Department of Health and Human Services

Centers for Medicare & Medicaid Services

West Virginia Focused Program Integrity Review

Final Report

February 2022

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Executive Summary

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, the Centers for Medicare & Medicaid Services (CMS) set forth its strategy to safeguard the integrity of the Medicaid program. This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have fraud detection and investigation programs and oversight strategies that meet minimal federal standards. One way that CMS ensures oversight over the Medicaid program is through state program integrity reviews.

CMS conducts focused program integrity reviews on high-risk areas, such as managed care, new statutory and regulatory provisions, nonemergency medical transportation, and personal care services (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. The benefits of performing focused program integrity reviews include: (1) providing states with effective tools/strategies to improve programintegrity operations and performance, (2) providing the opportunity for technical assistance related to program integrity trends, (3) assisting CMS in determining/identifying future guidancethat would be beneficial to states, and (4) assisting with identifying and sharing promising practices related to program integrity.

CMS conducted a focused review of the PCS provided under the West Virginia Medicaid program. The primary objective of the review was to assess the level of program integrity oversight of Medicaid PCS at the state level. A secondary objective of the review was to provide the state with useful feedback, discussions, and technical assistance resources that may be used to enhance program integrity in the delivery of these services.

Medicaid PCS (sometimes referred to as a personal attendant or personal assistance services) includes a range of assistance services that are provided to beneficiaries of all ages with disabilities and chronic conditions. Provision of these services in the beneficiary's home is intended to serve as an alternative to institutionalization. Assistance may either be in the form of direct provision of a task by a Personal Care Attendant (PCA), or cueing/prompting by a PCA so that the beneficiary may perform the task. Such assistance most often involves activities of daily living (ADLs), including eating, drinking, bathing, dressing, grooming, toileting, transferring, and mobility assistance.

States administer their Medicaid programs within broad federal rules and according to requirements of the specific authority approved by CMS. Services offered under Medicaid PCS are an optional benefit, except when medically necessary for children who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services. Pursuant to 42 CFR 440.167, PCS are a Medicaid benefit furnished to eligible beneficiaries according to an approved Medicaid state plan, waiver, or section 1115 demonstration. Services must be approved by a physician or someother 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 individualswho have met certain training and enrollment requirements, as designated by each state.

In May 2021, CMS conducted a virtual review of the West Virginia Bureau for Medical Services

(BMS). CMS conducted interviews with numerous state staff involved in program integrity and the administration of PCS to validate the state's program integrity practices with regard to PCS. One sister agency, the Bureau of Senior Services (BoSS), and four PCS agencies were also interviewed as part of the review. CMS also evaluated the status of West Virginia's previous corrective action plan, which was developed by the state in response to a PCS focused review conducted by CMS in 2016.

During this review, CMS identified a total of 12 recommendations based upon the completed focused review modules, supporting documentation, and discussions and/or interviews with key stakeholders and providers of PCS services. The review and recommendations encompassed the following eight areas:

1. State oversight of PCS program integrity activities and expenditures
2. Payment suspensions based on credible allegations of fraud
3. Federal database checks
4. Screening levels for Medicaid providers
5. State oversight of self-directed services
6. Agency-based PCS providers
7. Oversight of PCS agency providers
8. Electronic Visit Verification (EVV)

Overview of West Virginia Medicaid PCS

In accordance with 42 CFR 431.10, a State Plan must specify a single state agency established or designated to administer or supervise the administration of the plan. The Bureau for Medical Services (BMS) is the single state agency designated to administer the Medicaid program in the state of West Virginia. The BMS offers PCS under the Medicaid State Plan and through a series of Medicaid waiver programs. The BMS utilizes an Operating Agency (OA) and a Utilization Management Contractor (UMC) to provide daily oversight of the PCS program.

