Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Mississippi Personal Care Services

Focused Program Integrity Review

Final Report

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of the Mississippi 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 may be used to advance the program integrity in the delivery of these services.

Ascertaining that billed services are provided safeguards against improper payments to providers, and protects the health and welfare of beneficiaries by ensuring that they receive essential non-medical services instrumental to improving the quality of their daily living activities. It is the responsibility of all parties involved in providing, authorizing, supervising, and furnishing PCS to protect and preserve Medicaid program integrity.

Background

Medicaid PCS is categorized as a range of human assistance services provided to persons with disabilities and chronic conditions which enables them to accomplish activities of daily living (ADLs) or instrumental activities of daily living. It is a Medicaid benefit furnished to eligible beneficiaries according to a state's approved plan, waiver, or demonstration. These services are provided in the beneficiary's home setting or at other locations. Services offered under Medicaid PCS are optional, 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.

Services must be approved by a physician or by 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.

States administer their Medicaid programs within broad federal rules and according to a state plan approved by CMS. In addition to providing PCS under their state plans, states may also seek permission from CMS to provide PCS under waivers of traditional Medicaid requirements.

Pursuant to the regulations found at 42 CFR 440.167 and 42 CFR 441.303(f)(8), 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 the PCA may provide cuing/prompting to the beneficiary in order to perform a task. Such assistance most often involves ADLs, such as eating and drinking, bathing, dressing, grooming, toileting, transferring, and mobility.

Also, the regulation at 42 CFR 441.450 provides the opportunity for participants (or their representatives) to exercise choice and control over services. Beneficiaries are afforded the decision-making authority to recruit, hire, train, and supervise the individuals who furnish their services under self-directed care models. Beneficiaries may also have decision-making authority over how the Medicaid funds in their service budget are spent.

The Mississippi Division of Medicaid (DOM) is the designated single state agency responsible for administering Medicaid and providing oversight for the delivery of PCS. The state only provides PCS through CMS approved 1915(c) waiver authority using the fee-for-service (FFS) reimbursement methodology. Mississippi's current 1915(c) home and community based (HCBS) waiver programs include: (1) Elderly & Disabled (E&D); (2) Independent Living (IL); (3) Traumatic Brain Injury/Spinal Cord Injury (TB/SCI); and (4) Intellectual Disability/ Developmentally Disabled (ID/DD).

Methodology of the Review

In advance of the onsite visit, CMS requested that Mississippi 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 and review guide modules were sent to PCS providers and/or provider agencies in order to gain an understanding of their role in program integrity. A three-person review team reviewed the responses and materials submitted by the state in advance of the onsite visit.

During the week of August 15, 2017 the CMS review team visited DOM. They conducted interviews with numerous state staff involved in program integrity and administration of PCS. In addition, the CMS review team conducted sampling of program integrity cases and other 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

Mississippi provides Medicaid PCS to eligible beneficiaries according to the state's approved 1915(c) HCBS waiver programs. The state does offer self-directed services under two of the HCBS waiver programs in order to provide personal choice and control over the delivery of waiver services.

Summary Information of the Waivers Reviewed

The description of the approved 1915(c) HCBS waiver programs offered in Mississippi are detailed below. The provision of HCBS waiver services is intended to support eligible beneficiaries in the home or community settings 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
E& D Waiver Implemented 1994	Section 1915(c)	E&D waiver	DOM
IL Waiver Implemented 1994	Section 1915(c)	IL waiver	DOM
TBI/SCI Waiver Implemented 2001	Section 1915(c)	TB/SCI waiver	DOM
ID/DD Waiver Implemented 1995	Section 1915(c)	ID/DD Waiver	DOM

The E&D waiver permits Medicaid eligible beneficiaries that are 21 years or older and are aged and/or disabled who require nursing facility (NF) level of care to receive medical and social services in their homes or a community-based setting instead of in a NF. The services provided under the E&D waiver include: case management, PCS, adult day care, in-home respite, institutional respite, home delivered meals, transition assistance, physical therapy, speech therapy, and extended state plan home health care services. The E&D waiver is administered by the DOM's Office of Long Term Care and has approximately 17,097 unduplicated participants for FFY 2016. Under this waiver, PCS is provided through a PCS provider agency of the participant's choice and under a provider-managed delivery model.

