Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Arkansas Personal Care Services (PCS)

Focused Program Integrity Review

Final Report

December 2018

Table of Contents

Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of the Arkansas 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 and technical assistance resources that maybe used to advance the 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 CFR 440.167, PCS is a Medicaid benefit furnished to eligible beneficiaries according to an approved Medicaid state plan, waiver, or section 1115 demonstration. States administer their Medicaid programs within broad federal rules and according to requirements of the specific authority approved by CMS. Services must be approved by a physician, or some other authority recognized by the state. Personal care beneficiaries cannot be inpatients or residents of a hospital, nursing facility, intermediate care facility for the developmentally disabled or institution for mental disease. Services can only be rendered by qualified individuals, as designated by each state.

Methodology of the Review

In advance of the onsite visit, CMS requested that Arkansas complete a review guide that will provide CMS's 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 these responses and materials in advance of the onsite visit.

During the week of March 26, 2018, the CMS review team visited the Arkansas Department of Human Services (DHS). The review team conducted interviews with numerous state staff involved in program integrity and administration of PCS. In addition, CMS's 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

CMS's review team identified areas of concern within 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

In Arkansas, the DHS provides Medicaid PCS to eligible beneficiaries under the state's approved state plan, as well as through approved waiver services. Medicaid PCS is delivered to Medicaid beneficiaries under the fee-for-service (FFS) model. The DHS offers a self-directed PCS option, which promotes personal choice and control over the delivery of services to Medicaid beneficiaries.

Arkansas maintains a collaborative and coordinated effort between the state agencies, DHS and the Office of Medicaid Inspector General (OMIG) and also between the entities that have administrative responsibilities over the State Plan services and waivers.

The DHS is the single state Medicaid agency designated to administer the Medicaid program under Title XIX of the Social Security Act. Thus, DHS is responsible for administrating PCS to the state's eligible Medicaid population. The DHS has a large organizational structure with a substantial number of divisions that all play a role in its program integrity program.

The DHS integrates program integrity throughout all layers of the organization. The mission of the OMIG is to prevent, detect, and investigate fraud, waste, and abuse within the medical assistance program. This mission is achieved through auditing Medicaid providers and medical assistance program functions; recovering improperly expended funds; referring appropriate cases for criminal prosecution; and, working closely with providers and the medical assistance program to prevent fraud, waste, and abuse. The OMIG fulfills the federal program integrity requirement by ensuring compliance, efficiency, and accountability within the Medicaid program. Pursuant to Arkansas Code §20-77-2501, OMIG shall: (1) Prevent, detect, and investigate fraud and abuse within the medical assistance program; (2) Refer appropriate cases for criminal prosecution; (3) Recover improperly expended medical assistance funds; (4) Audit medical assistance program functions; and (5) Establish a medical assistance program for fraud and abuse prevention.

Arkansas' Medicaid home care service programs utilize a workforce of home health aides (HHAs) and PCAs who provide direct care services. All beneficiaries have access to HHAs and PCAs depending on their medical plan of care (POC).

The current programs authorized by Title XIX of the Social Security Act pursuant to which Arkansas provides PCS are outlined in Table l below. Most of the PCS in Arkansas are delivered under the self-directed model, also known as the consumer-directed model. The DHS currently contracts with 506 providers who deliver PCS.

Summary Information of the PCS State Plan Services and/or Waivers Reviewed

Table 1.

