Department of Health and Human Services

Centers for Medicare and Medicaid Services

Center for Program Integrity

Connecticut Focused Program Integrity Review

Final Report

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review to determine the extent of program integrity oversight of the Personal Care Assistance (PCA) Services Waiver at the state level. The CMS review team also endeavored to assess the Department of Social Services (DSS) Office of Quality Assurance's (OQA's) oversight of the program integrity activities performed by the fiscal intermediary (FI) under contract with the state Medicaid agency. The OQA is responsible for program integrity in the DSS Medicaid program. In addition, we took the opportunity to follow up on items identified in the corrective action plan (CAP) which Connecticut submitted in response to CMS's previous comprehensive program integrity review held in 2011.

Background: State Medicaid Program Overview

The DSS is the single state agency that administers Medicaid and the Children's Health Insurance Program (CHIP). The agency delivers most of its programs through 12 field offices located throughout the state with central administrative offices located in Hartford. In addition, many services funded by the agency are available through community-based agencies and partner contractors.

HUSKY Health is the state of Connecticut's public health coverage program for eligible children, parents, relative caregivers, elders, individuals with disabilities, adults without children, and pregnant women. The eligibility criterion varies. There is no family income limit for coverage for children under age 19. HUSKY Health encompasses: HUSKY A (Medicaid for children/parents/relative caregivers and pregnant women), HUSKY B (non-Medicaid CHIP), HUSKY C (Medicaid for the aged, blind, and disabled, also known as Title XIX and including long-term care services), and HUSKY D (Medicaid for low-income adults).

Methodology of the Review

In advance of the onsite visit, CMS requested that Connecticut complete a PCA review guide that provided the review team with detailed insight into the program's operational activities. A four-person team reviewed the responses and materials that the state provided in advance of the onsite visit.

It is necessary to point out that the focus of this review is centered on program integrity activities and the provision of PCA services under the Home Community Based Services (HCBS) waiver prior to July 1, 2015. Shortly before the review, the HCBS waiver changed. Connecticut's Community First Choice state plan amendment was approved by CMS and became effective on July 1, 2015. The Community First Choice state plan benefit authorized under section 1915(k) of the Social Security Act assumed provision of PCA services from some of the HCBS waivers, in part or in full depending on the HCBS waiver. This amendment removed most PCA services from the HCBS waiver and those service would become self-directed personal care services under the Community First Choice program. The remaining HCBS waiver services under the

PCA waiver consist of care management, independent support broker, and adult family living/foster care.

During the week of September 14, 2015, the review team visited DSS's OQA, as well as the compliance staff of the FI, to discuss their program integrity activities at length. In addition, the review team also conducted sampling of Medicaid provider investigations and other primary data to substantiate OQA oversight of the FI's program integrity policies and procedures. The review team also met with the director of the DSS's HCBS program to assess the relationship between HCBS, OQA, and the FI.

Results of the Review

The review team identified nine areas of concern with the state's PCA program integrity activities and FI oversight, thereby creating risks to the Medicaid program. These issues and CMS's recommendations for improvement are described in detail in this report. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible.

Section 1: Personal Care Services

Personal Care Services Overview

The HCBS staff operates the PCA Medicaid waiver program that assists eligible disabled adults by paying for PCA services. The purpose of this waiver program is to provide adults who have permanent, severe, and chronic physical disabilities with access to PCA services to help them with self-care activities and enable them to reside in the community rather than an institution. The HCBS is responsible for calculating the consumer's share of liability that can be applied to the cost of waiver services. The HCBS also informs individuals determined eligible to receive waiver services of their due process rights and gives them the choice of institutional or home and community-based services.

The DSS contracts with an FI, Allied Community Resources (ACR), to conduct training for waiver participants on employment laws and guidelines. The FI also engages in fiscal monitoring, claims processing, and the payment of PCAs.

Service Delivery

The PCA waiver is a self-directed model of care. The waiver participant must be able to hire, fire, train, and manage their PCA providers, or have a representative appointed. Clients must be between the ages of 18 to 64 to participate in the PCA Medicaid waiver program and must require physical assistance with at least two activities of daily living, that without these services, the individual would require institutionalization.

