks. The SMA relies on DHS to ensure that enrolled PCS agencies do not employ providers who have been terminated or convicted of a healthcare-related criminal offense. Although the SMA conducts provider database checks against all required lists upon initial enrollment, there are inconsistencies regarding monthly LEIE and SAM database checks for PCS providers who are actively enrolled. Of the four PCS agencies interviewed, only Circle of Life conducts the monthly LEIE database check; Prairie Lakes and HomeCare Services run LEIE exclusion checks every six months. However, Circle of Life did not report checking the SAM database monthly, and only HomeCare Services included SAM in recurring six-month database checks. **The SMA was unable to provide documented policies or verification that monthly LEIE and SAM database checks, as outlined in § 455.436, are part of the provider screening process.**

All entities providing PCS in South Dakota are required to have a National Provider Identifier (NPI) and be enrolled in Medicaid through the SMA. The SMA does not require individual PCAs to obtain an NPI if they render PCS through a Medicaid-enrolled entity, and the SMA does not maintain a list of individuals employed by Medicaid-enrolled entities. PCS providers, except for Medicare-certified Home Health Agencies and PCAs providing ADLS, are not required to be licensed or certified to furnish services. During the review, the SMA reported collaborating with external vendors to develop PCS certification curricula and oversight processes, but these efforts were delayed by EVV implementation and the COVID-19 public health emergency.

PCS provider agencies are required to establish an annual purchase of services agreement with DHS that serves as the contract vehicle authorizing the agency to provide PCS. DHS staff conduct an annual site visit and documentation review of the enrolling agency as part of their validation process. DHS is responsible for determining any waiver-specific conditions that providers must meet, as outlined in contract addendums. HOPE waiver providers must complete a self-assessment, provider questionnaire, health insurance attestation, supplemental agreements, and onsite compliance review. The ADLS and FS360 waiver programs have additional qualifications for individuals acting as consumer preparation specialists or personal attendants, including one year of relevant experience or a state-approved PCA certification.

Recommendation #1: The SMA should ensure that PCS agencies screen PCS aides in accordance with § 455.436, to ensure consistency with screening across all PCS agencies.

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. In accordance with § 441.464, 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. These safeguards must include provisions for 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.

South Dakota's Medicaid self-directed PCS program operates under the ADLS and FS360 HCBS waiver authorities. The ADLS waiver provides three services through self-directed care: personal attendant care, respite care, and consumer preparation services. FS360 waiver supports include service coordination, adaptive medical equipment, companion services, respite care, and personal attendant care for beneficiaries with intellectual and developmental disabilities. The SMA reported that all beneficiaries who elect for self-directed PCS must go through the state's contracted provider agencies. During the review period, four agencies were contracted to furnish ADLS waiver services, and five agencies were contracted to deliver FMS for the FS360 waiver program. South Dakota utilizes the "Agency With Choice" model for self-directed PCS, which encourages beneficiaries and their advocates to be directly involved in the planning, hiring, and maintenance of their support workers. In this model, the contracted provider agency serves as the "Agency With Choice" and acts as "…the employer of record [to] ensure compliance with all IRS, Federal, and state Department of Labor guidelines," according to Appendix E: Participation Direction of Services, of the ADLS and FS360 waivers.

Direct care workers hired through the contracted provider agency to furnish ADLS waiver services must meet the agency's provider enrollment criteria, along with additional qualifications, depending on their role. PCAs providing ADLS waiver services must complete an SMA-approved training program, provide a certificate of competency signed by a licensed physician, or pass the state's PCA certification test. Respite care workers providing ADLS waiver services must be at least 18 years of age. Beneficiaries recruit, screen, train, and direct their PCS delivered under the ADLS waiver authority, with support from an agency-based consumer preparation specialist and the DHS Service Coordinator, as needed. In the FS360 waiver program, beneficiaries select and work with a support coordinator employed by a qualified provider agency to develop a service plan, which must be approved by DHS. Personal care workers selected by the beneficiary to provide FS360 waiver services must meet the provider agency's enrollment standards. In both waiver programs, the beneficiary and provider agency have co-employer authority of the hired PCA. Family members of the beneficiary are allowed to be aides in the ADLS and FS360 programs; however, spouses and parents of minors are not eligible to provide PCS. For both waiver programs, the contracted provider agency is

delegated to conduct federally required background checks and death screens in accordance with waiver requirements. DHS reimburses the "Agency With Choice" for the cost of employee background checks and fingerprinting as an administrative expense under the FS360 program; for the ADLS waiver this is a part of the fee for the service rate.