The BMS contracts with an OA, the BoSS, which acts as an agent of BMS and administers the operation of the PCS program and the Aged & Disabled waiver. The West Virginia BoSS, a sister state agency, was created as a cabinet-level agency in the Senior Services Act of 1997. The BoSS serves as the primary agency within state government designated to receive federal Older Americans Act funds and to provide services to the senior population. The BoSS provides day-to-day operations of the aforementioned programs, such as managing provider certification and enrollment, conducting provider education, responding to policy questions and providing clarifications in collaboration with BMS, performing annual on-site reviews and desk documentation reviews as requested by BMS to monitor program compliance, and conducting quality reviews. The PCS providers are required to be certified by the OA and enrolled as a Medicaid provider by BMS.

The BMS also contracts with a UMC, Kepro, which provides independent medical eligibility of applicants, reviews service-level change requests and authorizes PCS for all waiver and State Plan PCS. The UMC provides authorization for services that are based on the member's assessedneeds and forwards authorization information to the claim's payer. The UMC also acts as an agent of BMS, and provides day-to-day operations of the IDD and TBI waivers.

Summary of Medicaid PCS Programs in West Virginia

West Virginia administers Medicaid PCS to eligible beneficiaries under the Section 1905(a) State plan authority and Section 1915(c) Home and Community-Based Services (HCBS) waiver authority. The provision of PCS in the beneficiaries' homes or community settings is intended to serve as an alternative for individuals who would otherwise require institutional care. The Table 1 below provides details of West Virginia's programs.

Table1. Summary of PCS Programs

Program Name/Federal Authority	Administered By	Description of the Program
Section 1905(a) Personal Care Services Program	BoSS	PCS are available to assist Medicaid eligible members to perform ADLs and Instrumental Activities of Daily Living (IADLs) in the member's home, place of employment or community.
Section 1915(c) HCBS Waiver Authorities		
Section 1915(c) Traumatic Brain Injury (TBI) Waiver	BMS	Established in 2012, the TBI waiver provides case management, personal attendant services, community transition services, personal emergency response system, pre-transition case management, and transportation to individuals with brain injury ages 3 and up.
Section 1915(c) Aged and Disabled (A&D) Waiver	BoSS	Established in 1983, the A&D waiver provides case management, personal attendant services, community transition services, non-medical transportation, personalemergency response system, pre-transition case management, skilled nursing for aged with physical disabilities ages 18-64.
Section 1915(c) Intellectual Developmental Disability (IDD) Waiver	BMS	Established in 1983, the IDD waiver offers a comprehensive scope of services and supports to eligible individuals in order to avoid or delay institutionalization within each member's individualized budget for ages 3 and up.
Section 1915(c) Personal Options Program	BMS/BoSS	The Personal Options program serves waiver program beneficiaries that receive PCS, and allows beneficiariesenrolled in a waiver program the option to self-direct certain PCS at their discretion.

Summary of PCS Expenditures and Beneficiary Data

In Federal Fiscal Year (FY) 2019, West Virginia's total Medicaid expenditures were approximately $3.95 billion, providing coverage to approximately 564,790 beneficiaries. West

Virginia's Medicaid expenditures for PCS totaled approximately $493 million, and 16,494 unduplicated beneficiaries[1] received PCS. The State offers both agency-based and participant-directed PCS options. PCS are reimbursed via fee-for-service payment methodology.

West Virginia's State plan PCS program experienced a nominal decline in expenditures from FY 2017 to FY 2019. Beneficiary enrollment under the State plan PCS program also experienced a nominal decline, which accounts for the consistent decrease in expenditures. Table 2-A and Table2-B below provide details of the PCS expenditures from FY 2017 to FY 2019.

Table 2-A PCS Expenditures by Federal Authorities

1905(a) State Plan Authority	FY 2017	FY 2018	FY 2019
PCS Program	$72.6 Million	$68.2 Million	$67.6 Million

Table 2-B PCS Expenditures by Federal Authorities

1915(c) HCBS Waiver Authority	FY 2017	FY 2018	FY 2019
TBI Waiver	$1.5 Million	$1.6 Million	$1.7 Million
A&D Waiver	$94.9 Million	$97.2 Million	$117.6 Million
IDD Waiver	$222.3 Million	$222.7 Million	$233.7 Million
Total Expenditures	$318.7 Million	$321.5 Million	$353 Million

