Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Delaware Personal Care Services (PCS)

Focused Program Integrity Review

Final Report

January 2019

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Delaware Medicaid Personal Care Services (PCS). The 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 can be used to advance the program integrity of delivery of these services.

Background

Medicaid PCS (sometimes referred to as personal attendant or personal assistance services) includes a range of assistance services provided to beneficiaries with disabilities and chronic conditions of all ages. 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 the personal care attendant (PCA) or cuing/prompting by the PCA so that the beneficiary may perform the task. Such assistance most often involves activities of daily living (ADLs) such as eating, drinking, bathing, dressing, grooming, toileting, transferring, and mobility. Services offered under Medicaid PCS are an optional benefit, except when they are medically necessary for children who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment benefit that provides comprehensive and preventive health care services.

Pursuant to the regulations found at 42 CFR 440.167 PCS is a Medicaid benefit furnished to eligible beneficiaries according to an approved Medicaid state plan, waiver, or section 1115 demonstration. States administer their Medicaid programs within broad federal rules and according to requirements of the specific authority approved by CMS. Services must be approved by a physician, or some other authority recognized by the state. Personal care beneficiaries cannot be inpatients or residents of a hospital, nursing facility, intermediate care facility for the developmentally disabled or institution for mental disease. Services can only be rendered by qualified individuals, as designated by each state.

Methodology of the Review

In advance of the onsite visit, CMS requested that Delaware complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. In addition, questionnaires were sent to one MCO and four home health agencies in order to help gain an understanding of their role in PCS program integrity. A three-person review team reviewed these responses and materials in advance of the onsite visit.

During the week of July 31-August 2, 2018, the CMS review team visited the DMMA. CMS conducted interviews with numerous state staff involved in program integrity and administration of PCS. In addition, the CMS team reviewed primary data to validate the state's program integrity practices with regard to PCS.

Results of the Review

The CMS team identified areas of concern with the state's PCS program integrity oversight, thereby creating 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. These issues and CMS's recommendations for improvement are described in detail in this report. In addition, CMS has included technical assistance resources for the state to consider utilizing in its provision of PCS.

Section 1: Personal Care Services

Overview of the State's PCS

The Delaware Health and Social Services (DHSS) is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. The Division of Medicaid and Medical Assistance (DMMA), within DHSS, has direct responsibility for administering the Delaware Medical Assistance Program (DMAP). The Director of DMMA reports to the Secretary of DHSS.

Delaware's Medicaid home care service programs utilize a workforce of Certified Nursing Assistants (CNAs), home health aides, direct care workers, and attendants to provide PCS. The CNAs make up the majority of home care workers that render PCS, even though PCS are a lesser skilled level of service that can be provided by home health aides.

Certain sections of the Social Security Act authorizes the U.S. Department of Health and Human Services Secretary to allow states to engage in experimental, pilot, or demonstration projects. The majority of beneficiaries within the Delaware Medicaid program receive PCS through Managed Care Organizations (MCOs). The Section 1115 Diamond State Health Plan (DSHP), a managed care delivery service model, is the primary method for PCS delivery for the Delaware Medicaid program. The state offers Home and Community-Based Services (HCBS) under Section 1915(c) Medicaid waiver authority. The Delaware Department of Disability Services (DDDS) HCBS Lifespan Waiver is administered by DDDS. The PCS within the HCBS Lifespan Waiver are reimbursed by DDDS utilizing fee-for-service (FFS) payment methodology.

The DMMA does offer self-directed attendant care services to Medicaid recipients enrolled in the DSHP-Plus Demonstration Waiver, or the Lifespan Waiver. Self-Directed PCS are administered by workers providing care to recipients that are self-directing, are referred to as attendants, and are not required to have specialized skills or home care certifications. Family members are allowed to render services and receive reimbursement as direct care workers.

Summary Information of the State Plan Services and Waivers Reviewed

Delaware provides PCS to eligible 1915(C) HCBS beneficiaries, and MCO plan enrollees under the 1115 demonstration waiver. As previously mentioned, provision of these services in the

beneficiaries' homes or community settings is intended to serve as an alternative for individuals who would otherwise require institutional care.

Table 1.

Program Name/ Year Implemented	State Plan or Waiver Type	Service or Program	Administered By
Managed Care Implemented 1996	Section 1115	Diamond State Health Plan	DMMA/MCOs
Managed Care Implemented 2012	Section 1115	Diamond State Health Plan-Plus	DMMA/MCOs
HCBS Implemented 1983	Waiver Authorities Section 1915(c)	DDDS HCBS Lifespan Waiver	DDDS
Self-Directed PCS Implemented 2012	State Plan Authority 1915(i) Managed Care Section 1115	Self-Directed Attendant Care (SDAC) Diamond State Health Plan-Plus	DDDS MCOs

Approximately 97 percent of Delaware's Medicaid population receive services through managed care delivery. The following state plan services are carved out from the Medicaid MCO benefit package, and are paid on a FFS basis by DMMA: Pharmacy, children's dental, non-emergency transportation (except for emergency ambulance transportation), day habilitation services authorized by DDDS, medically necessary behavioral health services for both children and adults in excess of MCO plan benefit coverage, and prescribed pediatric extended care. Newly enrolled Medicaid beneficiaries are not immediately assigned to a Medicaid MCO, but are assigned to a MCO within 30 days of enrollment. The DMMA reimburses providers utilizing FFS payment methodology for Medicaid services until the beneficiary is assigned to a MCO. The PCS Medicaid benefits are administrated and delivered, exclusively, by contracted MCOs and DDDS.

The Diamond State Health Plan (DSHP), implemented on January 1, 1996, is a mandatory Medicaid managed care program operating under a Section 1115 Demonstration Waiver. The demonstration mandatorily enrolls most Medicaid recipients into MCOs to create efficiencies in the Medicaid program, and enable the expansion of coverage to certain individuals who would otherwise not be eligible for Medicaid. All Medicaid benefits are included in the demonstration except: Non-emergency transportation; extended mental health and substance abuse benefits; and some specialized services for children. The demonstration also provides long term care services and support (LTSS) to eligible individuals through a mandated managed care delivery system, entitled DSHP-Plus.

The DSHP-Plus, implemented in 2012, was authorized to expand the DSHP to mandate care through MCOs for additional state plan populations, including: individuals receiving care at

nursing facilities (NF) other than intermediate care facilities for the mentally retarded (ICF/MR); children in pediatric nursing facilities; individuals who receive benefits from both Medicaid and Medicare (dual eligibles); and workers with disabilities who buy-in for coverage.

The DDDS Home and Community Based Services Lifespan Waiver provides services and supports as an alternative to institutional placement for individuals with intellectual developmental disabilities (IDD) (including brain injury). The HCBS provided under the DDDS 1915(c) waiver are carved out of the managed care benefit package and are reimbursed on a FFS basis. Medicaid recipients enrolled in the DDDS waiver are exempt from managed care enrollment. The DMMA designates the authority for operation of the waiver to DDDS through a Memorandum of Understanding (MOU) between DDDS and DMMA. The DMMA maintain administrative and supervisory oversight of the DDDS Lifespan Waiver.

Delaware has a self-direction PCS option known as Self Directed Attendant Care (SDAC). The SDAC PCS are provided by the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD), an agency within DDDS. Lifespan Waiver recipients are eligible to receive self-directed PCS, which is reimbursed by FFS payment methodology. The DSHP-Plus beneficiaries are eligible to receive self-directed PCS through MCO service delivery. Beneficiaries are required to choose a financial management service (FMS) to aid in the administration of self-directed PCS.

The state does not mandate an electronic voice verification (EVV) system for in-home scheduling, tracking, and billing of PCS. Some home health agencies utilize EVV even though it is not required by DMMA.