A DSS-HCBS case manager conducts a home visit during the initial assessment phase and when there is a redetermination or request for a change in the level of service. During this assessment, the self-direction process is explained to the client. The client, in collaboration with the case manager, will decide if they are willing and able to self-direct and, if not, whom he or she would like to appoint as their representative. Participants must either have the cognitive capacity to understand the requirements of self-direction or appoint someone to act on their behalf.

The FI provides employer training which presents an opportunity for participants to verbalize their understanding and willingness to continue with self-direction. The employer training manual does not include education related to identifying or reporting provider fraud, waste, and abuse in the PCA program. It only touches on how to prevent timesheet fraud by immediately notifying the beneficiary's assigned social worker when a PCA provider is no longer in the beneficiary's employ. The PCA provider training manual does include education on how to identify and report fraud, waste, and abuse. It also includes a section on the False Claims Act.

Program Integrity Oversight

The OQA is responsible for ensuring the fiscal and programmatic integrity of programs administered by DSS. In addition, OQA is responsible for ensuring the integrity of administrative functions of the DSS. The OQA has five separate divisions, each with unique program integrity functions: Audit; Investigations and Recoveries; Special Investigations; Quality Control; and Third Party Liability.

Interactions between OQA and HCBS include collaboration on regulations and policy issues; collaboration regarding problematic providers; and access to the DSS case manager electronic database that includes client case notes and service plans. Two full-time forensic investigators have been assigned to the PCA waiver program.

The OQA utilizes data mining to identify outliers and aberrant billing patterns by individual PCA providers and PCA waiver participants. There is an edit in place in the Medicaid Management Information System (MMIS) that is set to deny PCA services that overlap with an inpatient stay only if the inpatient claim is submitted to the department first. The edit is designed to deny PCA services that fall in between the admission and discharge dates of an inpatient hospital stay.

The OQA is responsible for auditing the ACR. The objectives of ACR audits are as follows:

1. The services were rendered to an eligible beneficiary.
2. The billings properly reflect the type and amount of services rendered.
3. The services were medically necessary.
4. Original documentation was maintained to accurately evidence the services provided and the medical necessity of such services.
5. The provider adhered to all applicable federal and state statutes and regulations.
6. All available third party insurance was properly billed.
7. The provider adhered to all standards for licensure governing the type of service rendered.

8. The provider adhered to all terms and conditions of its provider agreement with the Department.

Section 2: Fiscal Intermediary

Summary of Fiscal Intermediary

The ACR compliance staff consists of a compliance director, compliance supervisor, intake manager, and a provider services manager. The ACR is a community-based provider of both financial management and direct support disability services for the state's PCA Medicaid waiver program, Connecticut Home Care Program for Elders (CHCPE), Acquired Brain Injury Medicaid Waiver Program (ABI), and the Money Follows the Person Program. The original information provided to CMS from ACR indicated they had over 30,000 PCA providers; however, there were only 12,625 active providers and 4,992 active household providers in the PCA directory at the time of the review.

Although the ACR maintains a provider directory that lists individual PCA providers who are eligible to provide services, not all providers listed in the directory are employed and not all providers who are employees chose to be listed in the directory. The directory is a listing of individuals willing and able to perform the duties expected of a PCA. It is available to participants of Connecticut Medicaid waiver programs who need to hire employees to work within their homes. Beneficiaries can hire more than one PCA provider, based on the level of care determination.

The ACR further explained that some PCA providers prefer not to be listed in the directory because they only want to care for the individual/client who hired them. It should be noted that the client's spouse, conservators, and individuals related to conservators cannot be hired to provide services to that client.

The ACR is not enrolled in Husky Health as a provider. However, the DSS's OQA provider enrollment staff has collected all of the disclosures required under 42 CFR 455.104 through 106 for the ACR. The review team reviewed the disclosures during the onsite for compliance to the regulations at 42 CFR 455.104 through 106. All disclosures were in compliance with regulation.

The ACR is responsible for enrolling the individual PCAs. The ACR enrollment process consists of a criminal background check and a check of the Department of Health and Human Services Office of Inspector General (HHS-OIG) List of Excluded Individuals and Entities (LEIE). The criminal background check is limited to the Connecticut criminal database or crimes committed in Connecticut. The ACR does conduct monthly database checks of the LEIE. The ACR does verify individual social security numbers, but does not check the Social Security Administration's Death Master File (SSADMF), the General Services Administration's System for Awards Management (SAM), or the National Plan and Provider Enumeration System (NPPES) at any time during the enrollment process. The ACR does not routinely re-credential PCAs unless the PCA is taking on additional clients.

