Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

District of Columbia Focused Program Integrity Review

Final Report

December 2015

Submitted By:
Barbara Davidson
Iris Allen
Richard Colangelo
Lauren Reinertsen
Mark Rogers
Debra Tubbs
Joel Truman, Review Manager

Table of Contents

District of Columbia PI Review Final Report
December 2015

Objective of the Review

The Centers for Medicare and Medicaid Services (CMS) conducted a focused review to determine the processes used by the District of Columbia's Medicaid agency to identify, investigate, and act upon potential fraud and abuse in its personal care services (PCS) programs. The review included an examination of the District's oversight and monitoring of PCS and associated providers. The review also included a follow up on the state's progress in implementing its corrective action plan (CAP) that resulted from CMS's last program integrity review in 2012.

The report below discusses the background and results of the PCS review in the District. The assessment of the Medicaid agency's CAP is included as an addendum to this report.

Background: Overview of PCS Programs in the District

The District provides home care primarily as a Medicaid State Plan service, but home care is also provided within the framework of home and community based services (HCBS) waiver and managed care programs. PCS programs are delivered in all cases through home health agencies (HHAs). Personal care attendants (PCAs) are employees of the HHAs and are not directly enrolled as providers in the Medicaid program. Fraud and abuse in the District's PCS programs have raised concerns for some time. For example, a 2010 report by the United States Department of Health & Human Services' Office of Inspector General (HHS-OIG) noted significant problems in 2006-07 with a major PCS provider in the District,[1] including lack of documentation or prior authorization to support claims and generally limited or poor state oversight. The District itself referred several HHAs to its Medicaid Fraud Control Unit (MFCU) in 2009, which requested a hold on any administrative actions while the cases were being worked. Their status as ongoing investigations hindered the District for several years from taking action against certain agencies which were known to be overbilling Medicaid. Finally, in February 2014, the Federal Bureau of Investigation (FBI) raided 5 of the HHAs that had been referred to the D.C. MFCU and arrested over 20 individuals for whom it had warrants on charges of Medicaid fraud.[2] This led to a series of payment suspensions, termination actions, and administrative sanctions against the most egregious agencies. At the time of the CMS review, some terminations and administrative sanctions were still subject to appeal.

The utilization of PCS and corresponding Medicaid expenditures has grown enormously in the last decade. The FBI estimated that the District paid roughly $40 million for PCS on behalf of 2,500 Medicaid beneficiaries in 2006. By the District's fiscal year (FY) 2013, around 10,000 beneficiaries certified as eligible for PCS; and between FY 2011 and FY 2013, Medicaid

[1] Department of Health & Human Services, Office of Inspector General-Office of Audit Services, Report # A-03-08-00207, Review of Personal Care Services Provided by Tri-State Home Health And Equipment Services, Inc., in the District Of Columbia, Nov. 2010. Available online at http://oig.hhs.gov/oas/reports/region3/30800207.asp.

[2] U.S. Attorney's Office, District of Columbia, press release of Feb. 20, 2014, available online at http://www.fbi.gov/washingtondc/press-releases/2014/more-than-20-people-arrested-following-investigations-into-widespread-health-care-fraud-in-d.c.-medicaid-program.

spending for State Plan PCS alone had jumped from nearly $102 million to almost $262 million (including $183 million in federal dollars), a 157 percent increase.[3]

The District contributed to this increase by failing to put processes in place that would have prevented abusive actions by the HHA providers who came under law enforcement scrutiny. Prior to November 2013, the District's regulations allowed HHAs to assess potential PCS clients, authorize and repeatedly re-authorize PCS service levels, and then exercise an option to provide those services to the same beneficiaries. This allowed the agencies to drive the process of authorization for their own services and gave unethical providers opportunities to inflate beneficiary service needs for their own gain.

Methodology of the Review

In advance of the onsite visit, CMS requested that the District and the one managed care organization (MCO) that furnished significant amounts of PCS complete a review guide that asked detailed questions about the operational areas covered by this focused review. A five-person team reviewed the responses and materials that the state provided in advance of the onsite visit.