Medicaid and PCS Expenditure Information

Delaware's total Medicaid expenditures in federal fiscal year (FFY) 2017 was $1.9 billion dollars. There were 200,155 unduplicated beneficiaries enrolled in Delaware's Medicaid program in FFY 2017. Delaware's total Medicaid expenditures for PCS in FFY 2017 was $62.16 million. The unduplicated number of beneficiaries who received PCS in FFY17 were 4,983. There were seventeen PCS agency providers enrolled by DMMA in FFY 2017. PCS are administered by DDDS, and MCOs contracted with DMMA.

Table 2-A.

1115 Demonstration Waiver	FFY2015	FFY2016	FFY2017
Diamond State Health Plan/Diamond State Health Plan Plus	$43.11 million	$44.16 million	$62.16 million

The DMMA attributed the increase in expenditures to an increase of beneficiaries utilizing the PCS benefit. Also, DMMA had a significant increase in self-directed expenditures which are reimbursed through the DSHP-Plus. Easter Seals, one of two self-directed PCS providers, was reimbursed $7.4 million in FFY 2016 and $11.8 million in FFY 2017.

Table 2-B.

1915 (C) HCBS Waiver	FFY2015	FFY2016	FFY2017
DDDS Lifespan Waiver*	$5,748.00	$2,977.00	$3,597.00

*The Lifespan Waiver serviced one unduplicated beneficiary for each FFY.

Table 3.

	FFY 2015	FFY 2016	FFY 2017
Total PCS Expenditures	$43.12 million	$44.16 million	$62.16 million
% Agency-Directed PCS Expenditures	89.75%	83.81%	79.58%
% Self-Directed PCS Expenditures	10.25%	16.19%	20.42%

Beneficiaries within the Delaware Medicaid program mainly utilize the agency directed delivery method in order to access PCS services. The PCS expenditure analysis table indicates there was a ten percent increase in self-directed PCS expenditures in the last three FFYs, and a ten percent decrease in agency-directed PCS expenditures during the same time period.

Table 4-A.

State Plan Authority Service/Program	FFY 2015	FFY 2016	FFY 2017
1115 Demonstration Waiver	2595	2785	3166
1915 (C) HCBS Waiver	1	1	1
Total Unduplicated Beneficiaries for All Agency-Directed PCS	**2596**	**2786**	**3167**

Table 4-B.

State Plan Authority Service/Program	FFY 2015	FFY 2016	FFY 2017
1115 Demonstration Waiver	1196	1435	1815
1915 (C) HCBS Waiver	1	0	1
Total Unduplicated Beneficiaries for Self-Directed PCS	**1197**	**1435**	**1816**

The amount of beneficiaries accessing self-directed PCS has increased by 65 percent from FFY 2015 to FFY 2017. The significant increase in the beneficiaries that utilize the benefit now account for 20 percent of overall PCS expenditures. The DMMA attributed the increase due to beneficiaries becoming more knowledgeable about the program.

State Oversight of PCS Expenditures

The DMMA Surveillance & Utilization Review Unit (SUR) is primarily responsible for the detection and prevention of fraud, waste and abuse. The SUR consists of nine FTE's: The chief administrator, one supervisor, one administrator, two auditors, three nurse reviewers, and one data analyst. The DMMA also utilizes a contractor called Qlarant (previously Health Integrity) who assists with data mining, and creating ad-hoc reports and queries from the claims data warehouse. The SUR does not create an annual audit work plan. Therefore, there is no audit plan that includes oversight of PCS providers, and self-directed services. The DMMA should consider creating annual audit work plans that serve as guidance to MCOs on state oversight objectives and oversight priorities. The SUR does not initiate data mining activities of encounter data to identify suspected fraud, and do not have the ability to conduct adequate data mining activities due to the lack of quality encounter data received. A lack of quality encounter data to analyze severely limit DMMA's ability to provide adequate oversight over managed care expenditures. Therefore, the unit does not independently initiate audits of MCO network PCS providers. The SUR relies heavily on the contracted MCOs to identify, report, and refer suspected fraud. The SUR should consider conducting regular data mining activities on MCO encounter data. Approximately 97 percent of Delaware Medicaid beneficiaries are enrolled in MCOs to receive Medicaid benefits. The DMMA is providing limited oversight of MCO expenditures by failing to adequately data mine encounter data for suspected fraud or abuse, and relying on MCOs for conduct the majority of the oversight of the Medicaid program. The DMMA should consider allocating appropriate FTEs to enhance oversight of MCO expenditures.

Upon positive findings of suspected fraud, the MCO is responsible for notifying the DMMA and MFCU, simultaneously, to advise that suspected fraud has been identified. Upon receipt of the notification, the MFCU screens the complaint notification to review the allegations and to determine if there is an ongoing criminal case involving the entity identified in the notification. The MCOs must receive clearance from the MFCU before continuing the preliminary investigation, or taking administrative action against the provider. The MFCU provides DMMA with written notice within 30 days of notification. If the MFCU requests additional information to continue with the case review, the MCO conducts a more in-depth preliminary investigation, and the suspected fraud allegation is shared with the other contracted MCO in Delaware to determine the complete suspected fraud exposure. The SUR reviews the MCO referral to determine whether the provider identified is also enrolled in Medicaid FFS in order to determine if there is additional risk to the state. If so, the SUR will initiate a preliminary investigation on the provider to determine FFS suspected fraud exposure.

Eighteen suspected fraud PCS referrals were opened by the MFCU in the last three FFYs. However, DMMA has not enacted a payment suspension in the last three FFYs, in accordance with 42 CFR 455.23. In the absence of a provider payment suspension, DMMA was unable to

provide a good cause exception for any of the fourteen investigations referred to the MFCU in the last three FFYs. The DMMA provided CMS with a MOU that cited provider payment suspension policies in accordance with 42 CFR 455.23. Additional good cause exception criteria is listed in the MOU, consistent with the aforementioned federal payment suspension policy. However, DMMA was unable to provide procedures for enacting provider payment suspensions, or exercising good cause exceptions as described in 42 CFR 455.23. Furthermore, DMMA was unable to articulate why they did not follow their listed policies for provider payment suspensions. DMMA's failure to adequately review credible allegations of fraud, and consider federally mandated payment suspensions are a vulnerability to the Delaware Medicaid program. The DMMA should consider revising their internal procedures to ensure the agency is in compliance with 42 CFR 455.23.

Additional divisions within DHSS share the responsibility for PCS oversight. The Division of Long Term Care Residents Protection (DLTCRP) is responsible for the training and testing program for CNAs, maintaining the CNA Registry, maintaining the Adult Abuse Registry, conducting criminal background checks, and conducting mandatory drug testing. Also, DHSS relies on another state agency within DHSS to administer PCS. The DDDS administers the Lifespan Waiver, and is responsible for PCS delivery for a small beneficiary population. The DMMA does not have written memorandum of understandings (MOUs), or interagency agreements that detail oversight responsibilities of the aforementioned DHSS units. However, the DMMA does have a robust MOU with DDDS and the MFCU that detail operational, programmatic, and oversight responsibilities.

Table 5.

Agency-Directed and Self-Directed Combined	**FFY 2015**	**FFY 2016**	**FFY 2017**
Identified Overpayments	*	*	*
Recovered Overpayments	*	*	*
Terminated Providers	*	*	*
Suspected Fraud Referrals	1	0	18
# of Fraud Referrals Made to MFCU	1	0	13**

*DMMA failed to provide the requested information
**Two referrals from Highmark included multiple Easter Seals attendants, and separate complaints and cases were opened for each attendant.