The IL waiver permits Medicaid eligible beneficiaries that are 16 years or older that require cost-effective in-home support services/long-term care assistance to remain in the home and community based setting in lieu of institutionalization in a NF. The IL waiver utilizes the preadmission screening process that provides a single point of entry concept for beneficiaries seeking long-term care services and is designed to fill two primary functions: 1) determine eligibility for Medicaid long-term care across both institutional and HCBS settings; and 2) facilitate informed choices by persons applying for services. The services provided under the IL waiver include: case management, PCA service, financial management, environmental accessibility adaptation, specialized medical equipment and supplies, and transition assistance. The IL waiver is administered by the DOM's Office of Long Term Care and operated through an interagency agreement with the Mississippi Department of Rehabilitation Services (MDRS). The IL waiver had approximately 2,867 unduplicated participants for FFY 2016. Under this waiver, PCA services are provided by individuals of the participant's choice through a participant-directed delivery model.

The TBI/SCI waiver permits Medicaid eligible beneficiaries that are physically disabled and/or have suffered brain injuries to receive cost-effective in-home support services to remain in the

community in lieu of institutionalization for long-term care assistance. Services are available statewide without regard to age. The TBI/SCI waiver strives to identify the needs of the dependent participant through the comprehensive Long Term Support Services (LTSS) assessment process. The LTSS utilizes a "No Wrong Door" entry concept for beneficiaries seeking long-term care services and is designed to fill two primary functions: 1) determine eligibility for Medicaid long-term care across both institutional and HCBS settings; and 2) facilitate informed choices by persons applying for services. The services provided under the TBI/SCI waiver include: case management, PCA service, environmental accessibility adaptation, specialized medical equipment and supplies, respite, and transition assistance. This waiver is administered by the DOM's Office of Long Term Care and operated statewide through an interagency agreement with the MDRS. The TBI/SCI waiver had approximately 927 unduplicated participants for FFY 2016. Under this waiver, PCA services are provided by individuals of the participant's choice through a participant-directed delivery model.

The ID/DD waiver provides service to people who would require care in an intermediate care facility for beneficiaries with intellectual disabilities. Services are available statewide without regard to age and can be provided in community settings such as their own home, the family home, or another community setting with services and supports appropriate for their needs. This waiver is administered by the DOM's Office of Mental Health and operated through an interagency agreement with the Mississippi Department of Mental Health (DMH). The services provided under the ID/DD waiver include, but are not limited to: supervised living, behavior support, day services-adult, community respite, prevocational services, supported employment, specialized medical supplies, support coordination, occupational, physical and speech therapies, home and community supports, supported living, shared supported living, job discovery, crisis support and intervention, host homes, transition assistance, medical homes and in-home respite. There are approximately 1,259 unduplicated participants in this waiver for FFY 2016. Under this waiver, PCS is provided through a PCS provider agency of the participant's choice and under a provider-managed delivery model.

Mississippi's total Medicaid expenditures in federal fiscal year (FFY) 2016 were approximately $5.6 billion and covered almost 717,946 beneficiaries. Mississippi's total Medicaid expenditures for PCS in FFY 2016 were approximately $208.0 million. The unduplicated number of beneficiaries who received PCS in FFY 2016 was 22,150. Total unduplicated beneficiaries represents the count of unique individuals receiving PCS during a specified time period. The number of PCS providers enrolled in FFY 2016 was 280.

Table 2.

1915(c) Waiver Authority Service/Program	**FFY 2014**	**FFY 2015**	**FFY 2016**
E&D waiver	$78.7 million	$95.1 million	$108.0 million
IL waiver	$47.1 million	$51.0 million	$53.6 million
TBI/SCI waiver	$20.5 million	$21.5 million	$21.9 million
ID/DD waiver	$23.5 million	$24.4 million	$24.6 million
Total Expenditures	**$169.8 million**	**$192.0 million**	**$208.1 million**

The PCS expenditures overall showed some gradual increase from year to year during the three FFYs reviewed. Both the E&D and ID/DD waivers (agency-directed) account for an average of 75 percent of the total PCS expenditures over the three FFYs.

Table 3.