During the week of June 23-27, 2014, the CMS review team met with staff and managers from the District's Department of Health Care Finance (DHCF) who oversee program integrity and the PCS program. The team also met with personnel from the Medicaid managed care contractor in the District which provides specialized pediatric PCS to children and adolescents with special needs. In addition, the team interviewed officials at the Board of Nursing within the Department of Health's Health Regulatory Licensing Administration. This board has the responsibility for certifying personal care aides (PCAs). Lastly, the team visited the offices of a DHCF contractor which had taken over the function of performing impartial and unbiased beneficiary needs assessments for PCS in the preceding year.

The team likewise completed interviews and site visits at the four selected HHAs. The agencies chosen for review were not currently suspended or terminated from the DHCF Medicaid program or under review by CMS audit contractors. The purpose of the agency visits was to determine the extent to which problematic billing and assessment practices had been curbed in agencies that were not the immediate targets of the FBI sting or D.C.'s subsequent administrative sanctions after the District had put in place new safeguards. One of the HHAs selected primarily served clients in the pediatric special needs program. The other three agencies catered to clients using both State Plan PCS services and services provided under the authority of the District's Elderly & Persons with Physical Disabilities (EPD) waiver program. Because of time limitations, the review did not examine the provision of PCS for beneficiaries in the District's second HCBS waiver program, which serves individuals with intellectual and developmental

[3] Based on interviews, the team learned that this increase was in part attributable to a specific billing methodology employed by the District, which potentially shifted some personal care expenditures in one of its HCBS waiver programs to the State Plan PCS program. However, there is general consensus about the large increase in Medicaid PCS spending in recent years.

disabilities. While we focused on the larger EPD waiver program, many of the issues identified by the team would apply to the other waiver program.

To review the District's changing PCS process, the team selected four to seven beneficiaries from each of the four HHAs. The beneficiary sample was randomly selected but should not be considered a statistically valid sample. The team divided into two groups which visited two HHAs apiece. Each group was accompanied by a registered nurse from DHCF with extensive experience in HHA assessments and completed a record review for each beneficiary in the sample. The groups also looked at HHA service authorizations and billings between June 2013 and June 2014. These time parameters were chosen in order to confirm that the District's beneficiary assessment process changed after new PCS regulations were promulgated in November 2013, something that the team observed.

The onsite visits to the HHAs included a review of beneficiary Plans of Care (POCs) and of the timesheets which the PCAs who provide services must complete. The team also reviewed the personnel records of the PCAs assigned to the beneficiaries. It looked, among other things, for background checks, evidence of completion of mandated training, and ongoing supervisory reviews. After the on-site review of records, the team selected six beneficiaries and checked the authorization for care with DHCF and the assessment contractor. The team matched the amount of hours authorized with the hours provided, billed, and paid in the District's paid claims records. Additionally, the team reviewed a sample of HHA provider enrollment records and fraud referrals developed by DHCF.

Results of the Review

The review team observed that the District of Columbia has made several improvements in its regulations and processes to control improper payments to PCS providers and better monitor the PCS benefit. The team also identified some remaining problems and opportunities to further strengthen the District's PCS processes.

Improvements

New Regulations for PCA Services

In November 2013, the District promulgated new and stronger regulations which addressed several areas of concern in the PCS program.[4] To prevent HHAs from continuing to drive the assessment process and authorization for services, these new regulations established a process for an independent assessment of need and authorization for PCA services. The regulations also defined the responsibilities of HHAs for managing and supervising PCAs regardless of employment status and instituted accountability for compliance with all rules associated with PCA service delivery. They also strengthened prohibitions regarding financial relationships among HHAs, physicians, nurse practitioners, and staffing agencies.

[4] Chapter 50, Medicaid Reimbursement for Personal Care Aide Services, of Title 29, Public Welfare, of the District of Columbia Municipal Regulations (DCMR), Vol. 60 – No. 48, November 8, 2013

In addition, the new regulations included additional recordkeeping requirements, clarified the level of disability that a Medicaid beneficiary must have in order to qualify for PCA services, and established requirements for advance notice to beneficiaries who were required to leave a provider's care or were subject to a reduction or termination of PCA services.