Self-directed PCS suspected fraud referrals make up the majority of referrals submitted to the MFCU. Thirteen of the eighteen suspected fraud referrals opened by the MFCU were for suspected fraud in the self-directed PCS program. Oversight of self-directed PCS should be a priority for DMMA due to the apparent increase of suspected fraud activity being reported to the MFCU. The DMMA was unable to provide CMS with the amount of PCS overpayments, and number of PCS provider terminations for the last three FFYs. The DMMA should review internal processes and procedures to ensure overpayments and terminated providers are accurately recorded and tracked.

Section 2: PCS Provider Enrollment

Overview of PCS Provider Enrollment

Identifying and recovering overpayments may be resource intensive and take considerable time. Preventing ineligible entities and individuals from initially enrolling as providers allows the program to avoid the necessity to identify and recover overpayments. Provider screening enables states to identify such parties before they are able to enroll and begin billing.

DXC Technology is responsible for enrolling all Delaware Medicaid providers into the Medicaid program. DXC Technology is the DHSS fiscal agent that is responsible for enrolling and screening all fee-for-service Medicaid providers. DXC Technology is also responsible for enrolling and screening all DDDS providers. Managed care providers are not credentialed by DXC Technology unless they are also a fee-for-service Medicaid provider. There are three types of agency directed providers that render home health aide PCS for the Delaware Medicaid program: Skilled home care agencies, home health agencies, and personal assistant service agencies (PASA). Home health agencies and PASAs do not provide services that are eligible for FFS reimbursement by DMMA. As a result, home health agencies and PASAs are not credentialed or enrolled by DXC Technology, and are credentialed and enrolled exclusively by MCOs. DXC Technology credentials and enrolls skilled home care agencies. The application process includes the necessary database exclusion checks in accordance with CFR 42 455.436, and disclosure of ownership checks in accordance with 42 455.104. Specifically, skilled home care agencies are required to be enrolled and credentialed by Medicare before enrolling with DMAP. DXC Technology is responsible for verifying Medicare provider enrollment, and ensuring the provider was appropriately screened through the required databases.

In Delaware, home health care are services provided to an individual primarily in their place of residence, that include but are not limited to: Licensed nursing services; physical therapy, services; speech therapy services; audiology services; occupational therapy services; nutritional services; social services; or home health aide services. The CNAs, home health aides, and direct care workers are hired by the agencies to provide agency-directed home health aide services.

Skilled home care agencies provide services, ordered by a physician, rendered by licensed and certified aides for the purpose of promoting, maintaining, or restoring the health of an individual or to minimize the effects of injury, illness or disability. Skilled home care agencies also have the capacity to render PCS, but utilize licensed CNAs and home health aides to render non-medical home health aide services. Home health agencies provide two or more home care services, one of which must be either licensed nursing services or home health aide services, to an individual primarily in their place of residence. The PASAs are agencies that employ or contract with direct care workers to provide personal assistance services to consumers primarily in their place of residence. Personal assistance services are services that do not require the judgment and skills of a licensed nurse or other professional. The services are limited to individual assistance with/or supervision of activities of daily living, companion services, transportation services, homemaker services, reporting changes in consumer's condition and completing reports. The PASA services do not require physician's orders.

Summary of Information Reviewed

As previously mentioned, Delaware's Medicaid home care service programs utilize a workforce of CNAs, home health aides, and direct care workers to provide agency-directed PCS. The CNAs are required to have a minimum of 150 hours of training, equally divided between classroom and clinical hours. Furthermore, CNAs are required to complete 24 hours of approved continuing education and perform at least 64 hours of nursing-related services for pay in a health care setting under the supervision of a licensed nurse or physician during each 24-month certification period in order to qualify for recertification. Prospective CNAs in Delaware must enroll in a CNA training program that is approved by the DLTCRP, an agency that is also part of DHSS. The CNAs are required to be registered on the Nurse Aide Registry, which is regulated by the DLTCRP. After being listed on the registry, CNAs are required to renew their certification every 24 months.

Home health aides are employed by agencies that provide personal care services, companion services, homemaker services, transportation services; and may perform tasks delegated by a licensed nurse. Home health aides are non-licensed professionals, but have training requirements mandated by the state of Delaware. A home health aide is required to have at least one year of practical experience in a Department licensed or approved hospital, nursing home, or home care setting; or have satisfactorily completed an appropriate home care course including the training requirements contained within 24 Del.Ch 19; or is a student nurse pursuing a degree in nursing who has completed the clinical practicum portion of their training. Home health aide training requirements mandate at least seventy-five hours of training, which must include at least sixteen hours of clinical training. Further, there is a requirement to complete twelve hours of continuing education, annually. There is no state approved training program, or listing of suitable training entities that provide the required home health aide training. In addition, there is no state registry that agencies can utilize to identify and track qualified home health aides. Agencies are responsible for verifying whether home health aides have the necessary training required by DHSS.

Each skilled home care agency interviewed advised CMS that they hire few home health aides because it is difficult to verify whether a home health aide has acquired the appropriate training. Agencies prefer to hire CNAs because their training is regulated by DHSS, and the registry provides a level of oversight that is not apparent with home health aides. There is some overlap between the duties of a CNA and a home health aide, and they regularly compete for the same positions. However, CNAs are routinely hired to perform non-skilled tasks that could be completed by a home health aide. The DHSS should at least consider identifying specific, standardized training courses and curriculum that will aid agencies in appropriately identifying qualified home health aides. Further, DHSS should consider employing a home health aide registry with similar requirements as the DHSS CNA Registry.

Direct care workers are individuals (aide, assistant, caregiver, technician or other designation used) employed by or under contract to a PASA to provide personal care services, companion services, homemaker services, transportation services and those services as permitted in Title 24 Del. Chapter 19**,** Section 1921(a) to consumers. The direct care worker provides these services to an individual primarily in their place of residence. Direct care workers are required to pass a

competency test prior to providing care to consumers, and annually thereafter. The orientation program is cited in Title 16, Section 4469, and required to include, but not be limited to: Principles of infection control; observation, reporting and documentation of consumer status; activities of daily living; and applicable state regulations governing the delivery of personal assistance services to consumers.

State Oversight

As required by 42 CFR 455.450, the state has implemented the screening level provisions, including fingerprinting, based on the assigned level of risk for directly enrolled PCS providers. In addition, the state has implemented the federal database checks on any person with an ownership interest or who is an agent or managing employee of the provider as required. The state requires database checks of all parties against the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System on the System for Award Management (SAM) monthly after enrollment, and reenrollment as required at 42 CFR 455.436(c)(2).

As previously mentioned, DXC credentials and enrolls skilled home care agencies that are enrolled with DMMA to provide services that are reimbursed by FFS payment methodology. The DMMA has a requirement that high risk providers are mandated to enroll with Medicare prior to enrolling with DMMA. The DMMA advised CMS that enrollment with Medicare assures all federal screening requirements have been met. The Medicaid Provider Compendium states, "The SMA may rely on the new enrollment or revalidation screening conducted by Medicare or another State, but the SMA may not rely on Medicare or another State's Medicaid Plan to fulfill its own ongoing monthly database checks required under 42 CFR 455.436(c)(2). The Contractor shall submit to the State a completed DMMA provider disclosure form annually." The DMMA was unable to provide detailed procedures that verify screening requirements were followed in accordance with 42 CFR 455.436. Specifically, DMMA was unable to provide policies or procedures to verify providers are screened against the appropriate databases, on a monthly basis. As a result, it is unclear what procedures and databases DXC is utilizing to conduct ongoing monthly database screenings. The DMMA should review internal procedures to ensure skilled home agencies are enrolled in accordance with 42 CFR 455.436, and subsequently screened against the appropriate databases on a monthly basis.