The Personal Options program, which operates under Section 1915(c) authority, allows waiver program beneficiaries the option to self-direct PCS. Self-directed PCS allows beneficiaries, or their appointed representatives, to exercise decision making authority over certain aspects of their care, such as financial management and hiring and supervision of PCAs. Each Personal Options waiver program experienced a significant increase of expenditures. Overall, the PersonalOptions program experienced an 83 percent increase in expenditures from FY 2017 to FY 2019. The increase was attributed to significant growth in beneficiaries choosing to transfer from agency-directed PCS to self-directed PCS for the ability to select a PCA that may be known to the beneficiary. The largest increase occurred in the A&D waiver program, which experienced a 525 percent increase in expenditures over this time. Table 2-C below provides details of the Personal Options Program expenditures. These expenditures represent beneficiaries that have chosen to self-direct their care and are included in the total expenditures within Table 2-B, as well.

Table 2-C PCS Expenditures by Federal Authorities

1915(c) Personal Options Program	FY 2017	FY 2018	FY 2019
TBI Waiver	$383.9 Thousand	$784.7 Thousand	$961.2 Thousand
A&D Waiver	$4.1 Million	$17.3 Million	$25.5 Million
IDD Waiver	$35.1 Million	$38.5 Million	$45.8 Million
Total Expenditures	$39.6 Million	$56.6 Million	$72.3 Million

[1] The unduplicated beneficiary count is the number of individuals receiving services in a specified time period, not units of service.

Most PCS expenditures are allocated to agency-directed services in West Virginia, although the percentage of expenditures allocated to self-directed PCS have been increasing nominally overthe three FYs included in this review. Table 3 below provides additional details.

Table 3. PCS Expenditure Analysis

	FY 2017	FY 2018	FY 2019
Total PCS Expenditures	$430.9 Million	$446.3 Million	$492.9 Million
% Agency-Directed PCS Expenditures	91%	87%	85%
% Self-Directed PCS Expenditures	9%	13%	15%

The Section 1905(a) Personal Care Services Program experienced a nominal decline in thenumber of unduplicated beneficiaries receiving PCS services from FY 2017 to FY 2019.

Expenditures under the State plan PCS program also experienced a nominal decline, which is consistent with the reported decrease in unduplicated beneficiaries. Table 4-A below provides additional information by waiver for agency-directed unduplicated beneficiaries under State planand waiver authorities. It should be noted that the State plan authority does not allow for self-direction of services. Therefore, reported agency-directed unduplicated beneficiaries are equal to total unduplicated beneficiaries under State plan authority.

Table 4-A. Agency-directed Unduplicated Beneficiaries*

PCS Program	FY 2017	FY 2018	FY 2019
1905(a) State Plan Authority	6,939	6,753	6,566
1915(c) HCBS Waiver Authority – TBI Waiver	29	33	78
1915(c) HCBS Waiver Authority – A&D Waiver	915	984	1,092
1915(c) HCBS Waiver Authority – IDD Waiver	4,628	4,837	5,707
Total Agency-directed Unduplicated Beneficiaries	12,511	12,607	13,443

The listed waivers provide PCS through agency-directed service delivery. Overall, the unduplicated beneficiaries increased by approximately 23 percent from FY 2017 to FY 2019.The number of unduplicated beneficiaries remained consistent with the reported increased expenditures during the three FYs reviewed. Table 4-B provides additional details.

Table 4-B. Self-directed Unduplicated Beneficiaries*

1915(c) Personal Options Program	FY 2017	FY 2018	FY 2019
TBI Waiver	36	36	38
A&D Waiver	920	963	1,088
IDD Waiver	1,327	1,593	1,925
Total Self-directed Unduplicated Beneficiaries	**2,283**	**2,592**	**3,051**

Results of the Review

CMS evaluated the following eight areas of West Virginia's PCS program:

1. State oversight of PCS program integrity activities and expenditures
2. Payment suspension based on credible allegations of fraud

3. Federal database checks
4. Screening levels for Medicaid providers
5. State overview of self-directed services
6. Agency-based PCS providers
7. Oversight of PCS agency providers
8. Electronic Visit Verification (EVV)

CMS identified 12 areas of concern with the state's PCS program integrity oversight that may create risk to the Medicaid program. CMS will work closely with the State to ensure that all of the identified issues are satisfactorily resolved as soon as possible through implementation of a corrective action plan. These areas of concern and CMS' recommendations for improvement are described in detail below.