Conflict-Free Assessment and Authorization Process for PCS under State Plan and EPD Waiver

As part of the new PCA service regulations, the District's Medicaid program has contracted with a non-HHA provider to conduct beneficiary assessments for PCS under the State Plan and EPD waiver. This process allows the contractor to assess the beneficiary without a conflict of interest. The referral for services from the physician is received by the contractor, which then conducts the assessment of the beneficiary and authorizes the appropriate frequency and duration of service. During the transitional period in the first half of calendar year 2014 when a large number of clients had to transfer from problematic HHAs and required new assessments, DHCF augmented the work of the contractor by adding six other HHAs specifically contracted to conduct objective assessments.

Reduction in PCS Utilization

The District has experienced a reduction in the amount of PCS utilized. This may be attributable to several factors in its changing environment.

As noted above, the District now has a more impartial process for assessments through its use of a contractor and six temporary HHAs to assist with the recent transitional workload. This appears to have impacted the PCS census in 2014. The assessment contractor reported that from January through May 2014, 225 PCS clients from problematic HHAs and 183 potentially new PCS clients were denied PCS because they either failed to keep appointments or could not be contacted. These represented 20 percent of all the clients processed during this period. The assessment contractor also reported reductions in the total hours of care approved. For example, in May 2014 care hours were reduced for seven percent of the clients who had been previously assessed by and affiliated with problematic HHAs but who subsequently received conflict-free assessments. The use of a conflict-free assessment process appears to have generated a reduction in hours and had a gate-keeping effect.

The new PCA service regulations of November 2013 have also provided for enhanced HHA accountability, prohibited financial relationships among HHAs, physicians, nurse practitioners, and staffing agencies, and increased recordkeeping requirements. The law enforcement actions taken against HHAs and their personnel in the first half of 2014 also clearly sent a message to unethical providers that incidents involving fraud, waste, and abuse in PCS will be investigated fully and those involved will be prosecuted.

Increased Enforcement Actions Against Problem HHAs: Suspension of Payments, Transfer of PCS Clients, and Terminations

The widespread suspected fraud uncovered in the Medicaid PCS program in the District during the February 2014 takedown of HHA operators and nurse staffing agencies, office workers, and

PCAs by federal and local law enforcement helped lead to significant change in the PCS landscape in the District.

In the initial aftermath of these investigations, PCS clients from four Medicaid HHAs had to be immediately transferred to other HHA providers. The DHCF, with teams of its own nurses, worked aggressively to transfer clients quickly and successfully minimized care disruption. At the time of this review, the four HHAs in question were scheduled for termination in July. Per District representatives, the actual Medicaid termination date would depend on when appeals were concluded with the Office of Administrative Hearings and if a determination was decided in the District's favor. Roughly a month after the District's termination actions against the first four HHAs, it targeted two additional HHAs for termination. This required DHCF nurses and the assessment contractor to work cooperatively to provide hundreds of assessments, authorizations, and placements for additionally displaced clients. To assist, DHCF added six new HHAs to conduct assessments during this period. Since the CMS review, one of latter two targeted agencies has appealed. The other reached a settlement in which its payment suspension was lifted in return for agreeing to leave the Medicaid program.

Besides the terminated agencies, six other HHAs received payment suspensions. At the time of the review, some were actively appealing these actions, and some had received settlement agreements allowing them to continue in Medicaid but limiting their PCS client caseload. For example, one HHA was limited to not more than 200 PCS clients, while another agreed to cease providing PCS and limit its offerings to case management services. This information was supplied during the onsite review, but the status of certain agencies remains subject to change. The District's Program Integrity Director and Acting State Medicaid Director both emphasized in interviews that the HHA situation was dynamic.

