Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Texas 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 select state 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 program integrity in the 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 C.F.R. § 440.167, the provision of 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, an 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 the State 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[1]. 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

[1] The Texas report information and data is reflective of the original requested review timeframe of FFY2014, FFY2015 and FFY2016. The Texas review was originally scheduled for FFY2017; however, due to the events of Hurricane Harvey, the Texas review was postponed until FFY18, but the previously collected data did not change.

program integrity. A four-person review team reviewed these responses and materials in advance of the onsite visit.

During the week of February 26, 2018 - March 3, 2018, the CMS review team visited Texas' State Medicaid Agency (SMA), the Health and Human Services Commission (HHSC). They conducted interviews with numerous state staff involved in program integrity and the 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 Personal Care Services

In Texas, the HHSC provided Medicaid PCS to eligible beneficiaries under the state plan, 1915-waiver authority and section 1115 demonstration. Historically, the HHSC delivery method for the provision of PCS utilized both the fee-for-service (FFS) and managed care delivery models. During this review period, HHSC also provided PCS-like services through its approved 1915(c) waiver authorities until 2015. Beginning June 2015, HHSC also began delivering PCS-like services through Community First Choice (CFC), a 1915(k) option. The state's PCS continues to be delivered through either FFS and/or the managed care delivery model. The majority of beneficiaries are receiving PCS through the agency–directed model versus the self-directed model (consumer directed). Texas does offer the self-directed PCS option that promotes personal choice and control over the delivery of services to Medicaid beneficiaries enrolled in managed care or FFS through the Medicaid State Plan.

After 2015, the HHSC re-design of the health delivery system resulted in PCS being delivered through CFC, primarily through the state plan and/or section 1115 demonstration authority. Between federal fiscal year (FFY) 2014 and 2016, Texas had 16 individual programs that provided PCS. The various programs, along with the services provided under each, can be summarized as follows:

State Plan authority - PCS administered via the Medicaid state plan includes services provided under:

- 1905(a) authority and delivered through acute care FFS;
- CFC 1915(k) authority PCS, personal assistance services (PAS), and habilitation services operated in managed care and acute care FFS;
- CFC 1915(k) Intellectual and Developmental Disabilities waiver (IDD waiver) PAS/Habilitation delivered through long term services and support (LTSS) FFS;
- Primary Home Care (PHC) provided under 1905(a) authority; and
- Community attendant services are delivered through LTSS FFS.

1915(c) Waivers - PCS administered via 1915(c) waiver services includes:

- IDD waiver 1915(c) Residential Habilitation CLASS Service Group delivered through LTSS FFS (applicable prior to the 6/1/2015 CFC implementation);
- 1915(c): Intellectual and Developmental Disability (IDD) Waiver - Residential habilitation, Deaf, Blind and Multiple Disabilities (DBMD) Service Group;
- 1915(c): IDD Waiver - Residential habilitation, Home and Community Based Services (HCS) Service Group;
- 1915(c): IDD Waiver - Residential habilitation, Texas Home Living (TxHmL) Service Group; and
- 1915(c): Nursing Waiver - Personal attendant services, community based alternatives (CBA), which was delivered through LTSS FFS (applicable prior to the 9/1/2014 statewide expansion of Managed Long Term Services and Supports (MLTSS)).

Section 1115 Demonstration – PCS administered via the 1115 demonstration is referred to as a 1915(c)-like and includes all of the following services:

- Managed Care State Plan 1905(a) PAS - delivered through managed care (STAR+PLUS);
- CFC 1915(k) delivered and operated in managed care;
- CFC 1915(k) State Plan Personal Assistance Services/Habilitation (PAS/HAB) - delivered through managed care (STAR+PLUS);
- CFC 1915(k) State Plan Comprehensive Care Program (CCP) PAS/HAB - Delivered through Managed CARE (STAR Kids, STAR Health); HCBS (waiver) PAS/HAB - delivered through managed care (STAR+PLUS);
- Managed Care Home and Community Based Service (HCBS) PAS 1915(c)-like service delivered under 1115 authority - delivered through managed care (STAR+PLUS); and
- Managed Care State Plan 1905(a) PCS delivered under 1115 authority - delivered through managed care (STAR Kids, STAR Health).

Overview of Self-Directed PCS

Texas has authority to operate a self-directed type of PCS program, known as consumer directed services (CDS) and the delivery of PCS occurs using the state plan FFS program or its 1915(c) waivers and 1115 demonstration waivers. The regulation at 42 C.F.R. § 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.

A key component of the CDS model is the financial management. The financial management services agency (FMSA) is responsible for the following tasks:

- collecting and processing timesheets of the individual's attendant care providers;
- processing payroll, withholding, filing, and paying applicable federal, state, and local employment-related taxes and insurance;
- separately tracking budget funds and expenditures for each individual;
- tracking and reporting disbursements and balances of each individual's funds;
- processing and paying invoices for services in the person-centered service plan; and
- providing individual periodic reports of expenditures and the status of the approved service budget to the individual and to the contracted case manager or service coordinator for the relevant program.

The HHSC has specific requirements that FMSAs are expected to comply with as follows:

- FMSAs must participate in a mandatory enrollment training and must pass a knowledge test prior to contracting to provide services with HHSC or a managed care organization.
- FMSA must complete training on the following basis (1) initial, (2) quarterly, and (3) periodic training as requested; FMSAs are required to meet 90% compliance.
- FMSA monitoring reviews are conducted to assess performance based on standards related to conducting background checks, licensure verification, orientation of the consumer directed services employer, new hire process, employer budgets and expenditure reports, and payroll. The managed care entities (MCEs) are required to ensure their contracted FMSAs are qualified to perform services, comply with relevant program rules and requirements, and meet contractual obligations.

The HHSC conducts monitoring reviews of FMSAs to determine compliance with the Medicaid provider agreement and the relevant program rules and requirements. These reviews are conducted via desk review or at the location where the FMSA is providing FMS. The HHSC monitors 100% of the FMSAs at least every three years. The HHSC assesses a FMSA's performance by using a standardized monitoring tool to:

1. Measure adherence to rules as described in the state regulations contained in the Texas Administrative Code (TAC);
2. Ensure the required background and registry checks were conducted prior to hire of the consumer directed services option employee;
3. Match payroll, optional benefits, and tax deposits to time sheets;
4. Assess adherence to state and federal tax laws specific to operating as a vendor fiscal/employer agent;
5. Ensure that the hours worked and the rate of pay are consistent with individual budgets;
6. Review administrative payments; and
7. Review the Medicaid provider agreements.