Program Name/ Year Implemented	State Plan or Waiver Type	Service or Program	Administered By
State Plan PCS - Independent Choice	State plan authority	Arkansas' State Medicaid Personal Care Program	Arkansas Department of Human Services' and (DHS) Division of Aging and Adult Services (DAAS)
HCBS Implemented 07/01/2009 Implemented 07/01/2009 Implemented 07/01/2010 Implemented 02/01/2016	Section 1915(c) Section 1915(c) Section 1915(c) Section 1915(c)	Waivers AR Choices in Homecare (ACHC)/ AR Alternative Community Services (AACS)/ AR Alternatives for Adults with Physical Disabilities (AAPD)/ AR Living Choices Assisted Living (ALCAL)/	Arkansas Department of Human Services' and (DHS) Division of Aging and Adult Services (DAAS)

The Arkansas Personal Care program administered by the DHS and Division of Aging and Adult Services (DAAS) operates under both a state plan authority, Independent Choices and Home and Community- Based Services (HCBS) 1915 (c) waivers AR Choices in Homecare, AR Alternative Community Services, AR Alternatives for Adults with Physical Disabilities, and AR Living Choices Assisted Living.

The state plan authority, Independent Choices, is a self-directed model in which beneficiaries can elect to allocate monthly allowable funds towards personal care. Under this model, caregivers are permitted to be family members other than a spouse or legal guardian.

Under the HCBS 1915 (c) waivers, AR Choices in Homecare, AR Alternative Community Services, AR Alternatives for Adults with Physical Disabilities, and AR Living Choices Assisted Living, beneficiaries receive a variety of services that allow the beneficiary the ability to remain in the home. These programs are designed to prevent nursing home admissions. Services may include, light housekeeping, dressing, defined as Activities of Daily Living.

The DHS PCS providers do not render any additional services other than those described in the definition used in the introduction of this section. The state has a 40 hour minimum requirement for training, regardless of qualifications, positions, or education levels. Additionally, there is a minimum requirement for 12 hours of continuing education that must be completed at least annually.

Medicaid and PCS Expenditure Information

Arkansas's total Medicaid expenditures in federal fiscal year (FFY) 2017, were approximately $5.9 billion and covered almost 1,195,344 beneficiaries. Arkansas's total Medicaid expenditures for PCS in FFY 2017 was approximately $66,313,386 million. The unduplicated number of beneficiaries who received PCS in FFY 2017 was 7,926. The number of PCS providers enrolled in FFY 2017 was 410 agency-directed and 96 self-directed personal care providers.

Table 2.

State Plan and 1915(c) Waiver Authority Service/Program	FFY 2015	FFY 2016	FFY 2017
State Plan – Independent Choice	$29,865,931.61	$34,415,298.66	$52,731,627.79
AR Choices in Homecare	$8,032,504.44	$13,156,935.42	$1,890,771.61
AR Alternative Community Services	$9,528,844.00	$10,398,332.09	$10,609,652.73
AR Alternatives for Adults with Physical Disabilities	$2,264,931.78	$1,639,489.40	$876,911.17
AR Living Choices Assisted Living	$845,008.34	$546,661.18	$204,422.43
Total Expenditures	$50,537,220.17	$60,156,716.75	$66,313,385.73

The state reported the rationale for increased expenditures in ARChoices is attributed to the following: 1) combining AAPD and ElderChoices (EC) into one HCBS waiver (ARChoices) and 2) Personal care, attendant care, and respite providers received rate increases from $4.19 to $4.50 per 15 minute unit. In addition, when personal care services rates are increased, self-directed services rates will increase as well by 57.8 percent. The ADC received rate increases from $1.92 to $2.50 per 15 minute unit. The ADHC received rate increases from $2.54 to $3.12 per 15 minute unit.

Table 3.

	FFY 2015	FFY 2016	FFY 2017
Total PCS Expenditures (all PCS)	$50,537,220.17	$60,156,716.75	$66,313,385.73
Percent Agency-Directed PCS Expenditures Provider type 32 (From table 2)	40.90%	42.80%	20.49%
Percent Self-Directed PCS Expenditures (From Table 2)	59.10%	57.20%	79.51%

The overall PCS expenditures from FFY 2015 to FFY 2017 increased. Specifically, a 19 percent increase occurred from FFY 2015 to FFY 2016 and a 10 percent increase from FFY 2016 and FFY 2017. Self –directed PCS expenditures accounted for a significant portion of the total expenditures for the review period when compared to agency-directed PCS.