	FFY 2014	FFY 2015	FFY 2016
Total PCS Expenditures	$169.8 million	$192.0 million	$208.1 million
% Agency-Directed PCS Expenditures	74.8%	73.5%	63.7%
% Self-Directed PCS Expenditures*	25.2%	26.5%	36.3%

*All self-directed PCS is delivered via the IL and TBI/SCI waivers.

The PCS expenditures increased by 22 percent between FFY 2014 and FFY 2016, while the number of unduplicated beneficiaries remained fairly constant. A significant portion of the PCS expenditures were allocated to the agency-directed versus the self-directed.

Table 4-A.

1915(c) Waiver Authority Service/Program	FFY 2014	FFY 2015	FFY 2016
E&D	17,388	17,309	17,097
ID/DD	1,242	1,190	1,259
Total Agency-directed Unduplicated Beneficiaries	**18,630**	**18,499**	**18,356**

*Unduplicated beneficiary count is the number of individuals receiving services, not units of service.

Table 4-B.

1915(c) Waiver Authority Service/Program	FFY 2014	FFY 2015	FFY 2016
IL	2,669	2,777	2,867
TBI/SCI	904	922	927
Total Self-directed Unduplicated Beneficiaries	**3,573**	**3,699**	**3,794**

*Unduplicated beneficiary count is the number of individuals receiving services, not units of service.

State Oversight of PCS Expenditures

The E&D waiver receives oversight from two departments within DOM that includes Office of Long Term Care and Office of Financial and Performance Review along with case management agencies under the Mississippi planning and development districts. The Office of Long Term Care is responsible to review and process each agency's proposal to become a provider of PCS services prior to the provider submitting an application for a provider number. All providers must ensure that all direct care staff meet the established criteria and requirements as set forth in the CMS approved E&D waiver application. Each provider agency should maintain the documentation of their direct care staff's qualifications. Each provider agency is required to have PCS supervisors perform semi-monthly monitoring through supervisory home visits and phone calls.

The case management agency is responsible for monitoring the provision of services in accordance with the approved plan of services and supports (PSS). The individualized PSS is developed based upon the comprehensive assessment of a beneficiary's needs. The

comprehensive assessment areas include: identification of any medical, educational, social, or other service needs. The assessment should include obtaining a beneficiary's history, identifying and documenting the needs of the beneficiary, and gathering information from sources such as family members, medical providers, social workers, and educators, as appropriate. Case managers are required to monitor the provision of PCS during monthly contacts and quarterly home visits with the participant. In addition, the Office of Long Term Care staff conducts participant home visits in order to monitor the provision of services. The PCS agency supervisors are required to review claims prior to submission. The Office of Financial and Performance Review is responsible for conducting annual post-payment audits of PCS claims.

The ID/DD waiver receives administrative oversight from DOM. Responsibility for daily operations of the ID/DD waiver includes DMH, Bureau of Intellectual and Developmental Disabilities and the Division of HCBS. The PCS provider agencies are certified by DMH and approved by DOM Office of Mental Health prior to enrollment as Medicaid providers. The MDMH Bureau of Intellectual and Developmental Disabilities has a team of surveyors who are responsible for monitoring all services by ID/DD waiver providers. Support coordinators monitor the approved PSS/provision of PCS during monthly contacts and quarterly home visits with the participants. The PCS agency supervisors are required to review claims prior to submission for payment. Post-payment audits of PCS claims are conducted monthly by DMH. If any claims discrepancy is identified the information should be submitted to DOM Office of Mental Health for further review.

The oversight responsibilities for both the IL and TBI/SCI waivers is discussed in Section 3: Self-Directed/Participant-Directed Care Services. Mississippi does not have dedicated staff assigned only to monitoring PCS services; however, multiple layers of oversight are in place including monthly and quarterly monitoring of the provision of PCS by case managers during home visits with the participant and annual quality reviews by DOM's Office of Long Term Care. The current oversight responsibilities for PCS is shared among multiple agencies. Interagency agreements are in place between DOM and MDRS related to the provision and oversight of PCS.

Table 5.