State Oversight of Self-Directed Services

The HHSC relies heavily on its monitoring reviews to evaluate the effectiveness of its self-directed services. The self-directed PCS program is routinely monitored on an annual basis;

however, the HHSC stated in spite of the annual monitoring, CDS services has shown the greatest propensity for fraud, waste and abuse.

Although potential CDS employees are screened, they are not typically run through the exclusion databases to see if they are excluded from participating in the program. The interviewed PCS agencies stated that PCAs who are terminated from one agency often end up working for another agency. In addition, few audits are performed and verification of services with beneficiaries are not done as stipulated by 42 C.F.R. § 455.20. Only one of the agencies reviewed were verifying services with beneficiaries and conducting unannounced visits. The CMS review team recommends that HHSC review and modify program integrity contract requirements to ensure that the MCEs and PCS agencies verify services with beneficiaries in accordance with 42 C.F.R. § 455.20.

The HHSC CDS option appears to impose a risk to the Medicaid program due to the lack of oversight by MCEs and PCS agencies. Although HHSC monitors where family members are attendants in the CDS option, there are risks involved with allowing family members to be hired as PCAs. The PCS agencies indicated that the family conflicts could potentially compromise beneficiary quality of care. Family members generally are the PCAs who pose the most risk and have the ability to commit fraud related to the alleged PCS work schedules/hours that they submit for payment. In addition, at least one of the agencies, reported that more PCAs are moving over to the CDS option since the electronic visit verification (EVV) is not mandated. This PCA movement may not be reflective of the gross figures for the CDS program overall. The PCS agencies voiced concerns that the HHSC Office of Inspector General (HHSC-OIG) could improve their program integrity outreach by making the PCS agencies more aware of the fraud, waste and abuse activities going on in the state. The CMS review team suggest scheduling meetings and providing additional training to PCS providers on updated policies, rules and regulations, so that the agencies are more aware and informed about program integrity activities.

Medicaid and Personal Care Services Expenditure Information

The total Medicaid expenditures for Texas in FFY 2016 was approximately $40,329,673,422, with more than four million unduplicated beneficiaries enrolled. The total Medicaid expenditures for PCS in FFY 2016 were $3,327,678,259. The unduplicated number of beneficiaries who received PCS in FFY 2016 were 338,374. There were 3,231 PCS providers enrolled by HHSC in FFY 2016.

Table 1.

State Plan,1915(c) Waiver and 1115 Authority Service/Program	**FFY 2014**	**FFY 2015**	**FFY 2016**
State Plan PCS	$875.5 million	$970.1 million	$1.28 billion
1915(c) Waiver Authority	$286.5 million	$151 million	*$0
1115 Demonstration Services	$1.6 billion	$1.9 billion	$2.04 billion
Total Expenditures	$2.8 billion	$3.02 billion	$3.32 billion

*HHSC provided PCS through its approved 1915(c) waiver services until 2015; those services were then transitioned to FFS and /or managed care through the state's section 1115 demonstration authority.

Table 2.

	FFY 2014	**FFY 2015**	**FFY 2016**
Total PCS Expenditures	**$2.8 billion**	**$3.02 billion**	**$3.32 billion**
% Agency-Directed PCS Expenditures	96.0%	94.0%	96.0%
% Self-Directed PCS Expenditures	4.0%	6.0%	4.0%

A major portion of beneficiaries within the Texas Medicaid program utilize the agency-directed delivery model in order to access PCS services. While the self-directed program expenditures did increase in FFY 2015, they decreased to FFY 2014 levels in FFY 2016. The total PCS expenditures have increased each year of the review period.

Table 3.

***Agency Directed Duplicated Beneficiaries PCS Authorities**	**FFY 2014**	**FFY 2015**	**FFY 2016**
State Plan	140,475	150,698	164,966
1915(c) Waiver Authority	24,463	13,120	0
1115 Demonstration Authority	170,704	181,913	188,546
Total Agency-directed Beneficiaries	**335,642**	**345,731**	**353,512**

Table 4.

Self-Directed Beneficiaries PCS Authorities	**FFY 2014**	**FFY 2015**	**FFY 2016**
State Plan	1,826	3,061	644
1915(c) Waiver Authority	13,233	1,134	0
1115 Demonstration Authority	5,045	6,016	7,470
Total Self-directed Beneficiaries	**20,104**	**10,211**	**8,114**

*The figures in this table may contain approximately 23,000 duplicate beneficiaries due to the transition of those beneficiaries from the HHSC-approved 1915(c) waiver services that ended in 2015 to other programs resulting in dual reporting of those beneficiaries.

The majority of beneficiaries in the Medicaid program access PCS through the agency–directed delivery model. The PCS agencies are contracting with both the state in order to provide services via the FFS delivery system as well with MCEs in order to provide PCS as a benefit offered via the managed care plans.

State Oversight of Personal Care Services Program Integrity Activities and Expenditures

The HHSC is the single State agency designated to administer the Medicaid program under title XIX of the Social Security Act and provides PCS to the state's eligible Medicaid population. The HHSC is a large organizational structure with several components that all share

responsibility for program integrity functions and/or oversight. The entities include the Medical and Social Services Division (MSS), the Medicaid and CHIP Services (MCS) Department and the Department of Aging and Disability Services (DADS)[2]. The HHSC integrates program integrity throughout all layers of the organization. For example, the MSS has two Full Time Equivalents (FTE) that focus on policy and reporting for all contracts within the MSS division.

The HHSC-OIG has program integrity oversight over PCS expenditures and is involved in substantive policy changes. Policy changes are initiated by HHSC policy staff, but may also be impacted as the result of feedback received from HHSC leadership, state leadership, HHSC-OIG, or external stakeholders. Depending on the level and scope of the policy change, amendments to administrative rules, the State Plan, 1915(c) or 1115 waivers, and contracts may be required. The HHSC maintains processes and procedures for vetting and finalizing such amendments, which include legal review. Policy changes that require rule amendments are vetted through the Medical Care Advisory Committee, the HHSC Executive Council, and must be approved by the HHSC Executive Commissioner.

As a result of the Sunset review process[3], Texas endured a recent transition in HHSC to streamline and consolidate and reorganize over 100 programs and 24,100 staff positions over the course of two years. One of the concepts behind the transition at HHSC has allowed for the administration of PCS program integrity to be spread across HHSC as a whole. However, in practice, the state was unable to demonstrate to the CMS review team that they follow a formal process that ensures all identified instances of possible or suspected PCS fraud, waste and abuse are identified, documented, reported and evaluated for investigation. In light of the tremendous strides HHSC expressed has been made overall, the review team was particularly concerned that the agency-wide administration of PCS program integrity is not centralized enough, as well as not being as comprehensive or all-embracing throughout the entire agency as HHSC may have envisioned.