The MCOs are responsible for PCS provider screening and enrollment in Delaware that provide services in DSHP and DSHP Plus. The MCOs are responsible for providing PCS to the plan enrollees through network provider contracts, and the MCOs are responsible for managing those contracts and the PCS providers appropriately. The DMMA does not enroll PCS providers. The MCOs are responsible for performing all the required federal database checks for PCS providers, as well as collecting and storing all required disclosure information for enrolled providers during the enrollment process. The DMMA does not conduct onsite visits for high risk providers. The DMMA has contract language that require MCOs to conduct onsite visits of high risk providers. Specifically, the contract states MCOs "Are required to include work plans for conducting both announced and unannounced site visits and field audits to providers defined as high risk (e.g., providers with cycle/auto billing activities, providers offering DME, home health or behavioral health) to ensure services are rendered and billed correctly."

The DMMA requires MCOs to conduct checks of provider files, including atypical providers, against the LEIE, EPLS on the SAM, and Social Security Administration's Death Master File as part of credentialing and re-credentialing at least monthly on an ongoing basis. The DMMA MCO contract requires MCOs to "Include provisions regarding performing monthly checks for exclusions of the Contractor's Owners, agents, and managing employees." Highmark Health Options (Highmark), one of the two MCOs, has a process implemented to perform database exclusion checks on enrolled PCS providers upon initial credentialing, re-credentialing, and on a monthly basis. Highmark does not perform the required database screening on home health agency managing partners and individuals with a controlling interest, as required by 42 CFR 455.436, and their contract with DMMA. Failure to conduct the appropriate database checks on the applicable individuals are a vulnerability to the Medicaid program, and could result in improper payments to excluded individuals. Highmark requires participating providers to screen employees monthly to ensure they are not excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care program defined in Section 1128B(f) of the Social Security Act. However, Highmark does not specifically list the screening databases in their provider agreement that agency providers are required to utilize for screening. The DMMA should communicate expectations and provide guidance to ensure MCOs, downstream risk entities, and provider agencies utilize the appropriate database screening procedures in accordance with CFR 42 455.436. Required database screenings aid to ensure excluded or debarred individuals are not receiving Medicaid reimbursements.

The DMMA requires criminal background checks on persons applying for a position in a nursing home, or home health agency that affords access to patients or individuals receiving care at such a facility or private home. Further operators and owners of home health agencies are required to undergo criminal background checks. Moreover, all applicants for employment in long term care facilities and home health agencies must submit to drug testing. The Background Check Center (BCC), is an electronic system which combines data streams from various sources within, and outside the state of Delaware in order to assist an employer in determining the suitability of a person for employment in a nursing facility or similar facility, or home care agency. The BCC, established in 2012, is managed by DLTCRP and retrieves information from numerous state managed databases. The databases include: The State Bureau of Investigation - state and federal criminal background checks; Adult Abuse Registry; Nurse Aide Registry (certified nursing assistants); Public Sex Offender Registry; Professional Regulation - license verification; Office of the Inspector General; Department of Labor - service letters; Child Protection Registry; and the Delaware Health Information Network for drug test reporting. All persons working for agencies are required to be on the master list of the BCC. The master list is the list maintained by the BCC for each employer. The list contains the names of all persons who are employed by an employer; and employed by a temporary employment agency, home health or personal care agency, or any other entity to work for an agency in a facility or in a private residence. Employers are responsible for amending and updating the master list when required.

The BCC utilizes rap back to aid in monitoring employee background checks. Rap back is the process of continuous monitoring an employee's arrest and conviction record through Delaware Criminal Justice Information System. The rap back process is limited to Delaware arrests and convictions, and does not include convictions reported through the FBI. The BCC rap back is designed to provide employers with refreshed information related to the criminal convictions of

an employee in order to ensure the safety of the individuals served and; reduce the frequency of criminal background checks by maintaining current information regarding each employee's criminal record, avoiding the need to repeat the processing of criminal histories. The BCC automatically conducts a rap back on all employees listed on the master list. The rap back process provides DLTCRP with information regarding any new arrest or conviction in the state. The DLTCRP determines, at its discretion and depending of the nature of the alleged crime, whether or not to inform the employer of the arrest. The DLTCRP is tasked with monitoring the charge until there is a final disposition. Once the disposition is known, DLTCRP informs the employer of the outcome.

The DHSS requires post-employment references, known as service letters, to be entered into BCC. Service letters provide a documented trail of agency providers that can be contacted to verify a CNA's employment history. A transparent method to verify employment history helps to assist agencies to hire aides at a faster pace in order to meet patient needs and demands. However, agencies are prohibited from advising prospective hiring agencies if a CNA was terminated or suspected fraud or abuse. The four agencies reviewed by CMS indicated that agencies do not want to be legally liable for providing derogatory information even if it has been documented by the agency. Furthermore, agencies are reluctant to use "fraud" if there are no criminal charges to substantiate their statements. The four agencies reviewed by CMS indicated that they have terminated aides for improper billing, theft, and falsifying time sheets. The agencies indicated those aides had not been referred to DMMA or the MFCU, and they do not have a standard process for referring suspected fraud to DMMA or the MFCU. As a result, aides that may have engaged in credible fraud activity are under-reported to DMMA and likely rendering services for another agency. Delaware has a robust background check process, and the utilization of rap back to continuously monitor criminal reporting is a great safeguard for the Medicaid program. However, DMMA should revise oversight efforts to communicate expectations about suspected fraud reporting. The DMMA should ensure home care agencies report aide terminations to DMMA, and/or the MFCU, that were a result of suspected fraud. The DMMA should develop communication strategies to confirm providers are aware of how to report suspected fraud to DMMA. Provider agencies reviewed onsite advised CMS that they did not have a defined point of contact, or solidified process for reporting suspected fraud. Adequate reporting of aides that have engaged in suspected fraud will enhance the overall integrity of the Medicaid program, and will further ensure agencies do not hire aides that may have engaged in credible, suspected fraud activities.

Nevertheless, DMMA does not have an internal process for regularly reporting provider terminations to TIBCO. Provider terminations had not been reported through TIBCO since FFY 2016. The DMMA does have a policy for reporting provider terminations. DMAP policy 1.38.2.6, Provider Termination, states, "Section 6501 of the ACA mandates that States terminate enrollment of providers who have been terminated from Medicare or another State's Medicaid or CHIP program. On a monthly basis, DMAP will screen all enrolled providers through various federal databases for sanctions, exclusions, and terminations. All individuals and entities identified through annual disclosure statements are also subject to these screenings. The DMAP will terminate providers and disclosed entities or individuals who do not meet ACA screening guidelines unless DMAP, in its sole discretion, opts to request a waiver from CMS." The

DMMA should review and revise internal procedures to ensure compliance with their policy, and Section 6501 of the ACA. Specifically, DMMA should review state termination and Medicare revocation lists no less than monthly, and ensure providers terminated for adverse actions are reported to CMS through TIBCO. The MCOs do not have access to the TIBCO database to review terminated providers. The majority of the Medicaid benefits are administered by MCOs, and the majority of providers that render services aren't enrolled directly with DMMA. Therefore, the MCOs rely on DMMA to perform the appropriate termination reviews in TIBCO to ensure providers terminated by other states are not within the MCO provider networks.

The DMMA contract does not include clear language requiring MCOs to differentiate between "for cause" or "without cause," provider terminations. The MCOs are not required to identify and report providers that have been terminated "for cause." As a result, DMMA does not have a method or procedure to identify MCO providers that may have been terminated for adverse actions that would rise to the level of "for cause." CMS guidance indicates "for cause" adverse action terminations may include, but is not limited to, termination for reasons based upon fraud, integrity, or quality[1]. Section 6501 of the Affordable Care Act mandates that state Medicaid agencies effectively terminate providers that have been terminated "for cause." Furthermore, Highmark reported there were zero involuntary terminations in the last three FFYs even though there were several documented MFCU prosecutions documented by DMMA. The DMMA should develop adverse termination criteria consistent with Section 6501 of the Affordable Care Act, and amend the MCO contract to mandate prompt reporting of adverse action terminations. The DMMA should ensure MCOs develop and adopt similar criteria for adverse terminations, and develop clear reporting requirements for providers that have been terminated for adverse actions. The DMMA relies heavily on MCOs for the administration of Medicaid benefits. Consequently, MCOs have a greater responsibility to properly document and report "for cause" terminations that are a result of practices or behavior that occur within MCO provider networks.