Agency-Directed and Self-Directed Combined	FFY 2014	FFY 2015	FFY 2016
Identified Overpayments	$284,330.67	$1,074,785.08	**
Recovered Overpayments	$0.00	$66,892.08	**
Terminated Providers	0	0	**
Suspected Fraud Referrals	0	0	**
# of Fraud Referrals Made to MFCU	2	0	**

*Overpayments identified and recovered in FFYs 2014, 2015 and 2016 include fraud, waste, and abuse.
**The state was unable to provide data for the identified and recovered overpayments in FFY 2016.

Section 2: PCS Provider Enrollment

Overview of PCS Provider Enrollment

States pay PCS providers, who furnish services to eligible beneficiaries on either a FFS basis or through risk-based managed care arrangements. If state Medicaid agencies pay fraudulent providers, either directly or through managed care plans, for services that the providers did not furnish or for services they did furnish to beneficiaries they knew had no need for the services: (1) Medicaid funds are diverted from their intended purpose, and (2) beneficiaries who need services may not receive them.

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

In Mississippi, PCS can be offered through two delivery models: (1) agency-directed or (2) self-directed / participant-directed. The provider enrollment process for PCS provider agencies requires the provider to submit an application to the appropriate designated state entity for review and approval prior to enrollment as a Medicaid provider based upon the guidelines set forth in the applicable waiver application. Each agency is required to ensure that all employed PCAs meet all PCA qualifications. The provider enrollment process for self-directed PCS requires the approval/authorization of the participant's service plan by the designated state entity. Upon authorization to receive PCS the waiver participant can choose an individual to be their PCA. The PCA must be certified as meeting all PCA qualifications based upon the requirements set forth in the approved waiver application.

All PCS provider types are considered "high-risk" and Mississippi Medicaid has implemented the fingerprint-based criminal background check process as of May 1st, 2017. The DOM has also implemented the federal database checks on all PCS providers including owners and managers. The federal database screening is done by the fiscal agent at enrollment, reenrollment, re-validation and on a monthly basis thereafter. The DOM has a pre-screening process, which each provider's qualifications are reviewed against the requirements of each waiver before the provider can apply. Mississippi states that about 80 applications have been rejected as a results of this pre-screening process.

Summary of Information Reviewed

The CMS team reviewed the completed review guide, documentation submitted by the state and others, and interviewed state staff as a part of the review. The PCS claims for the E&D waiver, the IL waiver, and the TBI/SCI waiver, are audited annually by the Office of Financial and Performance Review, to ensure continued compliance by PCS agencies.

For the ID/DD waiver, a PCS provider must be certified by DMH as a home and community support provider. Once certified by DMH, the provider then submits an application to DOM. A DMH certification is required every three years. Therefore, the provider must submit a copy of their DMH certification to provider enrollment every three (3) years in order to update their provider file.

Mississippi does not have any individual PCS providers enrolled in its program as there is no requirement that they need to be licensed. Individual PCAs are utilized through the IL and TBI/SCI waivers. The PCAs are employees of an agency who contracts with an operating agency for each particular waiver. The employee's agency handles the payroll and human resources functions for the PCAs. The PCAs in the E&D and ID/DD waiver must work for an approved/certified agency and meet all the personnel and training requirements. All agencies are required to ensure that each PCA employed has passed a criminal background check and is not listed on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE) or the nurse aide abuse registry.

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 at 42 CFR 455.436. Also, the state does check all parties against the LEIE and the Excluded Parties List System monthly after enrollment/reenrollment as required at 42 CFR 455.436(c)(2).

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

Overview of Self-Directed Care Services

Mississippi has authority to operate a self-directed program for PCS under both the IL waiver and the TBI/SCI waiver. Each self-directed service is provided through a personal care agency.

The regulation at 42 CFR 441.450 provides participants, or their representatives, the opportunity to exercise choice and control over services. Beneficiaries are afforded the decision-making authority to recruit, hire, train and supervise the individuals who furnish their services under self-directed care models. Beneficiaries may also have decision-making authority over how the Medicaid funds in their service budget are spent.

Summary of Information Reviewed

The CMS team reviewed the completed review guide, documentation submitted by the state and others, and interviewed state staff as a part of the review. The PCS under the IL and TBI/SCI waivers are routinely monitored by the DOM (administrative authority) and the MDRS (operating agency) as described in the interagency agreement. Financial management services was an approved service on the IL waiver only; however, it was never implemented and has been removed from the renewal application recently submitted to CMS. Beneficiaries receiving self-directed PCS do not have budget authority, while claims for PCS, once reviewed for appropriateness, are submitted by the operating agency (MDRS) to the DOM for payment.