Since PCS program integrity is not comprehensively and concisely evident, it puts the Texas Medicaid PCS program at a higher risk for program integrity underperformance or a potential lack of oversight at a minimum. The review team recommends that HHSC look for additional ways at increasing and improving program integrity cohesiveness for its PCS program in such a large multi-layered organization. The state should consider developing detailed oversight responsibilities of each HHSC division responsible for oversight and administration of PCS program integrity activities.

Furthermore, based upon the information collected by the CMS review team, PCS program integrity appears to be a lesser programmatic program integrity priority at HHSC. The review team points to this position being highlighted during the state interview when HHSC informed the review team that the clinical unit was instructed to stop doing utilization reviews on PCS

[2] Effective September 1, 2017, all DADS functions were transferred to HHSC.

[3] The Sunset Review process looks at the effectiveness of state agencies in Texas. About 20-30 Texas agencies go through the Sunset process each legislative session, according to the Sunset Advisory Commission. The Sunset Advisory Commission began in 1977 as a way to look closely at the effectiveness of Texas state agencies and determine their utility and worth. The Commission's main function is to propose Sunset review recommendations to the Texas Legislature through a Sunset Bill.

providers. This came on the heels of the HHSC-OIG conducting general utilization reviews and finding general lack of documentation to justify the billed services. The identified overpayment for the services totaled $131,817.40 and were recovered from nine PCS providers. The state determined that guidelines available to the providers differed and the recoveries were refunded and no further reviews of this type were performed by this unit at HHSC-OIG. The state should look into the guidelines available to the providers and make sure they have consistent and effective guidelines in place to keep this situation from reoccurring.

The state should also consider developing detailed oversight responsibilities of each HHSC agency, division or unit responsible for oversight and administration of PCS. Since a robust program integrity program is essential to the Medicaid program, the state should have policies and procedures that specify which state division is responsible for all aspects of PCS monitoring, oversight and lines of communication between the divisions.

As a result, the review team found HHSC did not maintain the sufficient program integrity oversight to ensure that all identified instances of possible or potential suspected PCS fraud, waste and abuse are documented and evaluated for investigation throughout the PCS program. The review team concluded that this lack of oversight is relative and highlighted by the lack of PCS referrals from the agencies and the MCEs that were interviewed. This has been a long historical problem for HHSC, when the 2015 review team also found managed care referrals to be lacking from the MCEs. The HHSC submitted a Corrective Action Plan (CAP) that indicated report mechanisms were created and working better; however, this is not demonstrated by the low amount of PCS program integrity referrals from both the PCS agencies as well as the MCEs, for a widely-known high risk provider type.[4] The CMS review team recommends HHSC consider bringing all program integrity staff together to review and revise oversight efforts, as well as consider strategies to add more focus on MCE oversight, or enhance collaboration with MCEs due to larger shifts of beneficiaries into MCEs.
The 2018 CMS review team found that referrals of suspected PCS fraud cases were low and essentially non-existent in most cases with the PCS agencies, as well as with the MCEs who were interviewed during this present review period.

The 2018 review team also found there was a lack of payment suspensions as stipulated at 42 C.F.R. § 455.23. The HHSC was not utilizing this payment suspension regulation as a tool to combat fraud, waste and abuse in the Medicaid PCS program. The HHSC mentioned that payment suspensions occur based on directive of the Sanction Action Review Committee (SARC) committee, but it is beneficiary-service driven and not driven by credible allegation of fraud determinations by the HHSC-OIG. The HHSC provided the review team with language from its state statutes, which they perceive limits their ability to apply payment suspensions that will only be overturned at a case hearing. The review team recommends HHSC examine and explore solutions aimed at resolving any conflicts between 42 C.F.R. § 455.23 and its state statutes and regulations.

[4] 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

The review team found the PCS agencies and MCEs interviewed were not reporting identified and recovered overpayments, and the state mentioned program-wide inconsistencies in the reporting of overpayments. The HHSC did not have a sufficient and consistent format for the PCA agencies and MCEs to report overpayments, and HHSC's overpayment processes in place related to recoupments and overpayments differed across programs. During one of the interviews, Amerigroup mentioned that HHSC had already recognized this overpayment concern as a weakness. The MCE stated the MCEs and PCS agencies report all overpayments identified and recovered and mentioned that a state template is being finalized. This statement has subsequently been retracted by the MCE and it appears the MCEs and PCS agencies may be relying on the open case list as a means of reporting overpayments to HHSC. It is unclear to the review team whether anyone is accurately reporting overpayments to the state, and then on to CMS. Therefore, the review team recommends HHSC ensure there is clear contract language in regards to the MCEs and PCS agencies reporting requirements for identified and recovered overpayments. This language could ensure that the contracted entities are trained and educated on the proper reporting process, in addition to HHSC's development of a standardized overpayments reporting tool for the MCEs and PCS agencies to utilize.

In addition, the review team found risks may exist to the Medicaid program in the way PCS unlicensed provider terminations are handled. One agency stated, "An agency can terminate for fraud, report to the state, and the PCA could go work at another PCA agency." It appears that fraud, waste and abuse terminations may not be consistently reported on the employability registry. It was mentioned that there are no consequences for PCAs who are terminated for fraud, other than they won't be able to work at the agency they were terminated from. The fraud termination would only be uncovered if the PCA listed the agency they were terminated from on their reference check. If the PCA does not list the PCA agency on their reference check, then it would not be discovered by the hiring agency. This seems to be a flaw in the background checks for PCAs. The review team recommends HHSC review its oversight of all PCS program integrity termination procedures and take actions to ensure that PCS provider agencies do not employ individual PCAs who have been terminated by another Medicaid program or convicted of a health-care related criminal offense. For each of these reasons, HHSC should consider more frequent and more effective guidance and communication measures regarding program integrity activities within the PCS program overall.

Table 5.