Section 3: Self-Directed / Participant-Directed Care Services

Summary of Information Reviewed

Delaware has a self-direction option, which is limited to participants who live in their own private residence or the home of a family member. Aides that render PCS to beneficiaries are known as attendants. Beneficiaries have the flexibility to hire persons with whom they have a close personal relationship to serve as an attendant care employee, such as a neighbor, friend, or family member. However, a person who serves as a representative of a participant for the purpose of directing attendant services is ineligible to serve as a provider of attendant services for that beneficiary. Attendants are not required to be licensed or skilled to provide self-directed attendant care. Attendants are required to be at least 18 years of age, able to provide care to the client, and take CPR training according to Delaware Administrative Code Title 16 Health and Safety. Attendant care services include assistance with ADLs that include: Homemaker-type services, including cleaning, laundry, shopping and chore; companion-type services; assistance with cognitive tasks,

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

including bill payment and money management, planning activities and decision-making; assistance with transferring to and from a bed, wheelchair, vehicle, or other environmental setting; assistance with medical and nonmedical equipment, devices, or assistive technology; and assistance with routine bodily functions.

Participants serve as employers of their own attendants, and are required to choose a FMS as a co-employer. The FMS functions as the member's agent in performing payroll and other employer responsibilities that are required by Federal and State law. Beneficiaries have a choice of two FMS; Easter Seals Delaware and Maryland Eastern Shore (Easter Seals) or JEVS Human Services (JEVS), in order to facilitate self-directed PCS. The FMS is responsible for providing a number of support services. Support functions include: Coordinating with the member's case manager to develop, sign and update the beneficiary's POC to include self-directed attendant care services; recruit attendant care employees; maintain a roster of attendant care employees; secure and pay for background checks on prospective attendant care employees on behalf of members; and assists with hiring, supervising, evaluating and discharging attendant care employees.

The FMS is responsible for conducting attendant background checks through the BCC as part of the ***initial*** application process. Attendants are required to undergo criminal background check at state expense, a check of sex offender registry and abuse, neglect, mistreatment and financial exploitation registries; a Delaware criminal history records review from the State Bureau of Identification and a report of the person's entire federal criminal history record pursuant to the Federal Bureau of Investigation; child abuse and neglect registry information from the Department of Services for Children, Youth and Their Families; and the Division of Health Care Quality obtain nurse aide registry information from the Division of Health Care Quality the Department prior to employment. The background check utilizes rap back for continuous monitoring of the aforementioned state registries.

CMS was not provided with a DMMA FMS credentialing policy that included database screening requirements in compliance with 42 CFR 455.436. Highmark's provider agreement states, "Participating Provider shall screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care programs (as defined in Section 1128B (f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or barred." As previously stated, DMMA should consider providing guidance or further communication to ensure providers are aware of the specific databases that are utilized for screening. However, there is no information to indicate attendants are regularly screened against the OIG-LEIE, or SAM upon hire or on a monthly basis. The DMMA should ensure attendants are screened against the appropriate databases in order to verify attendants have not been excluded from receiving Medicaid reimbursements. The DMMA should further ensure attendants that have been terminated for adverse actions are reported to DMMA, and subsequently reported to CMS through TIBCO.

State Oversight of Self-Directed Services

The SUR is responsible for investigating complaints of all potential Medicaid fraud, waste, and abuse including allegations related to PCS for DHSS. However, the unit has not conducted any

audits or investigations of self-directed PCS. CMS observed that the MCOs provide the bulk of the training and guidance of the FMS, which is responsible for self-directed PCS delivery. Oversight of self-directed PCS is delegated to the FMS. The FMS conducts plan of care (POC) assessments to determine the level of care the beneficiary may require, and are also responsible for reviewing and monitoring the timesheets documenting services rendered. The beneficiary's case manager is the primary point of contact with the member and is responsible for notifying the FMS if suspected fraud or quality of care is of concern. The EVV is not mandated by DMMA; however, JEVS has implemented EVV as an additional safeguard. The DMMA does not verify services, but requires MCOs to verify services in accordance with 42 CFR 455.420. Highmark performs member service verification through a phone call system, rather than sending email or letter verification. Within the last three FFYs, Highmark contacted 127 beneficiaries specifically regarding services rendered by individual PCA's in self-directed programs. Zero errors had been identified for self-directed PCS services.

The DMMA advised CMS that they have not completed any audit, fiscal, or programmatic findings for self-directed PCS in the last three FFYs. The DMMA reported that eighteen PCS suspected fraud referrals were submitted by MCOs to the MFCU in the last three FFYs. Ten of the MCO referrals were for self-directed PCS suspected fraud. Out of eighteen total PCS suspected fraud referrals submitted by MCOs that were accepted for investigation by the MFCU, thirteen[2] were for self-directed PCS attendants. The complaints included billing for services not rendered, falsifying time sheets, and billing for services after date of death. The DMMA was unable to provide any details on the disposition of the complaints, or whether they had observed any suspected fraud trends with self-directed PCS. Overall, there is a lack of oversight of self-directed PCS by DMMA. Unduplicated beneficiaries that access self-directed PCS have increased by 65 percent in the last three FFYs, and accounted for twenty percent of PCS expenditures in FFY 2017. Further, self-directed PCS complaints accounted for the majority of all DMMA PCS investigations and referrals in the last three FFYs. The DMMA should consider substantially revising strategies for self-directed PCS oversight, and initiate thorough programmatic audits and investigations of the program.

Section 4: Managed Care

Overview of the State's Managed Care Providers

The DSHP demonstration mandatorily enrolls most Medicaid recipients into MCOs to create efficiencies in the Medicaid program. The demonstration also provides long term care services and support (LTSS) to eligible individuals through a mandated managed care delivery system, entitled DSHP-Plus. From FFY 2015-FFY 2017, Highmark and United Health Care were the two MCOs contracted with DMMA to deliver Medicaid managed care services through the DSHP and DSHP-Plus programs. In FFY 2017, United Health Care and DMMA severed their MCO delivery contractual relationship. AmeriHealth Caritas contracted with DMMA to provide Medicaid

[2] Two referrals from Highmark included multiple Easter Seals attendants, and separate complaints and cases were opened for each attendant. Unbundling the referrals after submission created more documented referrals than were originally submitted.

managed care services in January 2018. AmeriHealth Caritas was not an active MCO during the review period; therefore, they were not requested to participate in this review.

Managed Care Oversight of PCS

Highmark Health Options is a wholly owned subsidiary of Highmark Blue Cross Blue Shield of Delaware (Highmark BCBSD). Highmark represents a partnership among Highmark BCBSD, Gateway Health, Highmark Health, and Highmark, Inc. Highmark has been a Delaware State managed care plan since January 1, 2015, and serves approximately 161,000 DSHP and DSHP Plus beneficiaries. Highmark has a compliance program in place that complies with federal or state regulations. Highmark has a dedicated fraud, waste, and abuse payment integrity team through a related-party agreement with Gateway's Fraud and Integrity Review Department. Highmark has written policies and procedures that outline protocols for reporting, detecting and preventing fraud, waste, and abuse practices.