The DOM Office of Long Term Care, DOM Office of Financial and Performance Review and MDRS are the entities that provide oversight for PCS in the IL and TBI/ SCI waivers. Participants in both waivers may choose an individual to be their PCA. Each PCA must be certified as meeting all PCA qualifications, through a DOM approved certification process based on the requirements set forth in the CMS approved IL waiver application. This certification is conducted by the MDRS case manager in conjunction with the participant. The MDRS then maintains the documentation of each PCA certification. The MDRS case managers monitor the provision of services in accordance with the DOM approved PSS during required case management contacts/visits with the participant and review timesheets of PCAs monthly. The Office of Long Term Care staff conduct participant home visits to monitor service provision. Audits of PCA certification and billing documentation are conducted annually by the Office of Financial and Performance Review.

State Oversight of Self-Directed Services

Oversight of Mississippi's self-directed services involves the collaboration of several state offices. Self-directed services provided through both the IL and TBI/ SCI waivers are routinely monitored to ensure the quality of and compliance with the provisions of service. An independent review of PCA certifications and billings are performed annually. Additionally, procedures are in place to report instances that appear to be more than just billing errors to Medicaid Program Integrity Unit and the Medicaid Fraud Control Unit (MFCU). Cooperation and communication appear to be key in the design of the oversight function.

The MDRS case managers monitor the provision of services in accordance with the DOM approved PSS during the required case management contacts and home visits with the beneficiary. The PCA timesheets are reviewed monthly to ensure that they accurately reflect the PSS daily service notes. The DOM Office of Long Term Care staff conduct monthly beneficiary home visits to monitor service provisions.

Independent from the MDRS and the DOM Office of Long Term Care, the DOM Office of Financial and Performance Review conducts annual reviews including, but not limited to, PCA certification and billing documentation and reconciliation. All findings are reported back to both MDRS and the Office of Long Term Care for any corrective action needed with the providers. Overpayments found are collected from providers by adjustments through the MMIS.

Procedures are in place for the DOM program integrity staff to become involved in the oversight process when the reviews performed by the Office of Financial and Performance Review reveal a provider with excessive billing errors or patterns of fraud. Automatic triggers for referral are a possible overpayment in excess of $10,000 or a provider whose overpayments appear to be fraudulent in nature no matter the dollar amount. During the three year period reviewed, FFY 2014 through FFY 2016, however, neither of these occurred for self-directed care services.

The DOM Program Integrity Division did not receive any leads from any other sources and did not initiate other audits or reviews of any self-directed care services or providers during the three year period reviewed. While onsite, the team conducted a sample of case files and discovered

that one case was referred to DOM by way of PERM data, but had not been pursued. Further explanation could not be provided to the review team due to a turnover in key staff members.

The DOM leadership reported and emphasized that the current communication process adequately captures all self-directed care monitoring and auditing information and provides the feedback information to the appropriate staff. Leadership also emphasized that controlling risk was the responsibility of all managers and department heads; information about identified risks, issues with quality services, problematic providers or inappropriate billings, and the means of controlling those risks was communicated to all who were responsible for mitigating those risks.

Section 4: Electronic Visit Verification

Overview of the State's Electronic Visit Verification System

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

Summary of Information Reviewed

An EVV system is currently being implemented statewide for all HCBS waiver populations. The DOM contracted with FEi Solutions to launch the EVV system, known as MediKey, on July 3, 2017, for the ID/DD waiver and on November 1, 2017, for the E&D waiver.

Prior to the decision to go statewide, the DOM piloted the EVV system in a test environment. The pilot ran for the four week period from January 23 through February 28, 2017. The pilot program resulted in some modifications to the system to increase efficiency.

MediKey interacts with the state's LTSS, which now houses all of the PCAs' credentials as required by the waivers. The MediKey is designed with interactive voice recognition signifying that the system will recognize the PCA's voice when they call in to the service verification line from the beneficiary's home to "clock in, clock out". On the call, the PCA uses the set of randomly generated numbers, termed password, from the beneficiary's one time password device to verify time arrived and time departed for the service. Based on the "clock in, clock out" times, MediKey validates the data and submits to MMIS. An extract is updated to the original claim and paid.