Agency-Directed and Self-Directed Combined	**FFY 2014**	**FFY 2015**	**FFY 2016**
Identified Overpayments **	$2,191,697.74	$2,052,755.80	$1,117,279.70
Recovered Overpayments **	$2,191,697.74	$2,052,755.80	$1,117,279.70
Terminated Providers	2	2	5
Suspected Fraud Referrals	596	531	670
# of Fraud Referrals Made to MFCU	46	101	192

*All data is provided by HHSC in this table is limited to FFS only and not verified by CMS.
**Overpayments identified and recovered in FFY 2014, FFY 2015, and FFY 2016 were totaled for all PCS providers and include fraud, waste and abuse. In addition, the OIG reported $178,700 in overpayments identified and $122,014 in overpayments recovered.

Table 4 depicts a low number of terminated PCS providers in the Texas Medicaid program over the three-year review period for a total average of three PCS providers per year. Although the state averaged approximately 600 suspected PCS fraud referrals a year, the state issued two payment suspensions per year. On average, less than two out of every ten referrals or approximately 19% of the suspected fraud referrals are sent to the Medicaid Fraud Control Unit (MFCU). As discussed previously in the report, HHSC mentioned to the CMS review team that their Texas statute, Texas Government Code § 531.102 limits their ability to implement payment suspensions. The Texas statutory law appears to be at odds with the intent and goals behind the regulatory language found at 42 C.F.R. § 455.23 regarding payment suspensions and procedures for how HHSC should handle credible allegations of fraud within the Medicaid program. The CMS review team acknowledges the delicate nature in suspending payments to agencies may impact numerous individuals receiving services as well as those employed by the agency, but it does not necessarily justify a good cause exception for all cases. For this reason, each credible allegation of fraud case must be reviewed individually and in agreement with the guidelines outlined in HHSC's memorandum of understanding with the MFCU.

Section 2: Personal Care Services Provider Enrollment

Overview of Personal Care Services 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 of identifying and recovering overpayments. Provider screening enables states to identify these individuals before they are able to enroll and begin billing.

State Plan PCS providers must enroll as Medicaid providers. Although, there are no functional differences in enrollment for PCS providers, regardless of whether they provide services to clients in any waiver program (including the 1115 demonstration), there are different paths to enrollment (i.e. Texas Medicaid Healthcare Partnership or through HHSC-Long Term Care). The PCS providers must be enrolled in Texas Medicaid as a requirement to credential with any of the MCEs.

State Oversight of Personal Care Services Provider Enrollment

Beginning January 1, 2013, all Texas Medicaid providers are screened according to their level of risk. The Texas enrollment process complies with 42 C.F.R. Part 455 Subparts B and E[5]. The enrollment process complies with all state and federal database exclusion check requirements. The applicable federal database exclusion checks are completed for new-enrollment, re-enrollment, and revalidation applications as well as for existing-enrollment on a monthly basis.

The HHSC does not require fingerprinting for individual attendants as of this review period. However, fingerprinting is required for all high risk providers including owners and persons with

[5] The CMS focused PCS review does not include a complete review of HHSC's full Medicaid provider enrollment process in order to validate the accuracy of HHSC's responses regarding its compliance with 42 C.F.R. Part 455 Subparts B and E. Therefore, the inclusion of these comments does not indicate CMS's agreement with the comments.

controlling interest of five percent or more in newly enrolling and re-enrolling home health agencies. All attendants, including those employed by licensed or certified CFC providers and those employed by beneficiaries under the CDS option, are required to undergo screening for each of the following: (1) Nurse Aide Registry maintained by the SMA; (2) Employee Misconduct Registry maintained by the SMA; and (3) both the state and federal Office of Inspector General (OIG) Exclusions lists. This is a function of state licensure.

Upon the revocation of a licensed PCS provider's license, the HHSC may take administrative actions, including disenrollment, against the provider. Contract staff monitor a contractor's requirement for a written process for screening employees and contractors. It is documented on the PHC/Family Care/CAS monitoring tool.

Section 3: Personal Care Services Providers

Overview of the State's Personal Care Service Providers

Providers of PCS deliver non-medical services to Medicaid-eligible beneficiaries in their own home or communities who would otherwise require institutionalization. During FFY 2018, approximately 2,396 providers contracted directly with the state. In addition, PCS providers may be a part of a managed care network and contract directly with one or more of the 22 managed care entities operating in the Texas. As part of the onsite review, the CMS review team interviewed two MCEs and three provider agencies. The MCEs interviewed were Amerigroup Texas (Amerigroup) and Superior Health Plan (Superior). The provider agencies were Helping Restore Ability, New Hope Health Care, Inc. (New Hope) and Meals on Wheels Central Texas (MOWCTX) In-Home Care.

Oversight of Personal Care Services Providers[6]

Amerigroup Texas

Amerigroup is a managed care plan that has been operational as a Texas Medicaid plan since 1996. Amerigroup participates in the STAR, STAR Kids, and STAR+PLUS Medicaid programs. Amerigroup is a subsidiary of Anthem, Inc. In FFY 2016, Amerigroup provided or arranged agency-directed PCS providers for 38,668 Texas Medicaid beneficiaries. Amerigroup provided or arranged consumer-directed PCS providers for 3,167 beneficiaries, an increase of 66% for the 2,100 beneficiaries in FFY 2014.

Amerigroup's PCS expenditures for FFYs 2014-2016 totaled $309,219,670.82, $354,952,221.23 and $339,786,807.55 respectively. Amerigroup had a substantial increase in PCS expenditures from FFY 2014 to FFY 2015, which coincided with a significant increase in beneficiaries that received agency-directed PCS. Amerigroup's agency-directed PCS population had a slight increase from FFY 2015 to FFY 2016; however, their PCS expenditures dropped significantly from FFY 2015 levels.

[6] Interviews were conducted with the named entity and do not indicate HHSC's agreement with the comments by their contracted entities.

Amerigroup has a program integrity division that consists of several units. The Special Investigations Unit (SIU), Claims Payment Integrity Unit, and the Reimbursement Policy Management Unit monitor PCS services. The SIU conducts investigations of known or suspected fraudulent or abusive activities by providers, members, or associates. An MCE is required by 1 TAC § 353.502 to establish and maintain a SIU to investigate allegations of fraud, waste and abuse for all services in the MCE plan. The local Amerigroup SIU, dedicated to Texas, consists of six FTE investigators, and an investigative manager who dedicates approximately 25% of his responsibilities to overseeing fraud, waste and abuse operations in the Texas Medicaid program.