Table 4A.

State Plan and 1915(c) Waiver Authority Service/Program	FFY 2015	FFY 2016	FFY 2017
AR Choices in Homecare	1,595	3,758	1,579
AR Alternative Community Services	1,249	1,264	1,295
AR Alternatives for Adults with Physical Disabilities	484	342	188
AR Living Choices Assisted Living	207	147	60
Total Agency-directed Unduplicated Beneficiaries	3,535	5,511	3,122

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

Table 4B.

State Plan and 1915(c) Waiver Authority Service/Program	FFY 2015	FFY 2016	FFY 2017
Independent Choice	3,549	4,080	4,804
Total Self-directed Unduplicated Beneficiaries	3,549	4,080	4,804

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

State Oversight of PCS Program Integrity Activities and Expenditures

The OMIG, DHS, and the Medicaid Fraud Control Unit (MFCU) have a signed Memorandum of Understanding, which establishes the responsibilities of each agency as it relates to the Arkansas Medicaid program integrity oversight for administering PCS and monitoring PCS expenditures. The state has a work plan that includes PCS providers and/or self-directed services, which corresponds with provider enrollment's assessments of risk.

From August 2016 through June 2017, OMIG audited and investigated numerous PCS and HCBS providers with emphasis towards identifying performing providers and reviewing service plans. The investigations and reviews resulted in recoupments, suspensions for fraud, referrals for prosecution, and additional requests for information. The initiative confirmed that changes

and reforms of PCS or HCBS would provide additional protection and safety to a vulnerable Medicaid population, as well as reduce fraud, and potentially save the Arkansas Medicaid program millions of dollars.

Beginning in August 2017, OMIG implemented an initiative to review and investigate various programs in Medicaid involving HCBS. Concerns for ongoing fraud and abuse in these programs stem from OMIG audits, complaints, and investigations. In the last two years, over 200 audits or reviews of PCS and/or HCBS were conducted resulting in nearly $800,000.00 in recoupments and 73 payment suspensions or fraud referrals for criminal investigation. The OMIG invited DHS leadership to discuss concerns of fraud, waste, and abuse in PCS and HCBS. The primary recommendation was for Arkansas Medicaid to reform PCS and HCBS to develop and require additional claims data to identify rendering or performing providers that provide hands-on services to Medicaid beneficiaries.

Table 5.

Agency-Directed and Self-Directed Combined	FFY 2015	FFY 2016	FFY 2017
Identified Overpayments	$619,619.95	$134,230.09	$372,156.16
Recovered Overpayments	$175,865.80	$184,186.20	$185,835.68
Terminated Providers	0	0	0
Suspected Fraud Referrals	4	18	51
# of Fraud Referrals Made to MFCU	15	42	39

Table 5 above identifies Arkansas's program integrity activities (related to fraud, waste and abuse) for both agency- directed and self-directed PCS. The data provided indicates the level of activity related to overpayments identified and recovered, terminated providers, suspected fraud referrals and MFCU referrals for FFY 2015, FFY 2016, and FFY 2017.

Section 2: Self-Directed / Participant-Directed Care Services

Overview of Self-Directed Care Services

In the self-directed service model, the individual or the legally authorized representative is the common-law employer of service providers and has decision-making authority and budget authority over the services he or she is directing. The employer assumes and retains responsibility to recruit, determine the competence of, hire, train, manage, and terminate their employees.

The purpose of the Fiscal/Employer Agent (F/EA) contractor is to ensure the provision of the Self-Directed Services Budget (SDSB) and Financial Management Services (FMS) statewide to Arkansas Medicaid beneficiaries eligible and authorized to direct their care. The FMS will be provided to those Medicaid beneficiaries choosing to participate in a SDSB program.