Additionally, a beneficiary can hire individuals with a criminal background, if the beneficiary signs a waiver form acknowledging that they are aware of the person's criminal history. The program allows individuals with criminal histories that range from misdemeanor to felony convictions to participate as a PCA provider. The PCA providers with criminal backgrounds cannot be listed in the provider directory. Beneficiaries who decide to hire individuals with a criminal background and do not file a waiver with DSS are responsible for payment of wages to the PCA provider. The PCA providers who are identified as excluded on the LEIE are ineligible to participate in the program and cannot be hired.

The PCA providers invoice their billable PCA hours to ACR. The ACR is responsible for submitting the claim to the DSS through the DSS fiscal agent, Hewlett Packard. Claims are processed through the MMIS. The ACR is responsible for deducting payroll taxes and reimbursing the PCA provider.

Expenditures

For state fiscal year (SFY) 2015, PCA services were authorized for 1,111 beneficiaries and the expenditures for the year were approximately $32 million. This would indicate that the average expenditure for a PCA beneficiary in the year 2015 was approximately $28,713.

Table 1. Beneficiary Counts and Expenditures by SFY

Year	Client Count	Expenditure[1]
2013	1,044	$28,205,509
2014	1,072	$30,191,868
2015	1,111	$31,900,182

Section 3: Fraud, Waste, and Abuse and Audit Activities

Investigations of Fraud, Waste, and Abuse

Both OQA and ACR utilize data mining to identify outliers and aberrant billing patterns and work together on joint projects, such as identifying comparing a client's PCA claims and inpatient stay claims. The ACR and OQA staff indicated that it was difficult to recover monies associated with fraud, waste, and abuse because of the way the program is designed. Under the terms of the PCA Medicaid waiver program, a provider can be a Husky Health client this makes it hard to recoup overpayments as these individuals do not have the assets to lien or income to garnish. Once more, they cannot be excluded from receiving Medicaid services as long as they have legitimate medical needs. This holds true for beneficiaries who may be in collusion with PCA providers to defraud the PCA Medicaid waiver program.

[1] These numbers are based on dates of service and not paid dates.

Client services are authorized by the HCBS unit. A client's service plan defines the number of daily and/or weekly PCA service hours. The MMIS denies claims in excess of 24 hours of service on any single day. The DSS does not edit for the maximum daily hours allowable by each individual client's service plan. The ACR is responsible for provider claim review to ensure that claims do not exceed the maximum hours provided in the client's service plan.

Per OQA and ACR, the most common fraud schemes evident in the PCA program are billing for services when a client is in an inpatient setting, billing for services not rendered, and billing for more hours than approved. Individual PCAs cannot work more than 25.75 hours per client/per week; the PCA can exceed the hour limitation if the client has workers' compensation insurance. The OQA audit staff does not perform onsite audits of PCA providers. Onsite audits would serve as a useful tool in determining if the PCA providers are reporting to work, working the hours reported, and if collusion to defraud Husky Health exists between the provider and beneficiary. Based on ACR's HCBS contract, audits are the contractor's responsibility. The OQA reviews all complaints of fraud, waste, and abuse received from ACR. Those that have identified overpayments of $2,000 or greater and/or a credible allegation of fraud are referred to law enforcement. The OQA refers cases to the Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General (OAG) and the HHS-OIG.

It should be noted that ACR does conduct preliminary investigations of PCA provider allegations, but as described below the investigation is limited to verifying that the complainants, clients, and PCAs are participants in the program. A timesheet review is performed, if applicable, and a written statement is collected from the individual making the complaint.

The OQA has restructured the referral process to streamline information sent to the OAG's MFCU and the HHS-OIG. Previously, the OQA would obtain all supporting documentation from ACR prior to submitting the referral to law enforcement. Now, referrals contain enough information to support the "credible allegation of fraud" and allow law enforcement to collaborate with the OQA and ACR to obtain any additional information that may be warranted.

The OQA has limited access to the state wage database and has no way to match it to the PCA database either automatically or manually. Matches may be made by individual PCA provider, which is limited to a 15 month period, generally one to two quarters behind the current date; therefore, they are limited in their ability to determine if PCA providers are submitting claims for services rendered while being in the employ of another entity at the same time.