A review of the HHSC Uniform Managed Care Contract found that Amerigroup has a process implemented to perform all required database exclusion checks for PCS agency providers. Although the contract did not list a requirement for MCEs to have a method of verifying whether services are rendered, Amerigroup has a method for verifying member services and follows 42 C.F.R. §§ 455.20 and 433.116(e) for guidance on verifying services. Amerigroup reports overpayments using their own reporting template. The HHSC has not provided the MCEs with reporting guidance or a template to accurately record and report overpayments. Therefore, it is unclear to the CMS review team if Amerigroup accurately records and reports overpayments to HHSC.

The number of investigations referred to HHSC-OIG totaled one in FFY 2014, one in FFY 2015 and zero in FFY 2016. The SIU conducted nine full PCS investigations and two preliminary investigations in the review period. The PCS investigations included suspected beneficiary fraud, PCA fraud, and PCA agency fraud. The SIU identified $19,880.94 of potential PCS related overpayments during the review period. The SIU recovered an overpayment of $2,322.20 in FFY 2016, which was the end result of a full investigation of a PCS agency. The Amerigroup SIU submitted two credible allegations of fraud referrals to HHSC-OIG during the review period related to provision of PCS services by an attendant through a PCS provider agency.

The referrals included one case of suspected beneficiary fraud, and one case of suspected PCA fraud. The beneficiary fraud referral involved a beneficiary who signed timesheets validating PCS services were rendered by her son, who was her assigned PCA. The beneficiary signed and validated time sheets for several months during a time that included the relevant PCA being incarcerated.

According to Amerigroup, they refer cases of suspected fraud, waste and abuse in line with HHSC guidelines and policy; however, based on the lack of SIU cases generated and investigated, the CMS review team concluded that Amerigroup does not appear to make it a priority to refer PCA agencies to HHSC-OIG for further investigation. Amerigroup claims their Program Integrity Unit analyzes data upstream from the referral process to catch aberrant practices before limited Medicaid resources are impacted, which would in turn affect the resources available to Medicaid beneficiaries.

According to Amerigroup's Antifraud Addendum, the HHSC Uniform Contract, Section 8.1.19, Fraud & Abuse; 42 C.F.R. § 455.23 requires the State Medicaid agency to suspend all Medicaid

payments to a provider after the agency determines there is a credible allegation of fraud; unless the agency has good cause to not suspend payments or suspend payment only in part. Amerigroup informed the CMS review team that no payment suspensions were imposed due to a credible allegation of fraud during the review period. Therefore, HHSC is unable to make demonstrate contractor compliance with the requirements outlined in 42 C.F.R. § 455.23. Although documents provided by Amerigroup illustrate they routinely conducted full case investigations, it appears that at least on occasion Amerigroup refrains from referring case investigations to HHSC. The review team encourages HHSC to examine the nature of case referrals being held back, instead of submitted as case referrals. Amerigroup claims that when case investigations are referred they are done in accordance with HHSC guidelines and policy. Amerigroup added that they identify and recover overpayments from investigations that exhibited credible allegations of fraud.

Amerigroup's overpayments and recoveries from program integrity activities were as follows: Total identified overpayments were $9,453.85 in FFY 2014, $42,142.88 in FFY 2015, and $19,533.27 in FFY 2016, while total recovered overpayments were zero dollars in FFY 2014, $41,894.56 in FFY 2015 and $53,571.26 in FFY 2016. Amerigroup advised CMS that overpayments recovered from providers as a result of MCE fraud and abuse investigations or audits are reported as required under guidelines set by HHSC-OIG.

Overpayment recoveries are negotiated with the provider, the provider could be placed on pre-payment review, and/or the investigation may be referred to state and law enforcement entities if appropriate. The overwhelming majority of PCS overpayments recovered were the result of quality reviews conducted of agency-directed PCA agencies by clinical review and audit units within Amerigroup's program integrity division. Amerigroup's PCS clinical and audit reviews did not begin until FFY 2015, which accounts for the large increase in Amerigroup's PCS identified and recovered overpayments from FFY 2014 to FFY 2015.

Amerigroup's Antifraud addendum states that providers are presented with the SIU audit findings along with a CAP to sign at the conclusion of each investigation, acknowledging the investigation results. A lack of investigations of providers being referred to HHSC-OIG may be due to Amerigroup's aforementioned policy, which may not be in compliance with 42 C.F.R. § 455.23.

Amerigroup relies on its review of PCS agency-directed quality reviews in order to identify any programmatic, fiscal, or audit findings for consumer directed personal care services. In addition, Amerigroup had only one terminated PCS provider, which was due to a state-issued sanction.

The CMS review team concludes the consumer directed PCS program could benefit from more oversight due to the steady increase of beneficiaries accessing the consumer directed PCS during the review period. While onsite, PCS agencies speculated to CMS that the growing popularity of the consumer directed PCS program is due to the lack of an EVV requirement, which could pose a vulnerability for the Texas Medicaid program. The CMS review team also concludes the low referral environment is directly related to the lack of proper oversight and direction by HHSC in making PCS program integrity a greater priority and that Amerigroup's program integrity can be improved if the state adheres to the recommendations of this report.

Superior Health Plan

Superior Health Plan (Superior) began in El Paso, TX in 1999. Superior is a subsidiary of Centene Corporation. Today, Superior serves members in all 254 counties across the state. Superior works with the HHSC to provide Medicaid services for STAR (Medicaid), Children's Health Insurance Program (CHIP), CHIP Perinatal Care and STAR+PLUS and STAR Health. Superior has been the exclusive provider of STAR Health since 2008.

Superior's PCS total expenditures during the FFY periods of 2014-2016 were $1,806,826,594 which includes $44,978,851 in CDS. Superior's expenditures for PCS were $560,617,218 in 2014, $620,731,799 in 2015, and $625,477,577 in 2016. Superior's expenditures for self-directed PCS were $11,259,220 in 2014, $15,005,475 in 2015, and $18,714,156 in 2016. Superior served 158,043 PCS beneficiaries during the review period, including 49,084 beneficiaries in 2014, 55,545 beneficiaries in 2015 and 53,414 beneficiaries in 2016. Of these beneficiaries, 3,592 receive Medicaid services via the self-directed program, including 879 beneficiaries in 2014, 1,099 in 2015, and 1,614 and 2016. This annual growth is representative of the information presented to the review team by all interviewed entities. The interviewed MCEs mentioned to the CMS review team that they were seeing an increase of beneficiaries transitioning to the self-directed program. The percentage of increase was much higher for those beneficiaries in the self-directed program than those in the agency-directed. The HHSC did inform the review team that the growth by some MCEs is not reflective of the total aggregate for the PCS self-directed program administered by HHSC.