Collection of Affordable Care Act-related Information Supported by New Regulations and New Provider Enrollment Forms

Provider enrollment processes were strengthened in the District's Medicaid program through new regulations promulgated in the summer of 2013.[5] These new regulations include requirements to collect more complete information from providers, as required by the Affordable Care Act. They limit the number of times a new provider applicant and a provider subject to revalidation can resubmit an enrollment application to Medicaid following a denial without a significant waiting period.

Although the rule is in place and DHCF has created new enrollment forms to comply with the regulation; provider screening and enrollment processes that meet the regulatory requirements at 42 CFR 455 Subpart E were not fully implemented at the time of this review. For example, while the District has classified all home health providers as high risk for provider enrollment and screening purposes[6], it has not yet implemented site visits for moderate and high risk

[5] Chapter 94, Medicaid Provider and Supplier Screening, Enrollment and Termination, of Title 29, Public Welfare, of the DCMR, Vol. 60 – No. 30, July 12, 2013

[6] See section 9404.1(a) of the DCMR, Vol. 60 – No. 30, July 12, 2013, page 6.

providers.[7] It did not yet have the authority to collect application fees from Medicaid providers where appropriate[8]; and it was still working on coming into full compliance with all required federal database checks, such as matching providers against the Social Security Administration's Death Master File.[9]

Increasing Departmental Communication

The actions taken to curb abuses and tighten the District's oversight of Medicaid PCS have stimulated greater communication among the various agencies and components that exercise an oversight role and have responsibilities for this program. The DHCF Program Integrity Director, for example, cited a planned June 30, 2014 meeting of all components working on long term care issues. During this meeting, it was expected that further agency coordination on PCS issues would be discussed.

Standardized and Strengthened PCA Certification

In July 2012, the District finalized a regulation which required all new PCAs, after December 2013, to apply for certification with the Board of Nursing, which is part of the Health Regulation and Licensing Administration in the District's Department of Health. Certification requirements included an increase in PCA training from 75 to 125 hours, the passing of written and clinical skills exams, and the successful completion of criminal background checks. The regulation allowed PCAs to be grandfathered in if they could prove that they had been working for an HHA and had the required skills and training hours.[10] The Board of Nursing confirms qualifications of PCAs, monitors and sanctions PCAs for adverse actions, and keeps a database of all PCA certifications and disciplinary actions.

Well-Documented DHCF Program Integrity Investigations of Suspected Fraud

The CMS review team found in its sampling that the DHCF's Program Integrity investigation case files were well organized, well documented, and investigated thoroughly. All cases reviewed contained the key elements consistent with CMS performance standards for the referral of suspected fraud to Medicaid Fraud Control Units.[11]

Problems Found, Issues to Address, and Opportunities for Strengthening the Oversight of PCS

Notwithstanding the significant improvements which the District has made in its PCS program, the review team found a number of issues, problems, and areas in which the oversight of the program could be strengthened. The fact that these exist in the agencies surveyed by CMS that

[7] As required by 42 CFR 455.432
[8] As required by 42 CFR 455.460
[9] As required by 42 CFR 455.436
[10] Chapter 93, Home Health Aides, of Title 17, Business, Occupations, and Professions, of the DCMR, Sections 9301.1, 9303, 9305.1, 9305.2, and 9327.3
[11] See "Performance Standard For Referrals of Suspected Fraud From a Single State Agency To A Medicaid Fraud Control Unit," available at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance html.

were not specifically targeted for sanctions suggests that considerable room for monitoring improvement exists in the PCS program. The issues observed by the team are discussed in more detail below.

Limited Program Integrity Oversight of HHA Contracted with the MCO Providing Children and Adolescents with Special Needs

The review team found records in disarray and several instances of incomplete records during a site visit to the HHA which served children and adolescents with special needs through the District's Child and Adolescent Supplemental Security Income Program. Four client and four PCA records were reviewed at the agency's offices. The selected client files revealed non-compliant documents, such as POCs not signed by a Medical Doctor or Advanced Practice Registered Nurse or not being signed within the required timeframes, lack of progress notes on the beneficiary's health changes, and in some cases no evidence of having an initial order. In several beneficiary files, there was no indication of who provided the PCS. In a review of the records of four PCAs providing services for those clients, the team found that all four records did not meet standards for ongoing training and did not show evidence of required quarterly education. The HHA where this occurred stated that it served a total of 57 clients and had approximately 50 employees, including 30 PCAs.