DHS maintains administrative oversight responsibilities for the management of South Dakota's self-directed PCS program. Qualified providers under the ADLS waiver must undergo an annual DHS claims audit, using a random sample of participant claims to validate the accuracy of record keeping, supporting documentation, and claim submission. DHS service coordinators are reviewed annually by the ADLS waiver manager using an internal accountability and competency evaluation. Qualified FS360 waiver providers are required to submit an annual independent audit, which is reviewed by DHS fiscal staff, and undergo a biennial billing review with DHS using a random sample of claims from the preceding year. All billed charges under the FS360 program undergo a monthly compliance review by the consumer preparation specialist and/or FS360 service coordinators. The FS360 waiver manager can create corrective action plans (CAPs) based on audit findings, with SMA review and approval. Claims review findings for the ADLS and FS360 waivers are summarized and reported to the provider, the corresponding DHS waiver manager, and the SMA, as required in the state's MOU. The state reported that the SMA also reviews the PCS waiver activities annually.

As previously mentioned, qualified FS360 waiver providers can serve as the "Agency With Choice" to furnish FMS as an administrative activity for self-directed PCS. The qualified provider employs support coordinators who work with beneficiaries to authorize payment for PCS as directed in the DHS-approved service plan, made available via FOCOS, South Dakota's contracted software service for FMS. The FMS acts as an agent for the beneficiary/employer in verifying care worker employment status; processing payroll and taxes; collecting and processing timesheets; submitting required federal quarterly reporting; training participants in worker supervision; and providing a system for payment, tracking, and verification of services and supports provided. DHS monitors the FOCOS contractual obligations annually upon contract renewal and reports any issues to the SMA.

During the interview, the state reported zero cases of suspected provider fraud or abuse in the self-directed PCS waiver programs for the three FYs reviewed. In FY 2021, the ADLS waiver program identified an $1,103.60 audit overpayment due to one provider lacking required signatures for service verification; the provider adjusted the claims with the SMA and had no further errors in a follow-up claims review. There were zero dollars in FS360 FMS-related audit overpayments and recoveries for the three FYs reviewed. No qualified ADLS or FS360 provider agencies were sanctioned or had a CAP issued during the review period.

South Dakota had the necessary safeguards for beneficiary safety and financial accountability for self-directed services, in accordance with § 441.464. As such, CMS did not identify any findings or observations related to these requirements.

E. State Oversight of Agency-Based PCS Providers

Beneficiaries enrolled to receive services through a personal care agency have their care overseen, managed, and supervised by the agency. Agency-based PCS in South Dakota are available under the State plan and all three Section 1915(c) waiver authorities. 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 to assure the financial accountability for funds expended for agency-based PCS provided through waiver or state plan authority.

South Dakota Medicaid covers up to 500 hours of PCS under the State plan. All PCS under the State plan require a needs-based assessment and service plan that is evaluated and authorized by DHS service coordinators, within rules established by the DMS. Qualified, contracted provider agencies furnishing FS360 waiver PCS must electronically submit service plans for DHS authorization. ADLS and HOPE waiver service coordinators are DHS staff who determine the number of authorized hours and medically necessary services prior to service delivery. PCS in South Dakota are limited to basic personal care and grooming; assistance with bladder/bowel requirements; assistance with medications; assistance with nutrition activities if incidental to a medical need; household services if related to a medical need; and physician-prescribed maintenance nursing.