1. State Oversight of PCS Program Integrity Activities and Expenditures

Federal regulations require the State Plan for Medical Assistance to provide for the establishment and implementation of a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate utilization of care and services and excess payments. The BMS has designated the Office of Program Integrity (OPI) to perform this function. The OPI is responsible for detecting fraud and abuse within the Medicaid program through reviewing paid claims history and conducting field reviews and investigations, to determine provider abuse, deliberate misuse, and suspicion of fraud. The OPI is responsible for planning, developing, and directing Agency efforts to identify, prevent, and prosecute fraud, abuse, and/or misuse in the Medicaid program. This includes verifying that medical services are appropriate and rendered as billed, services are provided by qualified providers to eligible recipients, payments for those services are correct, and all funds identified for collection are pursued.

The BMS, the State Medicaid Agency, retains ultimate administrative authority and responsibility for the operation of the waiver programs by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities. The OPI did not conduct any audits of Medicaid PCS agencies from FY 2017 to FY 2019. The BMS relies on the OA and UMC for general oversight of Medicaid PCS providers and the administration of PCS. The OPI does not have a process for exploring Medicaid program risk assessments, nor do they create an annual audit work plan that identifies areas of risk as a guide for oversight measures. **The BMS should take a more active role in Medicaid program oversight and annually analyzing risks to the Medicaid program.**

CMS provided a risk assessment toolkit in the "Technical Assistance Resources" section, below,to aid West Virginia in this work.

Table 5. Summary of Overpayments, Terminated Providers & Fraud Referrals

Agency-Directed and Self-Directed Combined	FY 2017	FY 2018	FY 2019
Identified Overpayments*	$0	$0	$0
Recovered Overpayments*	$0	$0	$0
Terminated Providers	0	0	0
Suspected Fraud Referrals	0	0	0
# of Fraud Referrals Made to MFCU**	8	13	2

*Identified and recovered overpayments in FY 2017- FY 2019 only include identified credible allegations of fraud.
** Please note the number of fraud referrals submitted were issued directly to MFCU from HCBS contractors.

The BMS is responsible for developing oversight policies and procedures of the OA and UMC that administer and manage PCS delivery for the Medicaid program. The OA and UMC are primarily responsible for the detection and prevention of fraud, waste, and abuse within the respective programs that they administer. The primary means of monitoring PCS is through provider reviews conducted by the OA and UMC for their respective programs, annually as required by BMS. The OA and UMC perform annual on-site reviews and desk documentation reviews as required by BMS to monitor program compliance. The OA and UMC also perform annual continuing certification reviews for agency and staff compliance. Targeted on-site personal care reviews and/or desk reviews may be conducted in follow up to incident management reports, complaint data, and corrective action plans. As part of the annual certification review, the OA reviews all submitted certification documentation and provides a report to BMS. Services provided that do not meet policy requirements must be repaid. The non-compliant provider must remove employees who do not meet requirements from provisionof services until certification standards are met and required documentation is approved by the OA.

The executed contract with the OA and UMC list objectives, deliverables, and reporting that outline a general framework for oversight. Although a framework for general oversight is provided by BMS, goals and strategies on identifying suspected fraud are not provided. The OA and UMC do not have program integrity units that conduct suspected fraud investigations or datamining to detect aberrant trends. The OA has a Quality Assurance Manager and supporting

Full-Time Employees (FTEs) for programmatic and quality of care measures. The UMC FTEs generally consisted of service support facilitators, provider educators, hearings coordinators, registration coordinators, and member/family liaisons to carry out the day-to-day programmatic operations of the programs. **Refining the contract with the OA and UMC presents an opportunity to enhance program integrity oversight.**

The OA reported the following recoupments resulting from the annual certification review pcss for all PCS programs:

- $73,738 in FY 2017
- $145,187 in FY 2018
- $10,315 in FY 2019

The OPI was unable to provide specifics on the nature of the recoupments, whether they were significant programmatic deficiencies, or if they could have been a result of potential suspected fraud. These findings were reported deliverables in the executed contract with the OA. The UMC, Kepro, did not have any reported recoupments or findings for the IDD and TBI waivers during the review period.
The OPI referred zero cases of suspected PCS fraud referred to the Medicaid Fraud Control Unit (MFCU) for the three FYs reviewed. The OPI does not regularly analyze PCS claims data, and there have been zero suspected fraud overpayments identified or recovered for the three FYs reviewed. Three of the four PCS provideragencies advised CMS that they did have suspected fraud referrals within the review period, but they were referred directly to the MFCU. The OPI was not notified of the suspected fraud, nor were the providers aware they were required to refer the suspected fraud to OPI. The OPI advised CMS that the MFCU regularly contacted OPI about

suspected fraud referrals from other sources to gather additional information to build criminal investigations. However, OPI did not have direct knowledge of the suspected fraud beforehand or have knowledge of the status of the ongoing MFCU investigations. **The BMS should have clarified within their contracts with provider agencies, the OA and the UMC the communication process for fraud referrals, including timelines and reporting mechanisms for alerting the OPI of suspected fraud within the state PCS provider network.**

The OPI has significant room for improvement to create strategies to identify and investigate more suspected fraud cases. The MFCU has potentially established itself as the lead program integrity authority for the Medicaid program in West Virginia. Without an effective Memorandum of Understanding (MOU) with the MFCU to establish parameters on information sharing and transparency on suspected fraud referrals, OPI will continue to have a low amount ofsuspected fraud referrals. Nevertheless, a lack of any identified suspected fraud referrals may indicate more oversight efforts are necessary to ensure adequate program integrity. The BMS was able to articulate overpayment procedures but was unable to provide any documented controls or policies on recouping and reporting overpayments when overpayments have been identified. The OPI advised CMS that the MFCU initiates recoupment for overpayments identified from referrals that result from investigations. **Therefore, BMS should formally draft and implement post-payment recovery policies to address overpayments identified from a credible allegation of fraud.**

Recommendation #1: The OPI should use a risk assessment process to create an annual audit work plan that may serve as guidance to providers and stakeholders on oversight objectives, priorities, and areas of risk.

Recommendation #2: The BMS should enhance contractual requirement(s) for the OA and UMC to implement and maintain procedures designed to detect and prevent fraud, waste, and abuse.

Recommendation #3: The BMS should communicate expectations about reporting suspected provider fraud to OPI, and execute an effective MOU with the MFCU detailing processes for investigating and referring suspected fraud in compliance with CMS requirements.

Recommendation #4: The BMS should formally draft and implement post-payment recovery policies to address overpayments identified from a credible allegation of fraud.

2. Payment Suspension Based on Credible Allegations of Fraud

Federal regulations at 42 CFR 455.23(a) requires that when the State Medicaid agency determines there is a credible allegation of fraud, it must suspend all Medicaid payments to a provider, unless the agency has good cause not to suspend payments or to suspend payment onlyin part. There were zero suspected fraud PCS referrals from BMS referred to, or accepted by, the MFCU for further investigation for the three FYs reviewed. As a result, the BMS did not initiate a PCS payment suspension for the review period. As mentioned earlier, a lack of payment suspensions could be attributed to BMS not having an executed MOU with the MFCU to outline processes for investigating and referring suspected fraud to the MFCU. The MFCU regularly received suspected fraud referrals from other sources and investigated suspected fraud without BMS' direct

knowledge. This process circumvents the regulations listed in 42 CFR 455.23, leaving BMS out of compliance with the regulations and with less control of their contracted Medicaid providers. The BMS stated that they have written policies and procedures for payment suspension. **The BMS did not provide policies or procedures for enacting provider paymentsuspensions, or exercising good cause exceptions as described in 42 CFR 455.23 Suspensionof payment in cases of fraud.** As a result, CMS was unable to determine if BMS has payment suspension policies in compliance with 42 CFR 455.23.