During an interview with the team, the MCO that contracted with this agency described a number of steps it takes to assure quality of care in its contracted HHAs. However, with the exception of identifying one unsigned POC, its reviews of this HHA showed very high scores in all areas, raising questions about the degree of hands-on oversight exercised.

In addition, while it undertakes supervisory and reauthorization visits to beneficiaries as required by regulations, the MCO noted that client verification of services was not required by its contract. Without this type of safeguard, the District cannot be assured that services for which it paid were actually provided in the managed care program.

Need for Greater Scrutiny of HHA Provider Disclosures and Federal Database Checks

Provider enrollment records sampled by the team did not show evidence of consistent federal database checks or a careful review of listed personnel. One agency, for example, was approved even though it only listed its president on the application and did not list its director of nursing, billing director, or other managing employees or owners. Another application had been recommended for denial in 2008 because of the submission of multiple versions with contradictory information, but the District in the end approved it. One person, with a common name, listed as Chairman of the Board on an HHA application was found as an excluded person on the HHS-OIG's List of Excluded Individuals and Entities. This turned out to be a false positive, but there was no indication in the file that the "hit" had been researched during the enrollment process.

Lack of a System for Tracking "Problem" PCAs

The District does not directly enroll PCAs into Medicaid. Rather, PCAs work as employees of the HHAs, although they have to meet some District certification and training requirements as a condition of employment.

The District's Board of Nursing maintains a list of current PCAs which contains information on certification and disciplinary actions. However, the Medicaid agency does not have a system in place either to track problematic PCAs on its own or crosscheck the Board of Nursing's database on a regular basis. The DHCF Program Integrity Director stated that staff does check regular bulletins from the Board of Nursing, but according to Board of Nursing staff, information in these bulletins is not as current, complete, or timely as that in the database. The District also stated that it does not review PCA certifications or disciplinary actions on a regular basis unless it is involved with a regularly scheduled HHA audit during which a small sample of PCAs are reviewed. To help improve communication regarding PCA certifications and disciplinary actions, the Program Integrity director had initiated regular discussions with the Health Regulatory Licensing Administration manager who was directly involved in the PCA certification process.

Strengthening Use of the National Provider Identifier on Medicaid Claims

The District's Medicaid program has taken a step forward by requiring that PCAs have a unique National Provider Identifier (NPI) and that PCA NPIs be listed on Medicaid claims. However, the implementation of these requirements in practice could be strengthened to protect the program. During an analysis of selected paid claims, the review team noted that most Medicaid claims for PCS contained the NPI numbers of the rendering PCA but observed that they were missing on some claims. Additionally, the Program Integrity Director disclosed that the current claim form only allowed one PCA and NPI to be listed when multiple PCAs may have provided services during the time period being billed.

According to the current regulations for Medicaid payment of PCA services by the District, NPI numbers for providers and staffing agencies, and all personnel delivering PCS must be included in all Medicaid billings.[12] The omission of NPI numbers of the PCAs providing services makes it difficult to detect potential duplicate billings by PCAs who are employed by more than agency.

Posting of $50,000 Surety Bond by HHAs

The District's new PCS regulations[13] require each provider to post a continuous surety bond of $50,000 against all PCS claims, suits, judgments, or damages arising out of negligence of omissions in the course of providing services. In reviewing a sample of provider enrollment files, the team found no evidence that this requirement was in effect. According to the DHCF

[12] Chapter 50, Medicaid Reimbursement for Personal Care Aide Services, of Title 29, Public Welfare, of the District of Columbia Municipal Regulations (DCMR), Vol. 60 – No. 48, November 8, 2013), Section 5012.1

[13] Chapter 50, Medicaid Reimbursement for Personal Care Aide Services, of Title 29, Public Welfare, of the DCMR, Vol. 60 – No. 48, November 8, 2013), Section 5011.2

nurses who accompanied the review team on the HHA visits, the District was not yet enforcing this requirement.