Referrals

The ACR refers cases of provider and consumer fraud to OQA. Although CMS does not normally mention reports of consumer fraud, self-directed PCA programs such as the subject of this report differ from CPI traditional reviews. During interviews, the OQA and ACR acknowledged that a good number of the fraud complaints involve consumer fraud or a combination of provider and consumers working together to defraud Husky Health.

The following chart lists the number of complaints sent to the state agency over the course of the last three SFYs. Of the 139 cases referred to OQA, only five were referred to law enforcement. Of the five referred, three cases were accepted. The others were declined for low dollar amount or prosecutorial discretion.

Table 2. Summary Referral Numbers by Involved Party

Year	Provider	Consumer	Both Provider & Consumer	Total
2013	23	8	24	55
2014	25	11	12	48
2015	19	4	13	36

PCA Vulnerabilities

Limited program integrity requirements in the contract:
The OQA does not have input into HCBS contracts with ACR. Input from the OQA would help strengthen the program integrity language and give ACR more authority to audit providers and conduct more complex preliminary investigations.

Lack of OQA and HCBS staff communication:
The OQA reported that there have been periodic meetings with HCBS staff to discuss problematic providers and weaknesses in the program. However, there is no evidence of any ongoing collaboration between the units that has resulted in changes in program requirements that would help identify and prevent fraud, waste, and abuse in the HCBS program.

The OQA has not provided any fraud, waste, and abuse training to ACR compliance staff:
The ACR stated their belief that the relationship with OQA could stand to be stronger. This was brought to the attention of the review team during interviews with the FI. The ACR participates in formal trainings presented by DSS, but there is no formal scheduled training between ACR and OQA.

The OQA has limited communication with ACR compliance staff:
The ACR would like to receive more feedback when referring cases. The Special Investigations Division does communicate with ACR during the investigative process by way of requesting additional information or documentation, but once a complaint is closed or referred to law enforcement, communication is limited. The ACR staff is aware of the $2,000 threshold limit, but would like to hear back regarding case resolution. The ACR staff has met with audit and investigation supervisors to discuss coordination of agency audit and investigation activities, and has advocated more coordination in hospital inpatient payment audits.

The FI does not conduct adequate oversight activities, as expected by the state, to safeguard the PCA Medicaid waiver program:
The ACR staff indicated they are to only handle the administrative piece of the PCA Medicaid waiver program, CHCPE, ABI, and the Money Follows the Person Program; therefore, they only conduct very limited preliminary investigations. The ACR functions as a third party entity and

does not deviate from the stipulations outlined in the contract. However, when asked about the provisions in Part I, Section II: Scope of Services, Subsection 2.f. labeled QUALITY ASSURANCE, both the ACR and OQA stated that they were not aware of the provisions.

Part I, Section II: Scope of Services, Subsection 2.f. labeled QUALITY ASSURANCE of the contract states:

> "The Contractor, with the Department's input and consultation, shall develop and implement mechanisms to ensure that reimbursable waiver services have been provided in the quantity, scope and duration indicated on timesheets and/or invoices. Mechanisms may include, but are not limited to the following:
>
> - random calls,
> - investigation of complaints,
> - verification of the accuracy of time sheets and/or invoices in agreement with the waiver participants' approved service plans, and
> - review of signature cards or copy of signature on file."

The ACR stated that they support state investigations by providing information or documents, as requested, relating to their investigations. The ACR also provides the same to the MFCU, as requested. In addition, the OQA issues directives regarding provider removal from the directory, services, suspension on payments to providers, or money recovery from agencies.

The ACR staff did mention that they have software to monitor discrepancies and irregularities that may occur, such as PCA providers exceeding the hour multiple client limits, but the investigative work does not go any further.

It should be noted that since ACR is a third party liability contractor, they do not formally have a special investigations unit. They currently have one individual who handles all complaints related to any of the waiver programs they administer. All complaints received via telephone are directed to the ACR compliance supervisor for triage. The compliance supervisor addresses complaints in real time, solicits a written statement from the complainant, and checks the system for eligibility. The most common complaints received by ACR are related to the PCAs exceeding hours, multiple PCA providers, and timesheet fraud.