In preparation for implementation of the EVV system, the DOM has performed provider and PCA trainings. Training materials are available that include videos, manual material and training memos. In addition, staff anticipate the administrative code will be updated early 2018 to reflect the changes with the EVV system.

The DOM is anticipating an improvement in the accuracy of the PCS claims as a result of implementing the EVV system. This accuracy should result in some savings for the state. The

state mentioned that their studies of other states had shown savings of 10 to 12 percent, but they had not yet forecasted Mississippi's savings.

Section 5: Personal Care Service Providers

Overview of the State's Personal Care Service 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. These non-medical services assist beneficiaries with activities of daily living such as bathing, dressing and toileting. Mississippi does not provide PCS through any managed care arrangements. The number of PCS providers enrolled in FFY 2016 was 280.

Rehabilitation Centers, LLC d/b/a Millcreek Home and Community Based Services (Millcreek) is certified to provide ID/DD waiver services under the guidance of the DMH Bureau of Intellectual and Developmental Disabilities through an interagency agreement with DOM who administers the waiver. The Division of HCBS is responsible for the daily operation of the ID/DD waiver. Millcreek is a subsidiary of Acadia Healthcare (Acadia) which according to their website, "Acadia was established in January 2005 to develop and operate a network of behavioral health facilities across the country. Acadia provides psychiatric and chemical dependency services to its patients in a variety of settings, including inpatient psychiatric hospitals, specialty treatment facilities, residential treatment centers, outpatient clinics and therapeutic school-based programs." The 2015-2016 staffing levels were reported as 271 PCAs and 11 supervisors. The Medicaid payments of $4,067,090 were identified for 2015-2016.

SON Valley is a ministry of Baptist Homes, Inc., a non-profit organization, which has been open for 10 years. They have operated the only private, Christian, intermediate care facility for intellectual and developmental disabilities in Canton. SON Valley has two group homes where 10 adults with intellectual disabilities reside, yet they can function to live and perform chores in the household. With no more room to expand five years ago, SON Valley implemented home and community supports under the HCBS waiver and were certified in 2014. Their home office is located in Ridgeland and they currently have three clients. The HCBS waiver is administered and operated under the same waiver guidelines described in the previous paragraph. The 2015-2016 staffing levels were reported as 2 PCAs and 1 supervisor. The Medicaid payments of $25,137 were identified for 2015-2016.

Quality Healthcare and Hospice, LLC was incorporated in 2014 and began offering services in FFY15. The LLC, founded by two registered nurses, began small and slowly grew. The provider, which has offices is both Ridgeland and Meridian, provides both private duty nursing services, as well as PCS. The provider's PCS are provided under the E&D waiver. Approximately 90 percent of their patient mix is Medicaid. By FFY 2016, Quality Healthcare and Hospice, LLC served 115 Medicaid beneficiaries with PCS and received $489,588 in Medicaid payments.

Pleasant Living Care Coordination, LLC initially received authorization to provide Medicaid PCS services in 2007 and continues to serve as a PCS provider. The provider's principal office is located in Jackson with an additional office in Meridian. The provider's PCS are offered to beneficiaries served through the E&D waiver, however the provider does offer other services. The provider's array of other services include private duty nursing and private sitting services. The Medicaid patient mix is an estimated 60 percent.

Provider Oversight of Personal Care Services

Overall, the PCS providers interviewed demonstrated having a significant role in the oversight of the delivery of quality services, as well as the submission of appropriate claims for payment of these services. The providers reported that they comply with laws and regulations, monitoring and reviewing services and claims, and hiring and training personnel. The team did identify that none of the PCS providers had hotlines or anonymous reporting methods for beneficiaries to report fraud, waste and abuse. The interview also revealed that one of the providers did not pass a recertification review and as a result had been placed on a corrective action plan (CAP) and required mandatory training.