Issues Found During Paid Claims Sampling

The review team also found some minor discrepancies during its review of a small sample of paid claims.

The billings for at least one of the beneficiaries were greater than the approved POC. Weekends should have been billed for four hours a weekend day but the timesheets and paid claims record reflected six to eight hours being billed each weekend day. The estimated overpayment for this beneficiary during the time frame reviewed came to nearly $5,700.

The billings for another beneficiary continued to charge for eight hours per day of PCS even after the assessment contractor reassessed the beneficiary and reduced the approved PCA hours down to five hours each day. This resulted in an estimated overpayment of nearly $1,800 for the time period observed.

As these figures were not derived from a formal audit, the review team did not calculate a formal overpayment in the above two scenarios. It is recommending, however, that the District periodically compare time sheets and paid claims records with the hours approved in beneficiary POCs and recoup any Medicaid funds that were not paid appropriately.

Most POCs reviewed during sampling records in the four HHAs visited by the team were in order and appropriately signed. However, the team found POCs in two of the HHAs that contained no signatures. It was therefore not possible to determine if Advanced Practice Registered Nurse reviewed and approved them every 60 days as required by the District's regulations.[14] In one case, a doctor signed the POC more than 30 days after the start of care. This also is in violation of the D.C. regulation.

Recommendations

In addition to the issues found by CMS during the June onsite visit to the District, the team noted that a CMS contractor was undertaking a concurrent audit of several of the HHAs that the District had targeted for termination or more serious sanctions. Although the contractor's final audit report had not been issued at the time the results of this review were being drafted, preliminary audit findings showed more extensive problems with billings, record-keeping, and employee qualifications in the targeted agencies. Taking all of these observations into account, CMS has developed the following recommendations:

- Develop and implement the full range of policies and procedures needed to comply with the provider screening and enrollment requirements of 42 CFR 455 Subpart B and E. Section 1902(a)(77) of the Social Security Act mandates that each Medicaid State Plan address these requirements. As the District's HHAs are considered high-risk providers,

[14] Chapter 50, Medicaid Reimbursement for Personal Care Aide Services, of Title 29, Public Welfare, of the DCMR, Vol. 60 – No. 48, November 8, 2013), Section 5005.3

the requirements include but are not limited to pre-enrollment site visits, the performance of fingerprinting and criminal background checks, collection of all required ownership and control disclosures, collection of Medicaid application fees, and the performance of all required federal database checks. Special attention should be paid to the inclusion of criminal background checks in agency personnel files. The measures taken should provide for enhanced scrutiny of the personnel listed and disclosures furnished on HHA provider applications. Given Washington, D.C.'s history of HHA and PCS problems, it is essential that all mandated provider enrollment and screening procedures be implemented as soon as possible.

- Strengthen internal policies and procedures for monitoring the provision of PCS by the MCO serving clients in the District's Child and Adolescent Supplemental Security Income Program.
- Develop and implement a policy and procedure for tracking problem PCAs on a regular basis, either by maintaining an internal database listing certified PCAs who have received disciplinary sanctions or by systematically checking existing resources, such as the Board of Nursing's PCA listings. Ensure through regular communications with the agencies that PCAs currently under sanction cannot serve Medicaid beneficiaries in any of the District's contracted HHAs. As a long range solution, integrate PCA tracking methods with the District's Medicaid Management Information System so that automated tracking is possible on a routine basis.
- Ensure that billings submitted by the HHAs contain a record of all PCAs who served Medicaid beneficiaries consistent with District requirements. Ensure that such billings match the amounts of service approved by the independent assessment contractor and that POCs are signed appropriately and timely. Periodically audit HHA billing records and timesheets for discrepancies with approved amounts of service and recoup any overpayments found.
- Enhance the protocols for auditing HHAs serving Medicaid beneficiaries in the District to ensure that HHA audits by district personnel and/or qualified contractors are regularly conducted in a comprehensive manner.
- Ensure that elements of the new District regulations designed to protect against possible fraud and abuse in the District's PCS program, such as the surety bond requirements, are implemented and enforced as soon as possible.
- Ensure that all of the above recommendations are effectively adopted by developing a plan for monitoring PCS services in future years. At a minimum, this plan should describe what data sources and data analysis, as well as desk and field reviews or audits, the District will employ to ensure that PCS expenditures and utilization remain within acceptable bounds.