The ACR does not conduct unannounced site visits because it is not a contract requirement:
The ACR indicated that unannounced visits are not conducted for PCA providers because they are not contractually obligated to do it. Although, the state's contract with ACR indicates the following as it relates to ABI waiver agency vendors only:

> "The Department and/or the Contractor shall conduct (separately or jointly) site visits at funded facilities and program sites administered by the Contractor."

It appears that there is no contractual language that requires ACR to conduct any site visits, whether announced or unannounced, in the PCA Medicaid waiver program. Since January 1, 2015, caseworker services are contracted out to a separate contractor. Reporting requirements

are built around critical incidents, if a critical incident involves fraud, waste, or abuse. The HCBS staff will refer the case to OQA. Caseworkers are supposed to make site visits along with monthly calls; however, caseworkers have made some unannounced site visits based on policy violation findings. Although case workers are trained to identify physical abuse, they are not trained in how to detect, identify, and report instances of fraud. Although it is ACR's responsibility to monitor, identify, and report fraud, waste, and abuse to OQA, site visits by either party can be a powerful deterrent to PCA fraud.

The state's contract does not provide direction to ACR regarding the re-credentialing/re-enrollment of individual PCA providers, which is only performed when taking on new clients:
To get newly credentialed agencies started off well, they are audited at three to four months of service and again at the one year time period. However, this is done for agencies and not individual providers in the PCA Medicaid waiver program. The ACR is instructed to audit existing agencies randomly, unless directed to audit a specific agency based on reported problems such as a critical incident report. However, individual PCA providers are not re-credentialed or re-enrolled unless they are taking on new clients. If an event occurs at a client's house with an agency-based service provider, it is supposed to be submitted to the state's OQA for review. Sometimes, the state will ask for ACR to do a visit. If there are findings based on ACR's review of the case, ACR does not have the authority to stop an individual's employment, or remove employment or participation in the program. The state has to provide direction.

Per the contract, ACR must, "Implement national and local criminal background checks for all waiver programs as articulated in the provider credentialing sections of the ABI, PCA and CI-ICPE Waivers." It appears that ACR is abiding by this contract application in all the waiver programs which includes the PCA Medicaid waiver program.

The OQA has limited access to the state wage database:
During interviews, the OQA reported to the review team that it had limited access to the state wage database and had no way to match PCA social security numbers with the database to determine if a PCA is claiming time for working for a client, while actually being employed elsewhere. Matches may be made by individual PCA provider, which is limited to a fifteen month period, and is generally one to two quarters behind the current date; therefore, they are limited in their ability. Should full state wage database access be granted, resulting matches could be an important tool that may assist in identifying timesheet fraud.

HCBS Timesheets are vulnerable to manipulation:
During interviews with state and ACR staff, the review team was told several times that timesheet fraud occurs frequently within the PCA Medicaid waiver program. The ACR staff indicated that they receive many timesheet fraud complaints regarding the employer signing the timesheet and the employee later adding additional time to it.

As currently formatted, timesheets do not have a "total hours" column. In addition, PCAs can add hours after the client has signed off on the agreed upon hours. The employer training manual does not include education related to identifying or reporting provider fraud, waste, and abuse in the PCA program. It only touches on how to prevent timesheet fraud by immediately

notifying the beneficiary's assigned social worker when an PCA provider is no longer in the beneficiary's employ. The PCA provider training manual does include education on how to identify and report fraud, waste, and abuse. It also includes a section on the False Claims Act.

Recommendations for Improvement

- The state should ensure that OQA is given the opportunity to provide feedback and input on the program integrity provisions, such as the inclusion of language pertaining to unannounced site visits, in the FI contract with ACR.
- The state should ensure that OQA meets more frequently with HCBS staff to discuss program integrity concerns.
- Increase communications between OQA and ACR by facilitating regular meetings; providing fraud, waste, and abuse training for issues arising in the PCA waiver program; and developing a process to provide feedback regarding the disposition of fraud, waste, and abuse referrals.
- The state should require ACR to re-enroll individual PCA providers at a minimum of once every five years.
- The state HCBS should consider revising the timesheets to include a "total hours" column and educate the clients to not sign the timesheets until they are satisfactorily filled out.