Recommendation #5: The BMS should review their internal policies and procedures, or create policies and procedures, to ensure they are in compliance with federal regulations in 42 CFR 455.23.

3. Federal Database Checks

CMS regulations at 42 CFR 455.436 require that the state Medicaid agency confirm the identity and check the exclusion status of a provider or persons with an ownership or control interest in a provider, as well as agents and managing employees of a provider. The Medicaid agency must check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe. The appropriate databases must be consulted to confirm identity upon enrollment andreenrollment, and the LEIE and EPLS be checked no less frequently than monthly.

The PCS provider agencies are required to obtain a certificate of need through the West Virginia Health Care Authority, and obtain a provider certification from the OA, which includes an onsite review. In addition, they must enroll with DXC Technology for a Medicaid provider number and obtain a National Provider Identifier (NPI) number. DXC Technology is responsible for conducting the required screening and enrollment process for PCS agency providers. This agreement is solely with DXC Technology and the providers. Public Partnerships, the contractedfiscal agent for the Personal Options program, is also conducting the required screening based onBMS policies and guidelines. West Virginia is one of 28 states awarded grant funds from the CMS to design a comprehensive background check program for direct patient access employees.Required registry checks are determined based on state and federal policy and/or legislation.

West Virginia Clearance for Access: Registry & Employment Screening (WVCARES) is administered by the Department of Health & Human Resources and the West Virginia State Police Criminal Investigation Bureau in consultation with CMS, the Department of Justice, and the Federal Bureau of Investigation (FBI).

WVCARES provides record of arrest and prosecution (RAP) back reviews. RAP back is an FBI service that will allow authorized government agencies to receive notification of subsequent activity on individuals who are under criminal justice supervision or investigation, thus eliminating the need for repeated background checks on a person from the same applicant agency. Authorized government agencies will receive on-going status notifications of any criminal history record information reported to the FBI and State (if applicable) after the initial processing and retention of criminal transactions. By using fingerprint identification to identify persons arrested and prosecuted for crimes, rap back provides a nationwide notice to noncriminaljustice authorities regarding subsequent actions. Thus, monthly database checks are not required because this is monitored in

real time.

All long-term care facilities and providers are required to conduct employee background checks. Statewide background checks are required for all employees hired and must be performed prior to the date of hire. Employees are not allowed to provide services until after the results of the background check have been received. As mentioned above, the registry checks are determined based on state and federal policy and/or law. Policy documents referenced direct care workers must "pass an OIG Medicaid exclusion screening monthly and thereafter," but specific databaseswere never provided. The SAM database screening is not limited to OIG exclusions, and may notbe part of the screening processes. **The BMS was unable to provide policies or verification that the required databases listed in 42 CFR 455.436 are part of the screening process.**

Recommendation #6: The BMS should ensure compliance with federal policy on required database checks, amend current WVCARES federal database check procedures, and amend the provider agreement if necessary in accordance with 42 CFR 455.436 to ensure compliance in its entirety.

4. Screening Levels for Medicaid Providers

High-risk and moderate-risk providers are subject to enhanced screening that may include onsite visits, FBI background checks, and FBI fingerprinting. The SMA is required to assign Medicaid-only categories of providers to an appropriate risk level. **The BMS has not identified high-risk and moderate-risk providers in accordance with 42 CFR 455.450. The BMS advised CMS that PCS provider agencies do not have a risk designation assigned by the BMS when undergoing provider enrollment.**

Recommendation #7: The BMS should ensure all Medicaid providers have been considered for risk designation, in accordance with 42 CFR 455.450.

5. State Oversight of Self-Directed PCS

A direct care worker must be at least 18 years of age and have the ability to perform the tasks required for the beneficiary receiving PCS. In addition, they must complete annual competency-based training required by the BMS. All direct care workers training requirementsconsists of: cardiopulmonary resuscitation, provided by certified trainers of OA-approved courses; first aid, provided by certified trainers of OA-approved courses; infectious disease control; competency based universal precautions; competency based on assisting members withADLs/IADLs; competency-based abuse/neglect/exploitation identification; competency-based Health Insurance Portability and Accountability Act (HIPAA) requirements; competency-baseddirect care ethics; and competency-based member health and welfare. The beneficiary is the employer on record, and may hire friends or family members as their direct care worker. A spouse, legal guardian, or legal representative acting as decision-maker on the participant's behalf cannot be hired as a direct care worker. Direct care workers are also subject to the WVCARES background checks as any other direct care worker that may be hired by a PCS agency.