The Payment Integrity Staff is responsible for processing suspected fraud referrals, data mining, investigating allegations of fraud, and identifying inappropriate payments. Services billed are processed and paid using Highmark's internal claim processing system OSCAR (Optimum System for Claims Adjudication and Reporting), which utilizes PCS edits that prevent duplicate and inaccurate billing. Highmark also utilizes Cotiviti for pre-payment claim analysis review and monitoring to identify aberrant billing trends. Provider training is mandated by DMMA, which is outlined in the MCO contract. The PCS training is conducted by Highmark provider relations representatives and clinical transformation consultants who make yearly, and as needed visits to educate providers. Highmark has also developed informational and training presentations to educate the two contracted FMS providers. In addition, Highmark communicates and trains providers on updated rules and regulations via provider visits, the provider manual, provider forums, fax blasts, webinars, and website communications.

In addition to being tasked with providing robust oversight, the MCOs are actively involved with the bulk of the administration of PCS in the Delaware Medicaid program. Case managers, who are employed by the MCO, are responsible for developing a POC that reflect services that will be authorized. The case manager reviews member placement and services onsite, with the member and/or member representative, at least every 90 calendar days. The MCOs utilize a standardized form developed by DMMA for determining and re-determining level of care required. Each POC is reviewed and approved by the state.

The Managed Care Operations Division at DMMA conduct a handful of unannounced visits, quarterly, that focus on quality of care and service delivery. The DMMA should consider conducting regular assessment audits, and POC audits that focus on identifying overutilization of PCS, suspected fraud, or improper billing. The MCOs manage the PCS delivery; including the initiation of services, amendments to the POC, and increase in authorized units of service. In the absence of consistent conflict-free assessments, or regular program audits conducted by DMMA, there are more opportunities abuse in overutilization of services. Further, DMMA should consider implementing a reconciliation process to verify that the amount of services reimbursed does not exceed the amount of services authorized.

Overpayment Recoveries, Audit Activity, and Return on Investment

The DMMA does not require MCOs to return overpayments to the state. The DMMA requires MCOs to report on overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits. The overpayment recoveries factor into future rate setting capitation payments. Highmark reported $228,693.00 in PCS overpayment recoveries from between FFY 2015 and FFY 2017. In addition, Highmark reported $302,896.00 in PCS cost avoidance from pre-payment reviews. Highmark reported nine referrals of suspected PCS fraud between FFY 2015 and FFY 2017.

Highmark had a substantial increase in PCS expenditures from FFY 2015 through FFY 2017. Specifically, Highmark experienced a 33 percent increase from FFY 2015 to FFY 2016, and a 22 percent increase from FFY 2016 to FFY 2017. The increase in expenditures coincided with an increase in total unduplicated beneficiaries that received PCS.

Section 5: Personal Care Service Providers

Overview of the State's PCS Providers

Providers of PCS deliver supports to Medicaid eligible beneficiaries in their own home or communities who would otherwise require care in a medical institution. These non-medical services assist beneficiaries who have limited ability to care for themselves because of physical, developmental, or intellectual disabilities or conditions. Seventeen provider agencies that provide PCS were contracted directly with DMMA in FFY 2017. Two provider agencies were contracted with DDDS in FFY 2017. The majority of the state's PCS are rendered through agencies that are contracted with MCOs.

The CMS review team interviewed four provider agencies that render PCS. Those agencies were: Generations Home Care, Maxim Healthcare Services, Epic Health Services, and Bayada Home Healthcare. The agencies were randomly selected to complete a questionnaire, and they are all licensed as skilled home health agencies.

Provider Oversight of PCS

Generations Home Care

Generations Home Care, Inc. (Generations) is a local not-for-profit home care agency that was originally created as a ministry in 1961. Generations was incorporated in 1968, and expanded their services to include, but not limited to; physical and occupational therapies, skilled nursing services, home health aide services, and transportation. Generations provides Medicaid PCS services to eligible beneficiaries under the Section 1115 Demonstration waiver authority. Generations does not provide self-directed services. In FFY 2017, Generations served 143 Medicaid beneficiaries, employed 35 home care aides, and employed nine supervisory personnel.

Generations employed approximately 70 home care aides in FFY 2016; however, the number of aides employed diminished significantly in FFY 2017 due to poor management and staff turnover.

Generations does not have a corporate compliance officer or compliance committee. The Chief Clinical Officer establishes program objectives, performs compliance related functions, and is responsible for the final approval of compliance policies. Generations has a Quality Assurance Performance Improvement (QAPI) Committee which has not addressed fraud and abuse. Generations advised CMS that the CMS 2018 conditions of participation for home health agencies under 42 CFR 484.64 does address fraud and abuse, and they will be including fraud training in their new hire orientation checklist. Generations' corrective action and work conduct policy does address serious violations that may result in immediate termination of employment such as, but not limited to, falsifying reports, false recording of hours worked, theft and forgery etc. Currently, PCA services are documented on paper flow sheets. Employees are encouraged to identify problems and opportunities to improve care and services as part of the QAPI Program. Registered nurses, nurse managers, and aide schedulers collaborate to review quality of care and suspected fraud allegations. The nurse manager and Chief Clinical Officer collaborate to determine if reported, suspected fraud allegations should result in termination. Monitoring and auditing is primarily performed for quality purposes, and not to identify suspected fraud. Generations advised CMS that if fraud or abuse is suspected, it is investigated at the local level by the regional director and reported to the Board of Directors. Generations has an internal reconciliation process where they have identified overpayments for services rendered that they were not eligible to receive. Additionally, overpayments are identified in the electronic data interchange platform, and the identified claims are investigated by the MCO that issued the reimbursement.

Generations is licensed as a Skilled Home Health Agency (4410) under Title 16 Health and Safety of the Delaware Administrative Code. Generations primarily hires CNAs, and has very few home health aides on staff. Generations employs three home health aides that have been grandfathered in due to long term employment in the agency. Generations performs background checks on all new applicants who are offered employment. The employment application asks new candidates if they have ever been convicted of a crime, ever been disciplined by a professional group, organization, licensure board and if they have ever been excluded from participation in a federal health care program. Applicants are required to disclose if they have ever been disciplined, suspended or terminated from a prior employer. Service letters are reviewed from prior employers to verify work history. Pursuant to Delaware Code Title 16 Health and Safety 1145 and 1146, "New applicants must undertake a criminal background check and drug screening by signing and completing a BCC consent." Generations performs database checks using OIG's LEIE and the BCC. Generations did not provide a policy or procedure to indicate employees are screened against the OIG-LEIE and SAM/EPLS on a monthly basis.

Registered nurses (RN) are responsible for assessing the client's needs for care, and revising the POC as needed based on the condition of the client. The RN conducts supervisory visits of the home care aide at the client's home. Generations does not have an EVV system, but are exploring EVV systems to adopt as part of operational service delivery.

Maxim Healthcare Services

Maxim HealthCare Services (Maxim) is a national company and currently provides home health care services in over 35 states. Maxim has provided PCS under the Delaware Medicaid state plan, and Medicaid waivers since 2000. During FFY 2017, Maxim provided PCS in Delaware to approximately 105 participants, employed approximately 57 PCA staff, and four supervisory staff.

Maxim has an established compliance program, a compliance officer, and a compliance committee that provides guidance to various internal anti-fraud and abuse controls. Company-wide compliance efforts for Maxim are managed and overseen by the Senior VP and the Chief Compliance Officer. The Board of Directors has established the compliance committee, which also consists of not less than three and no more than five company directors. The compliance committee is tasked with overseeing the company's activities in the area of corporate compliance that may impact the company's business operations or public image. Further, the compliance committee considers applicable industry standards, legal and business trends, and public policy issues. In exercising its authority and carrying out its responsibilities, the compliance committee and the Chief Compliance Officer review at least annually the company's compliance program and Code of Conduct. The compliance committee annually affirms their commitment to educating staff personnel regarding compliance requirements and how to conduct their job duties in compliance with state and federal laws. In addition, they implement monitoring and auditing functions to measure the effectiveness of the compliance plan and to address problems in an efficient and timely manner.