Section 4: Status of Corrective Action Plan

Fiscal Year 2010 Cap Review

Overview:

Connecticut's last CMS program integrity review was comprehensive and was finalized in 2011. The 2015 review team conducted a review of the corrective actions submitted in 2011 which identified six federal regulatory compliance issues and nine areas of vulnerability. The review team acknowledged that a number of the regulatory compliance findings were no longer applicable, since the state ceased to contract with managed care organizations (MCOs) for the delivery of managed care services effective January 1, 2012. To that end, all references to MCOs in the October 2011 CAP letter were not referenced during the 2015 review. All issues except for vulnerabilities #1 and #2 were satisfactorily addressed by the state. Vulnerability #1 is considered outstanding because written policies and procedures were not in place at the time of the review. Vulnerability #2 is considered outstanding because the state could not assure the review team that all required databases are checked during enrollment, specifically the SSADMF.

Findings

1. ***The state does not refer all suspected provider fraud to the MFCU.***

   Status at time of review: Corrected

   The state continued to disagree with this finding, but also admitted to streamlining their process as they restructured their organization. There are four full-time employees assigned to the Special Investigations Division, with additional support for data mining activities from staff in other areas of the department. The core Special Investigations Division team has a background in fraud and forensic investigation, while the support staff includes account examiners. The state does not require any specific training from the Special Investigations Division staff, but they do encourage staff to attend the Medicaid Integrity Institute and report back after each session.

   There were 16 referrals forwarded to the MFCU as of September 2014, which surpassed the total amount submitted for the entire previous year.

2. ***The state withholding letter for payments does not reference the required federal regulation.***

   Status at time of review: Corrected

   The state supplied a letter to CMS that included the required language and reflected the requirements for payment suspension under 42 CFR 455.23.

3. ***The state does not report adverse actions taken on provider applications to HHS-OIG.***

   Status at time of review: Corrected

   The state indicated they have completed two adverse actions in the last year. The memorandum of understanding (MOU) between OQA, the MFCU, and HHS-OIG was revised in 2013 to clearly identify the responsible parties for each task.

4. ***Connecticut does not notify all required parties when there is a state-initiated exclusion.***

   Status at time of review: Corrected

   Initially, the state believed this finding was related to the MCOs which they no longer use for healthcare services; however, changes were made to the process. Currently, the state notifies all required parties when exclusions are initiated.

5. ***The state does not report all convictions of crimes against Medicaid to HHS-OIG.***

   Status at time of review: Corrected

The state reports convictions to the CMS portal. Otherwise, the MFCU is responsible for reporting healthcare convictions to HHS-OIG. The MOU was revised in 2013 to clearly identify which party is responsible for reporting criminal conviction information to HHS-OIG. A copy of the MOU was provided to CMS during this review.

Vulnerabilities

1. ***Not having adequate written policies and procedures.***

   Status at time of review: Not corrected

   In the state's CAP, Connecticut agreed to complete the development of written policies and procedures covering all program integrity processes to ensure compliance with federal regulations. This continues to be an ongoing process with a number of revisions to the document, but ultimately the complete development and implementation of written policies and procedures were never finalized. The state expects to have adequate written policies and procedures in place by the end of 2015.

2. ***Not conducting complete exclusion searches.***

   Status at time of review: Not corrected

   The state indicated that all required databases are checked upon enrollment, re-enrollment, and on a monthly basis thereafter. The databases that are checked include the LEIE, the Excluded Parties List System, the SAM, the NPPES, and the SSADMF.

Technical Assistance Resources

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

- Consult with CMS and other states to develop a process to ensure the DSS has adequate controls in place to oversee the PCA services being provided in the state. Refer to the HHS-OIG's 2012 portfolio on PCS for additional recommendations to improve the integrity of PCS in Medicaid. More information can be found at https://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf.
- Access information posted by states and CMS on personal care service issues in the Regional Information Sharing Systems as a means of gathering information and ideas that may improve the DSS program integrity monitoring efforts. For example, review the state PCS program best practices compiled by CMS in Dec. 2012 in the bulletin entitled *"Personal Care Services in State Medicaid Programs: Best Practices in Preventing and Identifying Fraud, Waste, and Abuse in Personal Care Services."*
- Take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to the

DSS's OQA based on the concerns identified in this report include those related to provider enrollment, screening, and emerging trends in home health care. More information can be found at http://www.justice.gov/usao/training/mii/training.html.

- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Consult with CMS's audit contractor on recommendations for strengthening oversight and monitoring in the state's PCS program.
- Access the annual program integrity review summary reports on the CMS's website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states, some of which touch on the areas covered by this focused review.