Technical Assistance Resources

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

- Consult with CMS and other states to develop a process to ensure the District has adequate controls in place to oversee the PCS being provided in the District. 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 District's 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 District 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 District'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

The District of Columbia has improved its oversight of the PCS program in the year preceding this review. CMS supports the District's efforts and encourages it to look for additional opportunities to strengthen its program integrity controls. However, this CMS focused review identified several remaining areas of concern and instances of regulatory non-compliance which should be addressed immediately.

We require the District 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 District will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction, along with the specific steps the District expects will take place, and identify which area of the Medicaid agency is responsible for correcting the issue. We are also requesting that the District 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 District 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 District has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

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

Review of the District's Most Recent CAP

As part of the focused review the CMS Review Team reviewed the District's CAP from the last Medicaid Comprehensive Program Integrity Review conducted in August 2012. The final report on the District's comprehensive review was issued February 2014. The District's CAP was submitted on May 29, 2014. During the focused review, the CMS review team asked about the status of planned corrective actions which were not yet completed or fully addressed in the CAP:

- In the 2012 Comprehensive Program Integrity Review Final Report CMS cited the District for not complying with the statutory requirements on False Claims Act Education. The District's CAP response indicated that they sent a transmittal to all providers with over $5 million per year in Medicaid revenue explaining that they must provide and document training to their employees on the False Claims Act and whistleblower protections. The District said it would provide CMS with copies of regulations/transmittals that address 42 CFR 455 Subpart E - False Claims Act Education updates as well as the Affordable Care Act provider screening and enrollment requirements.

  When the CMS Review Team followed up on this item during the District's focused review, the Program Integrity Director indicated that she would provide a copy of the August 2013 transmittal that the District published giving all providers information about the federal and the local False Claims Acts and related training material. She indicated that she would also provide a copy of the District's Subpart E Regulations. The CMS Review Team is still awaiting this information.

- In response to CMS citing the District for having inadequate program integrity activities, the Program Integrity Director indicated that a webpage was being developed which provided links to numerous District and federal compliance topics. The District was to notify CMS when the web page was up and running and provide a link. The District did draft a webpage after the CMS comprehensive review in FY 2012 and briefly posted it. However, it was quickly taken down because of perceived problems that needed correction. A revised version has gone to the District's public relations lead and the Program Integrity Unit's supervisor for approval. When approved, the webpage could be up and running within 1-2 weeks. As of the date of this report, the CMS Review Team has not been notified that the webpage is up and running.

- CMS cited the District for not having internal policies and procedures (P&Ps) on payment suspensions (or a link to them electronically). The District informed the CMS Review Team that the payment suspension P&P was put on hold due to all the other crises with which the District had to deal in recent months. It was being reviewed and revised again. The CMS Review Team is still awaiting the District's response as to whether a payment suspension P&P has been developed and shared with staff.

- CMS cited the District for not adequately incorporating program integrity principles and policies in its managed care program. The District's staff informed the CMS Review

Team that they started writing P&Ps on managed care this year, but these have not been completed due to the crises the District had been facing in recent months. The final version must also be negotiated with the managed care division and this process can take time. However, the incentive for overhauling the P&Ps is somewhat heightened because senior management has a greater appreciation of the importance of managed care program integrity. The CMS Review Team is still awaiting the District's response as to whether or not managed care P&Ps that adequately address program integrity oversight have been developed.