Based on information provided by DSS during the review, there were 118 PCS providers contracted to furnish State Plan PCS and nine waiver PCS providers in FY 2021. At the time of the review, PCS claims did not require any identifying information about the rendering PCA. The SMA reported that only PCS agencies are enrolled with South Dakota Medicaid and required to obtain and list their NPI as both the billing and rendering provider. Individual PCAs are not directly enrolled with or paid by the SMA. The SMA also indicated that claims data mining and analytics are conducted at the provider agency level. As a result, the SMA is limited in their ability to closely review PCS claims to identify suspected agency or individual PCA fraud. South Dakota does have written policies and procedures in place for suspected fraud referrals to the MFCU that meet federal requirements. However, from FY 2019 to FY 2021, the SMA did not identify or refer any cases of suspected PCS fraud to the MFCU. During the review, the state reported that complaints received during the review period were unsubstantiated due to poor quality of service but did not constitute fraud.

Observation #4:CMS encourages South Dakota to consider assigning a unique identifier or NPI for PCS aides because unique identifiers or NPIs facilitate more efficient and transparent tracking of each PCS service rendered and reimbursed. [8] This would allow South Dakota to identify aberrant trends from data mining and claims reviews.

F. PCS Agency Oversight of Staff and Attendants

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

[8] https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/FAQs-Using-NPIs-for-Medicaid-PCAs.pdf

part 441, subpart G. The conditions of participation for home health aides participating in PCS programs are further detailed at § 484.36. 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.

CMS selected four provider agencies to be interviewed: Circle of Life KOLA, HomeCare Services of South Dakota (HomeCare Services), Prairie Lakes Home Connections (Prairie Lakes), and Sanford Home Health. None of the PCS agencies reported issues with suspected or identified fraud, waste, or abuse during the review period. CMS confirmed that the agencies have policies and procedures in place for reporting suspected fraud to the SMA via the LTSS Case Manager.

CMS found the four provider agencies had adequate oversight of PCAs and other individuals providing PCS. As mentioned previously, South Dakota does not require PCAs to be licensed or certified. Three of the four agencies hire a registered nurse or other licensed caregiver (such as an occupational or physical therapist) to directly supervise PCAs; HomeCare Services' Branch Coordinator, who supervises PCAs and other PCS, is recommended, but not required, to have at least two years of verified basic homecare or home health care experience.

During the review, the SMA reported that each agency establishes their own PCS training to meet the requirements to furnish PCS as a qualified provider. Agencies are required to track PCS trainings as part of onsite review performance measures but are not required to report training confirmations directly to the state. According to item number 3, Program Requirements, of the LTSS PCS provider agency contract, "Each caregiver will complete a minimum of six hours of annual training [and] this training record will be housed within the agency and will indicate the date, length, and topic of training completed." The selected agencies reported varying levels of training requirements. Prairie Lakes and HomeCare Services conduct annual abuse, neglect, and misconduct training upon hire and annually thereafter. Sanford Home Health includes a fraud, waste, and abuse component in their required annual training courses. Circle of Life requires new employees to sign a fraud acknowledgement after reviewing training materials upon hire, but does not require ongoing training unless an issue arises. DSS confirmed that fraud, waste, and abuse trainings are not currently required by the state. Required and recurring fraud, waste, and abuse trainings can help the SMA ensure that PCAs and other caregivers are actively informed of Medicaid policies and can engage in identifying suspected fraud where possible.

> **Observation #5:** CMS encourages South Dakota to consider including fraud, waste, and abuse training in the required training for PCAs to ensure they are consistently informed across the program.

IV. CONCLUSION

CMS supports South Dakota's efforts and encourages the state to look for additional

opportunities to improve overall program integrity. CMS' focused review identified one recommendation and five observations that require the state's attention.

We require the state to provide a corrective action plan for the identified recommendations 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 recommendations have been addressed and will not reoccur. The corrective action plan should include the timeframe for the corrective actions, 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 the corrective action(s) will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct the compliance deficiency, the corrective action plan should identify the corrections as well.

The state is not required to develop a corrective action plan for the 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 South Dakota to build an effective and strengthened program integrity function.

V. APPENDICES

Appendix A:

South Dakota's last CMS program integrity review was in July 2017, and the report for that review was issued in February 2018. The report contained 11 recommendations for improvement. During the review in August 2022, CMS conducted a thorough review of the corrective actions taken by South Dakota to address all recommendations reported in calendar year 2018.