Conclusion

CMS supports Connecticut's efforts and encourages it to look for additional opportunities to improve overall program integrity. The CMS focused review identified areas of concern which should be addressed immediately.

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

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

Official Response from Connecticut
June 2016

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

June 9, 2016

Mark Majestic, Director
Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop AR-21-55
Baltimore, Maryland 21244-1850

Dear Mr. Majestic:

The Connecticut Department of Social Services (DSS), the dedicated state agency for the administration of the Medicaid program, has reviewed the Connecticut Focused Program Integrity Review Final Report issued by the Department of Health and Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS) on May 12, 2016.

The audit's objective was to "determine the extent of program integrity oversight of the Personal Care Assistance (PCA) Services Waiver at the state level." DSS appreciates the opportunity to provide comments concerning the CMS Vulnerabilities that were identified and the recommendations that were made.

DSS response to the CMS Current Vulnerabilities Identified:

CMS Vulnerability: Limited program integrity requirements in the contract.

Department Response: The Office of Quality Assurance will provide input into the next contract developed with the fiscal intermediary that will go into effect July 1, 2016. The current contract expires June 30, 2016.

CMS Vulnerability: Lack of Office of Quality Assurance and Home and Community Based Services staff communications.

Department Response: Quarterly meetings will be held to discuss the open investigations, status of complaints, and referrals and recommendations for strengthening controls and processes, as needed, to reduce fraud, waste and abuse. The first meeting will be held in July 2016. On a monthly basis, the Office of Quality Assurance will provide a status report to the program staff reporting on complaints that have been closed and complaints that have been opened for review.

CMS Vulnerability: The Office of Quality Assurance has not provided any fraud, waste, and abuse training to the fiscal intermediary compliance staff.

Department Response: The Office of Quality Assurance will evaluate the fiscal intermediary's current responsibilities concerning investigating complaints to determine whether any training is warranted. This evaluation will be performed in conjunction with updating the new contract that will go into effect July 1, 2016

CMS Vulnerability: The Office of Quality Assurance has limited communications with the fiscal intermediary.

Department Response: On a monthly basis, the Office of Quality Assurance will also provide a status report as mentioned above to the fiscal intermediary reporting on complaints that have been closed and complaints that have been opened for review. The monthly reports will be provided starting in September 2016.

CMS Vulnerability: The fiscal intermediary does not conduct adequate oversight activities to safeguard the PCA Medicaid waivers program.

Department Response: The Office of Quality Assurance with collaboration with the Home and Community Based Services staff will evaluate the provisions included in the current contract and update as needed to strengthen the program integrity of the PCA program in the most cost effective manner. As part of this collaboration, the Department will institute a process to monitor the fiscal intermediary's compliance with the contract. Any new process developed. will be implemented in conjunction with the new contract that will go into effect July 1, 2016.

CMS Vulnerability: The fiscal intermediary does not conduct unannounced visits because it is not a contract requirement.

Department Response: The Office of Quality Assurance with collaboration with the Home and Community Based Services staff will evaluate the provisions included in the current contract to determine whether unannounced visits would be a cost effective control that should be incorporated into the current contract. As part of this collaboration, the Department will institute a process to monitor the fiscal intermediary's compliance with the contract. Any new process developed will be implemented in conjunction with the new contract that will go into effect July 1, 2016.

CMS Vulnerability: The State's contract does not provide direction to the fiscal intermediary regarding re-credentialing/re-enrollment of individual PCA providers, which is only performed when taking on new clients.

Department Response: The Department will revise the contract as needed to incorporate provisions concerning re-credentialing/re-enrollment of individual PCA providers. The new contract will be effective July 1, 2016. As part of this revision, the Department will require the PCA providers to be re-credentialed every two years.

CMS Vulnerability: The Office of Quality Assurance has limited access to the state wage database.

Department Response: The Department will pursue revising its current Memorandum of Understanding with the State Department of Labor to ensure that the Department is obtaining the best available wage information to conduct its investigations. The implementation start date cannot be determined.

CMS Vulnerability: HCBS timesheets are vulnerable to manipulation

Department Response: HCBS has initiated the process to modify the time sheet to have a section for total hours worked. Additionally, the department is moving forward with offering an electronic visit verification system to consumers as an alternative to paper time sheets. We expect that this would increase program integrity. The implementation start date will be September 1, 2016.