The BMS maintains administrative oversight responsibilities for the quality-management of the

self-directed PCS program. The OA and UMC are responsible for the day-to-day management of quality activities in the quality management plan. The OA and UMC are responsible for ensuring the contract deliverables required by BMS are completed. The OA and UMC are required to monitor the FMS processes for prior authorization and timesheet review. The FMS acts as agent for the beneficiary/employer in gathering and maintaining relevant employee information; maintaining employer and employee files with necessary tax, Internal Revenue Service, and payroll information; and provide a system for payment and verification for services provided. The Personal Options program also provides beneficiaries with an added benefit of $1,000 per budget year for goods and services, not otherwise eligible for Medicaid reimbursement. Good and services are only available through the IDDW self-directed PCS program. IDWW also has Environmental Adaptations and Accessibility through the Traditional Model of $1,000 per budget year. The OA and UMC have the ability to conduct programmatic audits and investigate reported complaints as part of the contract deliverables with the BMS

The FMS identified 20 cases of suspected provider fraud or abuse in the A&D waiver program, 18 cases in the IDD waiver program, and no cases in the TBI waiver program for FY17, FY18, and FY19. The FMS vendor reported zero dollars in audit overpayments recovered for the three FYs reviewed. The BMS does not require the self-directed beneficiaries/employer of record to besubject to recoupments. If there are issues that arise during the OA/UMC A reviews related to the FMS contract deliverables with BMS; then the FMS is required to provide overpayments to the BMS and/or be subject to a corrective action plan (CAP). The FMS contract includes a requirement to provide reconciliation of claims submitted and claims paid to ensure no overpayments occurred.

PCS agency providers are subject to ongoing monitoring, programmatic audits, and overpayment recoupments. The BMS did not articulate a similar level of oversight and accountability for the Personal Options program. **The Personal Options program has a fraction of the expenditures and beneficiaries than the agency-directed programs, but more suspected fraud was identified in the Personal Options program than the other agency-directed programs. However, no overpayments or credible allegations of fraud were identified during the review period.** Even though beneficiaries may not be subject to recoupments due to program guidelines, vulnerabilities appear to exist and may require more oversight efforts to ensure adequate program integrity.

Recommendation #8: The BMS should review and revise self-directed PCS oversight efforts, initiate regular programmatic audits, and enhance investigations of self-directed PCS.

6. *Agency-Based Personal Care Services Providers*

As previously mentioned, providers of PCS deliver supports to Medicaid eligible beneficiariesin their own home or communities who would otherwise require care in a medical institution. These non-medical services assist beneficiaries with ADLs who have limited ability to care for themselves because of physical, developmental, or intellectual disabilities or conditions.

According to BMS, there were a total of 140 PCS agencies contracted to provide State Plan PCS,12 TBI waiver PCS providers, 139 A&D waiver PCS providers, and 85 IDD waiver PCS providers in FY 2019.

At the time of the review, rendering PCAs were not identified on claims data by any method. As a result, the BMS was limited in their ability to adequately review claims data to identify suspected PCS agency or individual PCS aide fraud. In fact, from FY 2017 to FY 2019, BMS didnot identify or refer any cases of suspected PCS fraud to the MFCU. As of October 2020, the BMS now requires all individual PCS aides to acquire an NPI, and the NPI must be listed in the rendering provider field on all claims billed for reimbursement. Having the ability to identify rendering PCAs on claims provide more transparency on services provided and allow BMS to adequately review claims data for aberrant billing trends.

The BMS also did not regularly conduct, require, or delegate unannounced onsite visits to further monitor PCA or agency activity. Unannounced visits to further verify services is an effective tool to identify suspected fraud, even when PCA identifiers are captured in claims dataor if they are not identified through aberrant trend data analysis.