The F/EA contractor must prepare and maintain a work plan to meet the terms of the scope of service. The work plan shall be comprehensive and shall incorporate a Quality Management Plan (QMP). The QMP must describe how the data system supports Quality Assurance/Quality

Improvement (QA/QI) and monitoring activities, where applicable. The work plan must include a detailed description of all activities required to implement and maintain operations in a logical and timely manner, and with an efficient use of resources.

The F/EA contractor is responsible for hiring of staff, managing payroll and employer related duties, providing purchase approval of goods and services, and tracking and monitoring the individual budget expenditures.

State Oversight of Self-Directed Services

All PCS in the self-directed model are routinely monitored by the SDSB counseling contractor and DHS Independent Choices staff. The counseling contractor is responsible for the oversight of the employers and their caregivers by providing a number of contractually required announced and unannounced home visits to the beneficiaries. DHS staff monitor the contractor to ensure the required number of monitoring visits are completed per contract standards. DHS monitors the contractor's visits, billing, funding, and disbursement of Medicaid funds, as well as the enrollment process. This approach represents a combination of both programmatic and financial monitoring.

The services of the beneficiary's FMS are routinely reviewed by DHS staff who monitor the F/EA contractor through daily, weekly, and monthly reporting. This allows for DHS staff to correct any billing and/or funding discrepancies and ensure the F/EA is complying with the performance indicators and program deliverables outlined in the F/EA contract.

The hiring process is overseen by the F/EA contractor for the caregivers (employees) in the SDSB program and all information regarding the caregivers is provided to DHS after all required documentation, criminal background check (CBC), and excluded provider checks are completed. Caregivers also undergo a CBC every five years as required by Arkansas state regulations and guidelines.

There have been no program integrity efforts by DHS in the last three FFYs that have resulted in an audit and/or review finding related to self-directed PCS. However, OMIG has been very involved in investigating fraud within the self-directed PCS program and works closely with the fiscal intermediary and DHS Independent Choices staff to identify and investigate fraud within self-directed services. Over the course of the last three FFY's OMIG has referred thirty-seven individuals to MFCU for a credible allegation of fraud.

Arkansas does not currently issue Explanation of Medicaid Beneficiary Medical Benefits (EOMB) verifications with regard to PCS furnished by individual PCAs in self-directed programs.

Section 3: PCS Provider Enrollment

Overview of PCS Provider Enrollment

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

Beginning April 1, 2014, Arkansas implemented a new online enrollment process for enrolling new providers. This process also includes the new enrollment application fee requirements that have been mandated as part of the Affordable Care Act (ACA).

The state utilizes the enrollment contractor DXC to process and enroll Medicaid PCS provider applicants. There are a number of agencies, organizations, and other entities that may qualify for enrollment in the Arkansas Medicaid PCS program. Participation requirements vary among these different types of providers, however, the review team was able to review Sections 200.110 through 200.160 of the Arkansas PCS Provider Manual, which outlines the participation requirements specific to each type of PCS provider. Section 201.000 of the Provider Manual describes the procedures required to enroll in the Medicaid program. Sections 201.010 through 201.050 set forth the licensing, certification, and other requirements specific to each type of PCS provider.

It should be noted that all owners, principals, employees, and contract staff of a PCS provider must comply with criminal background checks according to Arkansas State Law at 20-33-213 and 20-38-101 *et seq*. When DXC enrolls any provider, they are screened by running their names and pertinent information through Lexis Nexis. Lexis Nexis checks all federally required screening data bases. If the results from the screening has negative findings the state makes a determination on whether the applicant can enroll. All provider types are screened during the hiring process and on a monthly basis thereafter.

Private care agencies must also ensure that there is on file with the Medicaid Provider Enrollment Unit (PEU) a copy of their current license from the Arkansas Department of Health. Additionally, private care agencies must ensure that there is on file with the PEU proof of liability insurance coverage of not less than one million dollars ($1,000,000.00) covering their employees and independent contractors while those individuals and entities are engaged in providing covered Medicaid services. This requirement is audited annually for compliance, as indicated in the Arkansas PCS Manual.