DSS' Response to the Current Recommendations:

CMS Recommendation: The state should ensure that the Office of Quality Assurance is given an opportunity to provide feedback and input on the program integrity provisions in the fiscal intermediary contract.

Department Response: The Office of Quality Assurance will provide input to the provisions of the contract with the fiscal intermediary that will go into effect July 1, 2016. The current contract expires June 30, 2016. The draft of the new contract will be forwarded to the Office of Quality Assurance for its input prior to the new contract going into effect.

CMS Recommendation: The state should ensure that the OQA meets more frequently with the HCBS staff to discuss program integrity concerns.

Department Response: The Office of Quality Assurance will meet with the HCBS staff on a quarterly basis to discuss program integrity concerns. The meetings will initiate in July 2016.

CMS Recommendation: Increase communication between OQA and the fiscal intermediary by facilitating regular meetings; providing fraud, waste and abuse training for issues arising in the PCA waiver program; and developing a process to provide feedback regarding the disposition of fraud, waste, and abuse referrals.

Department Response: The Office of Quality Assurance will include the fiscal intermediary in the quarterly meeting with HCBS staff to discuss program integrity concerns. The meetings will initiate in July 2016. The Department will evaluate the fiscal intermediary's responsibilities concerning complaints and provide the necessary guidance in order for the fiscal intermediary to meet its responsibilities.

CMS Recommendation: The state should require the fiscal intermediary to re-enroll individual PCA providers at a minimum of once every five years.

Department Response: The Department will revise the contract as needed to incorporate provisions concerning re-credentialing/reenrollment of individual PCA providers. As part of this revision, the Department will require the PCA providers to be re-credentialed every two years. Notifications will be sent to providers in July 2016 that they need to reenroll by the end of September 30, 2016. Those providers that enrolled in the program in the month of September in a year 2014 or prior will need to reenroll by September 30, 2016. This monthly approach will take place until all providers have been reenrolled by August 2017. This approach would spread out the reenrollment proportionally throughout the year.

CMS Recommendation: The state HCBS should consider revising the timesheets to include a "total hours" column and educate the clients to not sign the timesheets until they are satisfactorily filled out.

Department Response: HCBS has initiated the process to modify the time sheet to have a section for total hours worked. Additionally, the department is moving forward with offering an electronic visit verification system to consumers as an alternative to paper time sheets. We expect that this would increase program integrity. The implementation start date will be September 1, 2016.

DSS Response to Prior Report Uncorrected Vulnerabilities:

CMS Vulnerability: Not having adequate written policies and procedures.

Department Response: The written policies remained in draft form due to the continue changes in state legislation that required the draft policies to be updated to meet the new legislation. The Department will finalize the procedures within the next year based on legislation that is in place as of June 30, 2016, Revisions to the written procedures will be made as necessary to accommodate any new legislation rather than continuing to maintain the procedures in draft form.

CMS Vulnerability: Not conducting complete exclusion searches.

Department Response: As indicated in the report, all required databases are checked. The Department believes this vulnerability was corrected.

Thank you for the opportunity to respond to these vulnerabilities and recommendations. The Connecticut Department of Social Services remains committed to maintaining the integrity of all aspects of the Medicaid program, from the health and well-being of our beneficiaries to the proper utilization of funds in support of payment of this vital program.

If you have any questions or comments or require any additional information from the Department, do not hesitate to contact my office. In my absence you should feel free to contact Deputy Commissioner Kathleen Brennan at kathleen.brennan@ct.gov; (860) 424-5693; John McCormick, Director, Office of Quality Assurance at john.mccormick@ct.gov; (860) 424-5920 or Frank LaRosa, Director, Office of Quality Assurance-Audit Division, at frank.larosa@ct.gov; (860) 424-5855.

Sincerely,

Kate McEvoy, Director
Division of Health Services

cc: Roderick L Bremby, Commissioner
Kathleen Brennan, Deputy Commissioner, Programs & Administration, DSS
John McCormick, Director, Office of Quality Assurance, DSS
Brenda Parrella, Director, Office of Legal Counsel, DSS
Frank LaRosa, Director, Audit Division, Office of Quality Assurance, DSS
Christopher Godialis, MFCU Director
Jackie Garner, CMCHO Consortium Administrator
Richard McGreal, DMCHO Associate Regional Administrator