- CMS cited the District for not checking the Tibco managed file transfer server (which houses CMS' database of Medicaid and Medicare provider terminations) when screening newly enrolling providers to ensure that they have not been terminated for cause by Medicare or another state Medicaid program or CHIP. The District acknowledged not checking the Tibco managed file transfer server. The Program Integrity Director indicated that she had talked to the Provider Enrollment Manager about all the databases which must be checked. At the time of the focused review, the District checked provider terminations in Maryland, Delaware, and Virginia and received notices of any termination actions that Maryland Medicaid takes. The CMS Review Team stressed the importance of coming into compliance with the database checking requirements because non-compliance may have potential financial consequences in the future.

- CMS cited the District for not complying with certain regulatory requirements on provider disclosures. Specifically, the District's forms and web-based enrollment process did not reflect the ownership and control disclosure requirements that became effective on March 25, 2011. The District provided the CMS Review Team with a copy of a revised provider enrollment form; however, at that time it was still not yet implemented. The CMS Review Team is still awaiting the District's response as to whether or not the form has gone into effect.

- CMS cited the state for not having P&Ps that provided for regular meetings between the MFCU and the program integrity section of the Medicaid agency. The District informed the CMS Review Team that those P&Ps have not been drafted yet. The former Program Integrity Director indicated that the Affordable Care Act Director had committed to drafting them, but had not provided a draft. The CMS Review Team is still awaiting the District's response as to whether or not these P&Ps have been developed.

- CMS cited the state for not having an updated Memorandum of Understanding (MOU) between the state agency and the MFCU to improve the referral process and facilitate the sharing and discussion of case information at regular meetings. At the time of the focused review this issue was pending. The Program Integrity Director and the District's MFCU Director had committed to jointly drafting a revised MOU. As part of that rewrite, the CMS Review Team recommended that the MOU address at a high level the payment suspension procedure and quarterly certification process. As of the date of this report, the CMS Review Team has not seen a revised version of the MOU.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/State Medicaid Director

December 11, 2015

Joi L. Campbell
Special Assistant, Investigations and Audits Group
Center for Program Integrity, Investigations and Audits Group
By Electronic Mail: Letitia.Leaks@cms.hhs.gov

Dear Ms. Campbell:

DHCF received the Program Integrity Focused Review Final Report on November 9, 2015. The review examined the processes employed by DHCF to address fraud, waste, and abuse in its personal care aide (PCA) programs. We appreciate the considerable efforts of your team to examine an area in which DHCF has demonstrated significant commitment and effort. As noted in the Final Report, DHCF implemented numerous changes to its PCA policies and requirements including the adoption of new PCA regulations that set forth rigorous and ongoing provider accountability requirements, and established additional safeguards to control utilization by ensuring that approved services are aligned with actual need. Toward that end, DHCF developed and implemented a comprehensive conflict free assessment tool and process that utilizes both quantitative and qualitative criteria to consider the unique needs of each person in relation to the scope and purpose of the PCA benefit. To ensure impartiality, the assessment is conducted by registered nurses employed by an independent, non-HHA contractor. These measures have enabled DHCF to exercise strong control over utilization and integrity, evidenced in no small part by a 43% reduction in PCA utilization in less than two years.

Strengthening the integrity of PCA programs continues to be a top priority for DHCF, and we look forward to the continued partnership with CMS in achieving this goal. The Final Report identifies seven recommendations for DHCF to further improve its PCA integrity functions. This letter sets forth DHCF's plan of correction in relation to each of the recommendations made by CMS in the Final Report.

Recommendation 1: Develop and implement policies and procedures to comply with federal screening and enrollment requirements.

In relation to home health agencies, CMS recommends that DHCF implement policies and procedures to implement the following requirements:

A. Pre-enrollment site visits;
B. Fingerprinting and criminal background checks;
C. Collection of disclosure and ownership information;
D. Performance of all required federal database checks.

A. Pre-enrollment site visits

DHCF implemented the pre-enrollment site visit requirement in August of 2014, and began collecting application fees on May 1, 2015. No further corrective action is needed for implementation of this requirement.