Superior has a claims payment system that reviews each provider claim submitted. Claims not meeting payment criteria are denied/suspended. Superior's claims system compares authorized units to billed units and will only reimburse to the units authorized. During the review period, Superior's volume of denied claims totaled 308,786. Some of the reasons for the denial throughout the review period included the following: service has exceeded the authorized limit, duplicate service, no authorization on file that matches service(s) billed, service and provider taxonomy code do not match, the time limit for filing a claim has expired, and some or all services dates could not be validated by the EVV vendor. In FFY 2016, 61,543 claims were denied because they could not be validated to EVV records

Superior reported that investigations have resulted in recovery of overpayments and one self-termination over the FFY 2014-2016 review periods. Superior reported having conducted a total of 71 investigations during the review period with 10 investigations performed in 2014, 13 investigations in 2015, and 48 investigations in 2016. In addition, Superior reported having identified $14,574,355 in total overpayments, while collecting $945,402 during the review period. Nearly all of the overpayments, over 99 percent, were identified and recovered in 2016. Over the review period, Superior made only one referral to the MFCU.

The CMS review team found that Superior has a low recovery percentage of identified overpayments for the three-year-review period. Superior realized only a 6.5 percent recovery rate on identified overpayments. Of the 71 investigations, only 15 resulted in an identified overpayment and only four of those resulted in a recovery. It should be noted, that one investigation represented the majority of both the identified overpayment amount and recovery

amount. If this is removed, the recovery rate actually falls to 2.4 percent. Furthermore, of the 71 investigations conducted, only one was referred to the MFCU.

The CMS team reviewed documentation submitted by Superior and interviewed its staff as a part of the review. The team found that it does not appear that program integrity priority meets the level of current risk within the PCS program. When the above conditions were discussed with Superior, they stated that they had not increased their program integrity activity to address the possibility of errors existing throughout the program. It is paramount for a program integrity unit to dedicate appropriate levels of resources and activities to address risks.

As depicted earlier, in the initial year of EVV utilization, 61,543 claims were denied because they could not be validated to EVV records. Superior explained that this was partly due to the implementation year and learning curve for the PCS attendants. Superior did state that such a high number was concerning but had not increased program integrity activities to ensure PCS services are being rendered and billed correctly. In discussing the SIU's review of a PCS agency case file with Superior, they acknowledged the error rate was egregious, but they had not increased program integrity activities to ensure PCS services are being rendered and billed correctly. In addition, Superior stated they did not monitor FMS to ensure services are being rendered and billed correctly. For these reasons, CMS team recommends that HHSC instruct the MCEs and PCS agencies to increase PCS program integrity activities to ensure PCS services are being rendered and billed correctly.

Superior reported that they do perform all required federal database exclusion checks. Superior reported that the name and/or NPI of the PCS is verified against applicable federal databases at the point of initial credentialing, monthly thereafter, and at the point of re-credentialing. In addition, Superior ensures there are no malpractice claims, applicable licensure is current, and that a PCS agency is appropriately certified.

The CMS team found that Texas PCAs when terminated for fraud from one agency were not consistently being placed on the employability registry. This results in PCAs being able to find employment with another agency. The CMS review team found that Superior terminated four PCAs and three of the four found work at other PCS agencies.

In addition, the interviewed MCEs and agencies voiced some concerns that OIG provides minimal program integrity information on reported PCS fraud. Therefore, the CMS review team recommends that HHSC schedule informative meetings and provide additional training to PCS providers on updated policies, rules and regulations, so they are more aware and informed on program integrity activities.

Provider Oversight of Personal Care Services

Helping Restore Ability

Restore Ability is a nonprofit corporation that has been providing PCS since 2009. Helping Restore Ability's Medicaid expenditures during the review period were $13,079,006 in 2014, $13,455,384 in 2015

and $16,267,512 in 2016. The number of Medicaid beneficiaries totaled 798 in 2014, 753 in 2015 and 933 in 2016. Helping Restore Ability reported Medicaid overpayments of $29,937 in 2014, $17,834 in 2015, and $42,039 in 2016. The agency employed 1684 PCA staff in 2014, 1769 in 2015, and 1984 in 2016. In addition, they employed nine supervisory staff in 2014 and 2015 and eight in 2016.

The CMS team reviewed documentation submitted by the agency and interviewed agency staff as a part of the review. The team found that Helping Restore Ability was checking the LEIE upon enrollment and reenrollment; however, the agency was not checking the System for Award Management (SAM) database. Since the state contractually places the requirement on owners of PCS agencies to ensure that agency attendants are not excluded from Medicaid, the agency is consequently leaving itself exposed by not checking the SAM database at enrollment, reenrollment and on a monthly basis. The HHSC should ensure that all contracted PCS agencies are conducting the required SAM database exclusion checks to meet the full requirements outlined in 42 C.F.R. § 455.436.

Furthermore, Helping Restore Ability mentioned in order to avoid the state's EVV, a great number of beneficiaries transitioned to CDS, which does not require stringent checks and balances. Helping Restore Ability also was unable to report identified overpayments and appeared not to have a clear understanding of what an overpayment was, or how an overpayment should be recorded. This is an example of where the state's development of a standardized overpayments reporting template will be of value to the program.

New Hope Health Care, Inc.

New Hope is a home care agency that has provided PCS services since September 12, 1988. New Hope's Medicaid expenditures during the FFYs reviewed were $1,222,339 in 2014, $1,143,446 in 2015 and $871,612 in 2016 for a total of $3,237,397. The number of Medicaid beneficiaries during the FFYs reviewed were 141 in 2014, 149 in 2015, and 123 in 2016 for a total of 413 beneficiaries. New Hope reported zero overpayments in each of the FFYs reviewed. The agency employed 321 PCA staff in 2014, 345 in 2015, and 305 in 2016. In addition, they employed 4 supervisory staff in each of those years.

New Hope does not have a formal compliance officer, or a corporate compliance plan. New Hope's policy and procedure manual is based on the standards for personal assistance services in the TAC, and are enforced by office staff. New Hope does not have a formal compliance committee. Two formal staff meetings are held each year to address quality assurance and process improvements. However, quality assurance and process improvements are also evaluated informally on an ongoing basis. New Hope routinely performs internal audits of client and personnel files.

The New Hope administrator fulfills the job responsibilities of a compliance officer and is responsible for ensuring all employees comply with agency policies. The administrator is also responsible for addressing any compliance issues of concern that may occur and reporting incidents of fraud, waste and abuse to the appropriate entities as necessary.