Maxim is licensed as a Skilled Home Health Agency (4410) under Title 16 Health and Safety of the Delaware Administrative Code. Maxim utilizes CNAs, and a handful of HHAs to provide PCS. Maxim requires all employees to take a general compliance training annually, which reviews Maxim's Corporate Integrity Agreement, Maxim's Code of Conduct, Compliance and Ethics Program, privacy, security, regulations, and enforcement efforts (which include fraud, waste, and abuse). All employees must pass a state mandated background check. Annual OIG-LEIE and SAM/EPLS database checks are completed by field support and human resources. Maxim's scheduling database, Vision, will not allow a scheduling assistant to allow aides to be scheduled unless they have updated database checks. Maxim did not provide a policy or procedure to indicate employees are screened against the OIG-LEIE and SAM/EPLS on a monthly basis.

Maxim has also implemented various policies, processes and procedures that assist in the company's auditing and monitoring tools which include: Field audits, unannounced audit visits, claims testing, incident reporting, home visits, and homecare quality metrics. Maxim has a robust claims monitoring system. Maxim utilizes the clearing house system, Change Healthcare, to ensure all claims are billed electronically and with the appropriate verifications and information. Upon submission of claims, Maxim has employed a series of automated system verifications for: Insurance verification, prior authorization, physician orders, home care agreement, denial/benefit coverage, nurse notes, and timesheets. Maxim is notified by Change Healthcare if a claim is processed through their clearing house without required information. Maxim was unable to provide CMS with a DMMA point of contact that would receive suspected fraud complaints. Further, Maxim does not have a method to report aide terminations to DMMA that were due to

suspected fraud, and have not reported any terminations resulting from suspected fraud within the last three FFYs. In FFY 2017, Maxim reported $21,442.00 in PCS overpayments.

Maxim Healthcare has developed its own EVV mobile application, MaximCare Mobile. The mobile application has been in place for almost two years, and they have continued to make updates to the app on a regular basis. MaximCare Mobile is approved in multiple states and meets all of the EVV requirements of the 21st Century Cures ACT. The mobile application provides the ability to identify services performed during the visit and services declined by the patient or their authorized signer for unskilled visits. The mobile application tracks services being provided through the location of the caregiver at the time they start the visit, the time they end the visit, and when the patient's signature is obtained. Skilled caregivers (RNs and LPNs/LVNs) can utilize the MaximCare Mobile for time in/out and to obtain the appropriate signatures to meet all EVV requirements.

Epic Health Services

Epic Health Services is part of the Aveanna Healthcare, Inc. family of companies providing PCS in the state of Delaware. Aveanna Healthcare family of companies is a national company, and currently provides PCS in seven states. Epic policies and procedures are under the umbrella of Aveanna, and therefore all references will be made to Aveanna Healthcare. During FFY 2017, Epic provided PCS in Delaware to approximately 164 participants, employed approximately 270 PCA staff, and ten supervisory staff.

Aveanna has an established compliance program, a Chief Compliance Officer, and a compliance committee to oversee the operations, findings, and recommendations of the compliance function. The compliance committee is comprised of the CEO, CFO, COO, General Counsel, Chief Clinical Officer, Director of People Services, and VP of Business Operations. The CCO reports directly to the President and CEO, with direct access to the Company's Board of Directors and Governing Body. Aveanna has a robust compliance program consisting of several elements; including a system to identify compliance risk area, annual self-evaluation based on audit results (internal and external), hotline calls, and investigation results. Aveanna has a process to respond to identified risk areas, a process for correcting compliance problems promptly and thoroughly, and a process for implementing corrective actions via updated policies, procedures, and systems to reduce potential for recurrence. Aveanna annually reviews and develops a compliance action plan that is tailored to fit their needs and the resources. At a minimum, internal reviews include: sample selection, data review and collection, data analysis, and reporting. Aveanna performs compliance training that meet all Deficit Reduction Act of 2005 and CMS requirements at new hire orientation, and annually for all employees. Aveanna employees are required to complete annual compliance training in order to ensure understanding of the code of conduct, relevant laws and regulations, how to report an allegation of misconduct or a concern, and other compliance policies and standards. Each year, company employees are notified when the compliance training materials, and corresponding tests are due. Each existing employee, and new employees are required to review the training materials and complete the corresponding test. New employees are required to complete the training during within 30 days of hire.

Aveanna is licensed as a Skilled Home Health Agency (4410) under Title 16 Health and Safety of the Delaware Administrative Code. Aveanna only hires CNAs to render PCS, and do not hire home health aides due to past difficulties identifying qualified home health aides. All employees must pass an initial background check through the Delaware BCC, NSOPR, OIG-LEIE, and SAM. Aveanna did not provide a policy or procedure to indicate employees are screened against the OIG-LEIE and SAM/EPLS on a monthly basis.

Aveanna has detailed audit policies and internal procedures to investigate and report suspected fraud. Audits and investigations of suspected fraud are jointly coordinated by the local field office where aide is employed, and corporate headquarters in Atlanta, GA. In addition, nursing supervisors conduct nursing reassessments every 56-60 days for each patient. While in the home, the nursing supervisors review the PCA's timesheets ("Aide Weekly Visit Record") compared to the home health aide POC. The beneficiaries review timesheets daily, initial daily to verify services, and sign the timesheet at the end of the week to verify accuracy of services rendered. The aide timesheet is submitted weekly and reviewed by the payroll specialist to ensure the care provider's name, dates of service, and services rendered are accurate before a claim, or encounter is submitted. In FFY 2017, Aveanna recorded $120,947.47 in overpayments. Aveanna does not have an EVV, but is actively developing plans to implement a system that is compliant with the 21st Century Cures Act.

Bayada Home Healthcare

Bayada Home Health Care (Bayada) is a national company that has provided home care services since 1975, formerly known as RN Home Health Care, Inc. and based in Philadelphia, PA. Bayada has provided PCS services since January 2010 to Delaware Medicaid beneficiaries. In FFY 2017, Bayada served 408 Delaware Medicaid beneficiaries, employed 598 PCA staff, and employed 26 supervisory personnel. Bayada provides Medicaid PCS services to eligible beneficiaries under the Section 1115 Demonstration waiver authority. Bayada does not provide self-directed services. Bayada has a formal compliance officer, corporate compliance plan and compliance committee. The corporate compliance committee meets on a monthly basis. The Chief Compliance Officer (CCO) has oversight responsibility for the compliance program, and along with the committee. The CCO is appointed by, and reports to the Board of Directors.

Bayada is currently licensed as a Skilled Home Health Agency (4410) under Title 16 Health and Safety of the Delaware Administrative Code. Bayada has offices located in four cities within Delaware. Bayada primarily hires CNAs to render PCS, but have a handful of home health aides on staff. All new hires are provided with an Honesty and Confidentiality booklet at orientation, and have 90 days to complete the modules and corresponding test. Honesty and Confidentiality training also occurs annually thereafter. Bayada provides initial and ongoing education for all employees.

Bayada's RN Clinical Manager provides a written centered POC with the assistance of the client and/or family member during the initial onsite assessment visit. The POC specifies tasks and duties of the PCA. Field supervisors conduct additional follow-up visits to ensure that duties and tasks performed by PCAs are specific and exclusive for the beneficiary. Bayada is statutorily

required under Title 16, Section 4410 Skilled Home Health Agency - Licensure, 6.6.4.2.2 to "make on-site supervisory visits to the patient's residence (while the HHA is providing care) no less than every sixty (60) calendar days" for care not requiring skilled services. Bayada's policy on clinical management and employee supervision adopts these requirements. Bayada ensures its hiring, contracting, operations, service provision and billing practices are compliant with regulatory mandates and requirements for minimum standards for a licensed Skilled Home Health Agency.