Individual PCA/PCS providers are not required to be licensed and are not easily identified by an individual state identifier. There are no additional compliance requirements specified, verified, or documented at this time. The CMS review team recommends that a statewide process be developed and implemented that will assign individual PCA/PCS providers a state identifier, as well as notify all PCS agencies of suspension or termination of providers through the development of a statewide database that captures this information.

State Oversight of PCS Provider Enrollment

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 and has implemented the federal database checks on any person with an ownership interest or who is an agent or managing employee of the provider as required. The state does check all parties against the federal List of Excluded Individuals and Entities and System for Award Management monthly after enrollment/reenrollment as required at 42 CFR 455.436(c)(2).

The state contracts with a firm that checks the excluded provider lists for all employees/caregivers being paid by Medicaid funds. In addition, the contractor will not make payment to any individual who fails any of the following: (1) criminal background check, (2) Medicaid or Medicare excluded provider list, and (3) Arkansas Adult or Child Maltreatment Central Registries.

The CMS review team recommends that the state take action 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.

Section 4: Personal Care Service Providers

Overview of the State's Personal Care Service Providers

During FFY 2017, 410 providers in the agency-directed option and 96 providers in the self-directed option contracted directly with the state. As part of the onsite review, CMS's review team interviewed six provider agencies that included: Area Agency on Aging of Northwest Arkansas; Carelink; Golden's Adult Daycare, Limited Liability Company (LLC); Home Instead Senior Care; PremierChoice, LLC; and Silver Lining Senior Care.

Oversight of Personal Care Services Providers

OMIG audits and investigations are developed from multiple sources. OMIG cases originate from data analytics, public complaints received through OMIG's fraud hotline and website, provider self-reports, internal referrals, and law enforcement agency referrals. In SFY 2017, OMIG increased its use of data analytics tools to identify providers for audit and investigation. The increased reliance on data analytics has contributed to more efficient and effective audits and investigations and increased recoupments and cost avoidance. CMS recommends that OMIG continue to enhance data mining capabilities by identifying outliers, using algorithms, or exception processing for personal care services claims to enhance the state's program integrity's ability to identify and recover improper payments. Since 2016, OMIG has been working to implement and assign unique identifiers to individual PCS providers. This would allow for more in depth analysis and tracking of providers from agency to agency.

For FFY 2017, the total number of audit reviews, requests, and provider letters conducted and/or issued was as follows: 70 onsite audits/reviews, 281 desk audits, 693 Provider Self Audit

Requests (PALS), 635 recoupment letters, 53 provider requests for information, and 121 False Claims Act compliance reviews.

One of OMIG's mechanisms for comprehensive oversight of PCS is to require the agency directed personal care agencies to perform a site visit no less than every 62 days. In addition, the agency is required to maintain service plans and review the PCA's service logs for accuracy and completeness.

Area Agency on Aging of Northwest Arkansas

Area Agency on Aging of Northwest Arkansas (AAANA) has been serving homebound and active older people and their family caregivers for more than thirty years through the state's Medicaid State Plan and the AR Choices Waiver. During FFY 2017, AAANA provided personal care services to approximately 395 beneficiaries, employed approximately 733 PCA staff and 25 supervisory staff. AAANA does have a compliance program. The Agency follows the standards set forth in the rules and regulations, which include, but are not limited to Arkansas Medicaid, Arkansas Department of Health, Department of Labor, Wage & Hour, DHS, U.S. Citizenship and Immigration Services, Arkansas Department of Human Services drug screening and criminal backgrounds policy, the agency Employee Handbook, Standard of Conduct, and the False Claims and Whistleblower protection policy.

The Medicaid biller balances billing against payroll to ensure AAANA is billing the correct number of units. He/she also checks for signatures on all timesheets and returns any with missing signatures to the branch office for correction. Dates of the care plans are put in the system to ensure that no billing is processed without a current care plan. The chart review Registered Nurse (RN) also checks for documentation and services provided.