New Hope indicated that they had no overpayments during the review period. Although CDS membership is growing for most of the PCS agencies interviewed, New Hope does not participate in the CDS program because it does not mandate EVV for PCAs, which New Hope perceives as a vulnerability. New Hope further indicated that they have not referred any potential fraud referrals to HHSC. New Hope was unable to provide the CMS review team with a clear reporting policy for reporting potential fraud. It does not appear that New Hope has satisfactory controls in place to report fraud and abuse, which poses a vulnerability to the fiscal integrity of the Medicaid program.

Meals on Wheels Central Texas (MOWCTX) In-Home Care

In October 2017, Helping the Aging, Needy and Disabled (H.A.N.D) was acquired by and officially changed its assumed name to Meals on Wheels Central Texas (MOWCTX) In-Home Care. The agency's total expenditures were $1,102,287 in FFY 2014, $1,124,279 in FFY 2015, and $877,802 in FFY 2016. In FFY 2016, the agency served approximately 351 Medicaid beneficiaries and employs approximately 190 PCAs and 12 administrative support staff, to include four part-time staff members.

MOWCTX In-Home Care agency is committed to an effective corporate Compliance Program that reviews the organization's business activities and consequent legal compliance, risks and education of its employees regarding the Code of Conduct and Business Ethics. They accomplish this by implementing auditing, monitoring, and reporting functions to measure the effectiveness of the Compliance Program and addresses areas of concern as needed. They conduct annual and ad-hoc beneficiary visits are conducted and discussions are held to ensure compliance with all applicable rules, regulations, policies and procedures. Case managers and supervisors re-access the beneficiary's needs and upon assessment and receipt of doctor orders, supervisors are required to update the service plans as needed, but not all beneficiaries receive doctor's orders. All PCAs are credentialed in accordance with the regulatory mandate contained in 1 TAC § 363.603.

The agency contracts with Providers Trust to perform exclusions testing and the agency's own Human Resources' personnel conduct background checks of all its current and newly hired employees using state and national databases for reference. Employment is contingent upon successful completion of the background investigation process. All applicants are screened and interviewed. All applicants offered employment, in addition to any individuals entering contracting, are screened and checked in accordance with state and federal regulations.

The agency also acknowledged having a single improper payment of $41.85 (Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA), Public Law 112-248) in FFY15 and three improper payments totaling approximately $652.94 in FFY 2016, all of which were refunded. In addition, the agency mentioned that no information prior to the acquisition in May 2016 was available to the review team. Therefore, they could not confirm or verify the number of terminations associated with fraud, waste and abuse during the review period.

Section 4: Electronic Visit Verification (EVV)

Overview of the State's EVV System

An EVV system is a telephonic and computer-based system that electronically verifies service visits occur and documents the precise time service begins and ends. Specifically, EVV documents the precise time and type of care provided by caregivers at the point of care. Some of the benefits of utilizing an EVV system include ensuring service visits occur and monitoring costs expenditures.

The HHSC mandates that certain home and community-based services implement and utilize EVV to verify PCS services. The HHSC requires PCS agencies to choose an EVV vendor that has been authorized by HHSC. The HHSC EVV started in February 2015. However, EVV has been in place in Texas since December 2010, which includes the EVV pilot with the DADS. The HHSC uses a standards-based system with two EVV vendors. Reportable outcomes are not applicable as there are no specific performance measures related to the program.

The HHSC implemented EVV to verify that authorized service visits occurred for which the state is being billed and conveyed to the review team that the system is working well. Time is logged using an HHSC-approved EVV system and an individual/member home landline telephone, or a small alternative device. When an attendant provides services to an individual/member in the home or the community, the attendant must use the HHSC-approved EVV system and the individual/member home landline telephone; or an HHSC-approved small alternative device.

Provider agencies required to use EVV must maintain a minimum compliance score for EVV. Providers that fail to meet the minimum requirement are not in compliance with EVV guidelines. Providers may be assessed liquidated damages, be required to submit a CAP, or may be subject to contract termination.

Amerigroup, for example, also monitors agency-directed PCS services through EVV. The PCS provider agencies are required to maintain a 90% or higher compliance score for EVV. Providers must submit a CAP after the second quarter of non-compliance. After the third quarter of non-compliance, the provider is subject to termination. All claims that require EVV, and do not have an EVV transaction match, are subject to overpayment recovery. Amerigroup did not record any overpayment recoveries, or initiate CAPs to PCS agencies during the review period for lack of EVV compliance.

In addition, New Hope selected VESTA Datalogic (VESTA) for their EVV vendor. The VESTA can integrate with a beneficiary's home telephone landline, or through a small alternative device that is installed in the beneficiary's home. For beneficiaries with a working home telephone landline, the attendant can "clock in" and "clock out" using the beneficiary's landline phone by entering their employee identification. If no landline is available, a small alternative device is installed in the beneficiary's home. A generated code which registers the "clock in" and "clock out" times can be called in on a cell phone from the beneficiary's home. Attendants are trained to use this process during the hiring process, and receive periodic coaching and additional training if necessary.

The attendant's arrival time and end of service time are recorded by the VESTA software in real time. Prior authorized service amounts are recorded in VESTA, compared, and reconciled against service amounts billed for reimbursement. Excess hours submitted for reimbursement that are more than the prior authorized service amount are not eligible for reimbursement. New Hope analyzes service data within the database, and may initiate calls to attendants and members to verify accuracy of services billed to maintain the 90% compliance rate required by HHSC and the Managed Care Organizations.

There are no reportable outcomes to date as the HHSC reported that no comprehensive analysis of the impact of EVV on expenditures has been completed. Additionally, at least one of the agencies made reference that a number of beneficiaries transitioned to CDS to avoid EVV, which does not require the same level of checks and balances and thereby increasing the potential of inappropriate behavior occurring within the Medicaid PCS program. Consequently, the CMS review team found that the program integrity oversight can be improved in order to complement the EVV system. Therefore, the review team recommends HHSC encourage PCS agencies to conduct unannounced visits to ensure accurate billing by PCAs, and services are rendered as per federal and state guidelines, at a minimum in the CDS program where there is no mandated EVV. Ultimately, HHSC should implement EVV across all FFS and managed care PCS programs and improve program integrity oversight by adhering to the recommendations of this report.