Bayada performs background checks on all new applicants who are offered employment. Employees must sign and complete a BCC form that comprises state and federal criminal history, child protection agency, and transmission of drug test results, and service letters which includes information about prior employment. Bayada screens all employees and aides against the OIG-LEIE and SAM databases upon hire, and on a monthly basis. The BCC includes rap back criminal history checks which provide continuous monitoring of local criminal database checks. Delaware requires service letters (post- employment references) to be entered into BCC.

Bayada has identified a vendor for EVV, and is in the process of implementing EVV by the end of 2018. CellTrack, Bayada's EVV vendor, offers web and mobile products for EVV, offers automation of POC documentation, enhances care gap monitoring, and improves reporting. CellTrack will reduce the need for paper timesheets, increase productivity, and has the capability to transmit a POC to the aide's phone. CellTrack records the services entered by the aide, which is reconciled with the service authorization. Services that do not align with the authorization are flagged for the scheduler, and service verification procedures are initiated.

Recommendations for Improvement

- Consider creating annual audit work plans that serve as guidance to MCOs on state oversight objectives and oversight priorities.
- Revise policies and procedures to ensure MCOs submit accurate encounter data that can be data mined and analyzed by DMMA for aberrant trends.
- Consider allocating appropriate FTEs to oversee managed care expenditures, and conduct regular data mining and audit activities on MCO encounter data.
- Consider revising policies and procedures to ensure compliance with payment suspensions under 42 CFR 455.23.
- The DMMA should review internal processes and procedures to ensure overpayments and terminated providers are accurately recorded and tracked.
- Consider identifying state approved training for home health aides, and developing a registry for home health aides.
- The DMMA should review internal procedures to ensure skilled home agencies are enrolled in accordance with 42 CFR 455.436, and subsequently screened against the appropriate databases on a monthly basis.
- Ensure MCOs screen managing partners and individuals with a controlling interest, as required by 42 CFR 455.436, against the appropriate databases.
- Consider amending the MCO contract to include specific guidance with regards to federal database checks, 42 CFR 455.436; namely for appropriate databases and which parties require screening. DMMA should communicate expectations and provide guidance to ensure MCOs, downstream risk entities, and provider agencies utilize the appropriate database screening procedures in accordance with CFR 42 455.436.
- The DMMA should revise oversight efforts to communicate expectations about suspected fraud reporting. The DMMA should ensure home care agencies report aide terminations to DMMA, and/or the MFCU, that were a result of suspected fraud.
- The DMMA should develop communication strategies to confirm providers are aware of how to report suspected fraud to DMMA.
- The DMMA should review and revise internal procedures to ensure state termination and Medicare revocation lists are reviewed no less than monthly, and ensure providers terminated for adverse actions are reported to CMS.
- The DMMA should develop adverse termination criteria consistent with Section 6501 of the Affordable Care Act, and amend the MCO contract to mandate prompt reporting of adverse action terminations. The DMMA should ensure MCOs develop similar criteria for adverse terminations, and develop clear reporting requirements for providers that have been terminated for adverse actions.
- Consider revising oversight self-directed PCS oversight efforts by initiating regular programmatic audits, and investigations of self-directed PCS.
- Ensure attendants are screened against the appropriate databases in order to verify attendants have not been excluded from receiving Medicaid reimbursements.
- Consider conducting regular assessment audits and POC audits to determine if there could be overutilization of PCS or improper billing. Or, consider implementing a conflict-free assessment procedure to determine appropriate services necessary for PCS delivery.

- Consider creating a reconciliation report run to match the number of hours billed against the hours authorized.

Status of Corrective Action Plan

Delaware's last CMS program integrity review was in June, 2015, and the report for this review was issued in February 2016. The report contained seven vulnerabilities. During the onsite review in August 2018, the CMS review team conducted a thorough review of the corrective actions taken by Delaware to address all issues reported in calendar year 2015. The findings of this review are described below.

Risk Areas-

1. ***Develop and Amend MCO contracts to require MCOs to perform federal database checks as specified in 42 CFR 455.436.***

Status at time of the review: Corrected

DMMA amended the MCO contracts for the 2016 contract year. Section 26.3.21.14.6 states that the MCO's must perform federal data base checks as specified in 42 CFR 455.436. Section 15.3.9.7.14 which states that providers must be checked in the data bases as part of their initial screening monthly screening. Section 3.9.7.14 states, "The Contractor shall screen all participating providers against the LEIE, SAM, EPLS and SSA DMF as part of initial credentialing and then monthly to ensure providers are not excluded."

2. Confirm expectations for the MCOs in making referrals, i.e., to the state and the MFCU as indicated in the contract, or just to the state. Amend contract language if needed. Educate all state staff in managed care and program integrity on any new processes.

Status at time of the review: Corrected

On June 5, 2015, DMMA sent memo #101-2015 (Attachment #2) to both Managed Care Organizations outlining the Program Integrity and Medicaid Fraud Control Unit (MFCU) reporting process. During regularly scheduled monthly meetings DMMA continued to remind the MCO's and MFCU about the process for making referrals.

3. Develop written policies and procedures which outline which state unit will be responsible for the various program integrity oversight functions.

Status at time of the review: Corrected

The policies and procedures can be found in the Surveillance and Utilization (SUR) Policy Manual (Attachment #3). The manual defines responsibility for the oversight functions of the Program Integrity Unit.

4. Continue efforts to improve ability to analyze encounter data reported by MCOs and perform state-initiated data mining activities to assist MCOs in identifying fraud, waste and abuse issues with network providers.

Status at time of the review: Corrected

The State is currently with two contractors Truven and Health Integrity to conduct data mining, predictive modeling, and claims analysis. This will assist DMMA in identifying fraud waste and abuse issues with both fee for service and the MCO network providers. DMMA will continue to work with the MCO's to improve our ability to analyze encounter data.

5. Provide formal trainings on Medicaid program integrity issues to the MCOs. These could be conducted at the quarterly meetings with the state's MCO unit.

Status at time of the review: Corrected

DMMA has both formal and informal meetings with the MCO's. During the quarterly meetings staff have conducted trainings and presentations about new fraud schemes, Medicaid Integrity Audits, Drug Diversion, OIG Audits, MFCU, and appropriate referrals.

6. State should report terminations by MCOs to CMS database.

Status at time of the review: Not Corrected

DMMA does not have an internal process, and has not reported terminations to the CMS database since FFY 2016. After repeated attempts to gain access to TIBCO the Division of Medicaid Medical Assistance Program Integrity (SUR) has registered all SUR staff into the replacement "DEX" system. SUR staff are in the process of completing training conducted by Division of Enrollment Operations (DEO) Provider Enrollment & Oversight Group at CMS. SUR has established two (2) System Administrators. Both individuals will be handling DEX reporting and inquiries for the SUR Team.

7. CMS recommends that the state clarify its expectations for the MCOs in making referrals and that this information be communicated clearly in the contract. All state staff involved in these processes should be educated on the contractual requirements.

Status at time of the review: Corrected

In the DMMA Operational Memo#101-2015 the expectations for referrals were clearly outlined.

Technical Assistance Resources

Technical Resources should be specific to areas identified during the onsite review as a finding, vulnerability, or risk. Choose any of the following. This list is not all inclusive.

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

- Continue to 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 Texas are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Review the document titled "Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services". This document can be accessed at the following link https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.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.
- Visit and utilize the information found on the CMS' Medicaid Program Integrity Education site. More information can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html.
- 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 issues.

Conclusion

CMS supports Delaware efforts and encourages it to explore 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 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 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 take action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

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