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 COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- 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 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. http://www.riss.net/
- 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.
- Consult with other states that have Medicaid managed care 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 managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C:

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

Table C-1. South Dakota Medicaid PCS Programs

Program Name/Federal Authority	Administered By	Description of the Program
Section 1905(a) State Plan Authority PCS Program	DSS	State plan PCS is provided in the eligible Medicaid beneficiary's home or place of employment, as prescribed in accordance with an approved plan of treatment. Services are provided by a qualified individual who is not a member of the beneficiary's family.
Section 1915(c) HCBS Waiver Authorities		
Home and Community Based Options for Person-Centered Excellence (HOPE) Waiver	DHS-LTSS	The HOPE waiver has been operational since 1988. The HOPE waiver provides services to adults 65 and older and adults over 18 with a qualifying disability, in their homes or the least restrictive community environment available. Eligible beneficiaries must meet a nursing facility level of care. Waiver services include, but are not limited to, adult day services, in-home respite care, specialized medical equipment, accessibility adaptations, meals, emergency response systems, community transition supports, and structured family caregiving. Waiver services are delivered by providers who are enrolled in Medicaid or through a Medicaid-enrolled oversight agency.
Family Support 360 (FS360) Waiver	DHS-DDD	The FS360 waiver has been operational since 1998. The FS360 waiver is for participants with intellectual or developmental disabilities, and participants and families who self-direct their services and supports to live as independently as possible in their communities.
Assistive Daily Living Services (ADLS) Waiver	DHS-DRS	The ADLS waiver has been operational since 1994. The ADLS waiver is for adults over 18 with quadriplegia, other neuromuscular or cerebral conditions or diseases, or an individual with four limbs absent due to disease, trauma, or congenital conditions. Eligible beneficiaries must meet a nursing facility level of care. Waiver services include activities crucial in helping participants to remain in their home. Personal attendant care, respite care, and consumer preparation services are delivered through participant direction. Accessibility adaptations, in-home nursing, personal emergency response, specialized medical equipment, and vehicle modifications are delivered through traditional service delivery methods. Services are delivered by qualified, enrolled Medicaid providers.

Table C-2. South Dakota PCS Unduplicated Enrollment by Authority

Authority	FY 2019	FY 2020	FY 2021
1905(a) State Plan Authority	1735	1750	1751
1915(c) HOPE Waiver	143	161	153
1915(c) FS360 Waiver	74	93	88
1915(c) ADLS Waiver	112	109	97

Table C-3. Summary of South Dakota PCS Expenditures by Authority

Authority	FY 2019	FY 2020	FY 2021
1905(a) State Plan Authority	$9,279,206	$8,978,914	$9,161,522
1915(c) HOPE Waiver	$1,786,936	$2,188,187	$1,980,937
1915(c) FS360 Waiver	$345,559	$595,367	$602,298
1915(c) ADLS Waiver	$4,657,454	$5,219,044	$4,531,776

Table C-4. Waiver Authority Expenditures by Type

Agency-Directed	FY 2019	FY 2020	FY 2021
HOPE Waiver	$1,786,936	$2,188,187	$1,980,937
FS360 Waiver	$345,559	$595,367	$602,298
ADLS Waiver	$4,657,454	$5,219,044	$4,531,776
Self-Directed	**FY 2019**	**FY 2020**	**FY 2021**
FS360 Waiver	$4,969,637	$5,324,614	$5,213,977
ADLS Waiver	$5,060,560	$5,816,477	$5,185,844

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

Agency-Directed and Self-Directed Combined	FY 2019	FY 2020	FY 2021
Identified Overpayments	$0	$0	$1104
Recovered Overpayments	$0	$0	$0
Terminated Providers	4	18	7
Suspected Fraud Referrals	0	0	0
Number of Fraud Referrals Made to MFCU	0	0	0

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
Recommendation #1	The SMA should ensure that PCS agencies screen PCS aides in accordance with § 455.436, to ensure consistency with screening across all PCS agencies.		

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)