Recommendations for Improvement

- The HHSC should look for additional ways at increasing and improving program integrity cohesiveness for its PCS program. In addition, HHSC should correct its policy discrepancy and consider developing detailed oversight responsibilities of each HHSC agency and division or unit responsible for oversight and administration of PCS program integrity activities. This may include, but is not limited to, policies and procedures that specify which state division is responsible for all aspects of PCS monitoring, oversight and lines of communication between the divisions.
- Consider bringing all program integrity staff together to review and revise oversight efforts, as well as consider strategies to add more focus on MCE oversight, or enhance collaboration with MCEs due to larger shifts of beneficiaries into MCEs.
- Examine and explore solutions aimed at resolving any conflicts between 42 C.F.R. § 455.23 and its state statutes and regulations.
- Ensure all PCS agencies and MCEs report their overpayments as well as ensuring the entities know about their contractual requirement to report overpayments made to Medicaid providers within the PCS program.
- Enhance HHSC's oversight functions by reviewing its program integrity termination procedures and taking the appropriate oversight actions to ensure that PCS provider agencies do not employ individual PCAs who have been terminated by another Medicaid program or convicted of a health-care related criminal offense.
- Review and modify program integrity contract requirements to ensure that the MCEs and PCS agencies verify PCS with beneficiaries in accordance with 42 C.F.R. § 455.20.
- Instruct the MCEs and PCS agencies to increase PCS program integrity activities to ensure PCS services are being rendered and billed correctly.
- Schedule informative meetings and provide additional training to PCS providers on updated policies rules and regulations so they are more aware and informed on program integrity activities.
- Ensure that all contracted PCS agencies are conducting the required SAM database exclusion checks, formerly the Exclude Parties List System (EPLS) as outlined by 42 C.F.R. § 455.436.
- Promote accurate billing and rendering of services in accordance federal and state guidelines by encouraging PCS agencies to conduct unannounced visits, at minimum in the CDS program where there is no mandated EVV. In addition, ensure that EVV is implemented across all FFS and managed care PCS programs.

Section 5: Status of Corrective Action Plan from 2015 Review

Texas' last CMS program integrity review was in 2015, and the report for this review was issued in 2016. The report contained several risks to the program. During the onsite review in 2015, the CMS review team conducted a thorough review of the corrective actions taken by Texas to address all issues reported in calendar year 2015. The findings of this review are described below.

Risks –

1. ***The state should amend the MCE contract to included comprehensive fraud, waste, and abuse FWA language that fully addresses all program integrity regulatory requirements for payment suspensions, and the performance of database checks.***

   Status at time of review: Uncorrected

   The HHSC will amend the MCE contracts to include language that addresses requirements for payment suspensions and the performance of database checks.

2. ***Develop and implement policies and procedures to facilitate stronger program integrity oversight of MCE program integrity activities. The policies and procedures should also address measures necessary to increase oversight for MCEs identified as not expending sufficient effort towards identifying and recovering overpayments to providers.***

   Status at time of review: Corrected

   The work with OIG focuses on fraud, waste and abuse activities. The HHSC worked with Medicaid/CHIP subject matter experts (SMEs) to clarify contract language, as well as created an operational manual to identify fraud, waste, and abuse. The audits of the SIUs found that compliance plans were not being followed and HHSC assessed and collected liquidated damages from MCEs for not complying with contract.

3. ***The state should ensure that the MCEs establish and maintain an SIU that meets contractual requirements. Along with the efforts of third party contractors, the SIUs should assist in the identification of potential fraud, waste, and abuse to increase MCE recoveries of overpayments to providers.***

   Status at time of review: Corrected

   MCEs must have an SIU that meets contractual requirements. See item #2 above.

4. ***Improve communication between the Managed Care Division within HHSC and the HHSC-OIG through attendance and participation at regularly scheduled meetings that facilitate the active sharing of program integrity information with regard to providers/provider types at risk for fraud, complaints against network providers, and investigation coordination.***

   Status at time of review: Corrected

   The OIG has leadership meeting with MCEs, SIU Quarterly Meetings started in 2012 and quarterly Texas Fraud Prevention meetings are a few of the regular meetings.

5. ***A process for monitoring the MCEs' compliance plans should be implemented to ensure that each MCE is actually adhering to their compliance plan.***

   Status at the time of review: Corrected

Implemented annual monitoring process that looks at the MCEs' compliance plans.

6. ***The state should obtain evidence from its MCEs in support of any statements attributing a decline in overpayments as the direct result of cost avoidance activities or proactive measures in place.***

   Status at time of the review: Corrected

   The state reviewed MCEs cost avoidance activities and a report was submitted to the legislature on 03/01/18. HHSC is looking at working through the challenges of developing standardized methodology. The state continues to work with MCEs on cost avoidance measures. See Item #7 below.

7. ***The state should create a better reporting process between the MCEs and the state, so that case referrals are clearly defined and result in a more consistent accounting of suspected fraud case referrals leading to both parties reflecting identical totals.***

   Status at the time of the review: Corrected

   The HHSC has been working with MCEs and created a reporting process that appears to be working better.

8. ***The state should not rely on disenrollment as the primary method to remove providers terminated from the MCE networks.***

   Status at the time of the review: Corrected

   The HHSC is following the compendium.

9. ***The state must enter terminated providers into the TIBCO system, upon receiving their information from the MCEs.***

   Status at the time of the review: Corrected

   The HHSC is entering terminated providers into the TIBCO system.

10. ***The state should confirm that all MCE delegates are searching the LEIE, EPLS, SSA-DMF, and National Plan & Provider Enumeration System upon contract execution, and check the LEIE and EPLS monthly thereafter for the names of any person with an ownership or control interest or who is an agent or managing employee.***

    Status at the time of the review: Corrected

    The HHSC checks for this during its annual monitoring audits.

11. ***The state should develop written policies and procedures for the MTP to address program activities, related activities, and functions such as suspending provider payments, and terminating NEMT providers from the program.***

    Status at the time of the review: Uncorrected

    The HHSC is working on developing and implementing policies and procedures for MTP program activities. The HHSC will update to include necessary language by September 2018.

12. ***The state should develop and implement a process to address NEMT enrollment, NEMT provider screening, and oversight.***

    Status at the time of the review: Uncorrected

    The HHSC is working on developing and implementing a process for NEMT enrollment, provider screening, and oversight.

13. ***Not reporting to HHS-OIG adverse actions taken on managed care provider applications.***

    Status at the time of the review: Corrected

    The HHSC will not allow MCEs to directly report adverse actions to HHS-OIG. MCEs will report to HHSC-OIG who will then determine if it is a reportable action.

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's 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 Texas' efforts and encourages it to look for additional opportunities to improve overall program integrity. The CMS focused review identifies 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 taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

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