The BMS has also not adopted compliant language, policies, and procedures for identifying and reporting adverse provider terminations. CMS guidance indicates "for cause" adverse terminations may include, but are not limited to, termination for reasons based upon fraud, integrity, or quality.[2] Section 6501 of the Affordable Care Act requires that state Medicaid agencies effectively terminate providers that have been terminated "for cause." These measures help to ensure adequate safeguards as a consequence for provider outlier behavior. Without proper notification procedures in place, the provider may be able to enroll as a Medicaid providerin another state. State Medicaid agencies are required to notify CMS of "for cause" terminations, which requires other Medicaid programs to initiate termination procedures for the provider if they are enrolled in another State Medicaid program.

Recommendation #9: The BMS and sister agencies should conduct or delegate regular unannounced onsite visits to further monitor PCAs and/or agency activities.

Recommendation #10: The BMS should: 1) Develop adverse provider termination criteria consistent with Section 6501 of the Affordable Care Act, including prompt notification requirements for adverse provider terminations. 2) Amend the provider agreement to communicate the criteria and requirements to providers.

7. Oversight of PCS Agency Providers

As part of the virtual review, CMS selected four provider agencies to be interviewed: Putnam County Aging, All Aid Services, Mulberry Street Management Services, and Prestera Center for Mental Health Services.

Each of the agencies advised CMS that they have encountered several circumstances where they terminated a PCS aide for suspected time sheet fraud. In each instance, there was no notification to the BMS or the MFCU of the suspected fraud. **None of these agencies have a policy or process for notifying the BMS when an employee is terminated for suspected fraud. The BMS also has not provided guidance on case referrals for employees terminated for fraudulent conduct.** Identifying and properly adjudicating PCA suspected fraud referrals will help to ensure that PCAs

[2] https://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/6501-Term.pdf

that engage in suspected fraud activity are identified and not recycled toother PCS agencies in the West Virginia Medicaid program.

Recommendation #11: The BMS should establish guidance on the basic requirements for all PCS providers regarding compliance program structure to ensure consistency within its MedicaidPCS program.

Recommendation #12: The BMS should establish guidance for PCS agencies on referring credible allegations of suspected fraud regarding individual PCS attendants to the BMS and/or the MFCU.

8. Electronic Visit Verification (EVV)

An EVV system is a telephonic and computer-based in-home scheduling, tracking, and billing system. Specifically, EVV documents the precise time and type of care provided by caregivers' right at the point of care. Some of the benefits of utilizing an EVV system include ensuring quality of care and monitoring costs expenditures.

Pursuant to Section 12006(a) of the 21st Century Cures Act, all states were required to implementan EVV system for PCS by January 1, 2020. During the review period, West Virginia had not implemented an EVV system for in-home scheduling, tracking and billing for PCS. West Virginia had a good faith exemption for implementing EVV that expired January 1, 2021. Due toCOVID, the EVV implementation was delayed and the good faith exemption expired without an operational EVV system. West Virginia received a financial penalty as a result of the delayed implementation. Currently, West Virginia does utilize an EVV system, which has been operational since March 2021.

CMS did not identify any recommendations regarding West Virginia's EVV system.

Status of West Virginia's 2016 Corrective Action Plan

West Virginia 's last CMS program integrity review was in April 2016, and the report for that review was issued in June 2017. The report contained eight findings and seven vulnerabilities. CMS completed a desk review of the CAP in April 2018. The desk review indicated that the findings from the 2016 review have all been satisfied by the state.

Technical Assistance Resources

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

- 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
- 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.
- Access Personal Care Services resource documents at the following link: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Personal-Care-Services
- 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.
- Consult with other states that have PCS programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of staff in program integrity.

Conclusion

CMS supports West Virginia efforts and encourages the state to look for additional opportunitiesto improve overall program integrity. CMS' focused review identified 12 areas of concern that should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the weaknesses will not reoccur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correctingthe issue. We are also requesting that the state provide any supporting documentation associated with the CAP, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

CMS looks forward to working with West Virginia to enhance and strengthen its program integrity function.