The implementation of compliance programs is a valuable tool in the prevention of fraud, waste and abuse, while at the same time furthering the fundamental mission to provide quality care to beneficiaries. Most of the PCS providers reviewed had separate policies and procedures that if combined, would only make a partial compliance program. These written policies and procedures described compliance expectations in a code of conduct or code of ethics, training and education of employees that occurred as a part of orientation and then periodically, and disciplinary policies. Only one PCS provider had a designated compliance officer. The composition of compliance committees varied greatly from structured, to informal, to none at all.

The CMS review team found that submitting appropriate claims appeared to be one of the highest priorities for all providers interviewed. Throughout the monitoring and review process, timesheets, service notes and the PSS are reviewed and compared at the service level, supervisory level and again at the office level for accuracy. Appropriateness and correctness of Medicaid claims was found to be a mantra from the top-down and throughout the organizations. Only one issue was associated with one of the reviewed PCS providers. The CMS review team identified a case/example that the PCS provider had failed to have the beneficiary or caregiver sign-off on timesheets and service notes acknowledging the PCS time spent and services rendered.

The requirement for mandatory training for PCS workers is included in the waivers; PCAs are able to take this training on-line. Beyond mandatory training, PCS agencies differ on amount and content of staff training but all provide continuing education to their PCA staff on relevant issues surrounding the population that they serve. It was noted that there were no educational or training classes specifically for supervisors or those who otherwise had oversight of PCAs. No matter the issue, the interviewed PCS providers told the CMS review team that they reinforce Medicaid fraud, waste, and abuse at every training session.

All PCS providers that were interviewed reported vetting potential employees, at the time of hire, through some type of screening process. Whether this screening process was a national screening company or the DOM, providers were unsure, however, of all of the federal or state requirements of the screening. None of the providers were familiar with the federal exclusion databases, such as the HHS/OIG website. Additionally, providers were not aware of the federal requirement to search exclusion websites monthly in order to capture exclusions, and reinstatements, that have occurred since the last search.

The Mississippi PCS providers interviewed appeared to be concerned about creating a health care culture aimed at providing quality health services by qualified and trained staff. Along with the provision of services, these providers are concerned with ensuring that they have a reasonable and consistent system of oversight that guards them from instances of fraud, waste, and abuse.

Recommendations for Improvement

- The state should consider requiring that any PCS providers participating in their Medicaid program have compliance policies and procedures. The state should consider establishing guidance on the basic requirements for all PCS providers regarding compliance program structure to ensure continuity within the Medicaid PCS program. In addition, PCS providers who are agencies should have designated staff tasked with ensuring that their agencies are in compliance with both internal policies/procedures, and all applicable state and federal regulatory requirements.
- The state should consider requiring annual continuing education for PCS agencies that may include updates on the current PCS policies and procedures, reporting, documentation and supervision requirements.
- The state should consider educating beneficiaries and PCS providers about the types of PCS fraud and resulting penalties. In addition, the state should ensure that both beneficiaries and PCS providers are aware of how to report suspected fraud, waste and abuse to the designated state hotline.
- The state should ensure that the full statewide implementation of the EVV system has occurred as a method to verify visit activity for Medicaid-provided PCS as required under Section 12006 of the 21st Century Cures Act. The EVV system should verify; the date of service; location of service; individual providing the service; type of service; individual receiving the service; and the time the service begins/ends.
- The state must ensure that service notes for ID/DD waiver have the appropriate signatures in compliance with DMH's Record Guide for Mental Health, Intellectual and Developmental Disabilities, and Substance Use Disorder Community Providers.
- The state must ensure that each PCS provider complete the necessary background checks, federal database checks and state-maintained abuse registry or registry identified in the waiver prior to hiring anyone with the responsibility of providing direct care to its beneficiaries.
- The state must ensure that PCS providers include initial and yearly training for all persons with the responsibility of providing direct care to beneficiaries, which includes PCAs and those in supervisory positions. Documentation of training completion must be kept by the provider agency.

Section 6: Status of Corrective Action Plan

Mississippi did not have a CAP to review and allow for the reporting of progression. It has been determined that Mississippi made a good faith effort to address all findings and vulnerabilities identified during the previous onsite review in 2012.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Mississippi 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 MS 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 Mississippi efforts and encourages it to explore additional opportunities to improve overall program integrity. The CMS focused review identified specific 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 corrected 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 Mississippi to build an effective and strengthened program integrity function.