AAANA does not currently utilize an Electronic Visit Verification (EVV) system and is awaiting further guidance from the state.

CareLink

CareLink is a nonprofit that has been serving homebound and active older people and their family caregivers for 38 years through the state's Medicaid State Plan and the AR Choices Waiver. During FFY 2017 CareLink provided personal care services to approximately 1,214 beneficiaries, employed approximately 864 PCA staff and 31 supervisory staff.

CareLink does have a compliance program, however, they do not have a formal compliance committee. The agency maintains a Senior Leadership Team comprised of the Chief Executive Officer, Vice President (VP) of Community Services, VP of Finance, and the VP of Development. Weekly meetings are held where various reports on company performance and objectives are presented. Once per month the Director of Home Care, Director of Center Services, and the Controller attend a meeting to present more detailed departmental reports. Quality assurance reports are also presented to the Board of Directors annually.

Forty hours of PCA training are required prior to an applicant becoming a certified personal care attendant. Once hired, PCA Continuing Education (CE) is offered online (through In the Know) and through quarterly in person training sessions taught by the CareLink compliance registered nurse (RN). CEs taken outside of CareLink are also counted if documentation is provided to Human Resources. Caregiver CE is tracked during the year to make sure 12 credits are completed. RN CE credits are the responsibility of the nurse to complete as part of maintaining their RN licensure. Scheduling staff are offered training related to their home care tasks.

Federal and/or state background checks are conducted on all employees. If an applicant has not been a resident of the state of Arkansas continually for the past five years, then a federal background check with fingerprinting is required (the five-year residency requirement is a state legislative mandate). If employees can prove five years of residence in the state of Arkansas then a state background check is sufficient. Results of the background check are forwarded to the Arkansas Office of Long Term Care who then issues either a "not disqualified for in-home aide services" or "disqualified" determination.

CareLink's caregivers are informed how to report acts of misconduct, fraud, and abuse issues during the PCA class and Departmental Orientation. Caregivers and office personnel are informed of the policy for False Claims and Whistleblower Protection in the class and handbook. Human Resources maintains written acknowledgement from each employee that he/she has received and read the applicable employee handbook. Home care staff are encouraged to report these issues in real time to home care management. Home care management takes immediate action to investigate the claim, interviewing both the caregiver and the beneficiary. Management takes disciplinary actions when a situation is warranted and records them in the personnel files. CareLink self-reports any instances of these issues to the appropriate auditing body.

Although CareLink does not conduct and document a formal risk assessment, staff and management are assessing, monitoring, and communicating within the organization about identified risks on a consistent and ongoing basis.

CareLink utilizes an EVV system. Implemented in 2006, the agency began by using the software vendor Santrax. Santrax was unable to adapt to the reporting procedures required by the OMIG so in 2016 they changed vendors to Generations. Data collection includes in and out times, services rendered, and tasks performed while in the home utilizing landline, cellular app for GPS, and/or electronic tablet GPS through an app for location and authentication. Additionally, care plans/service plans are entered into the system to establish appropriate hours and types of service delivery approved. The system requires management override to schedule more hours than are allotted on the care plan that has been entered into the system. A variety of reports allows management to monitor service delivery and compliance. Generations does not allow caregivers to clock in and out when there is no schedule pre-populated in the system. Generations will only allow a caregiver to clock in and out using the beneficiaries' phone or a GPS locator application. The scheduling time confirmer runs various reports prior to the billing/payroll export to check for variances such as two caregivers working for same beneficiary at the same time, worked hours that exceed the number of hours authorized on the service plans, and that units are confirmed in accordance to the correct service and beneficiary type.

Generation's data is exported to the SAMS billing software which has internal controls in place to mitigate improper billing.

Golden's Adult Daycare, LLC

Golden's Adult Day Care (hereinafter referred to as Golden's) is a LLC providing in-home care services in Arkansas through the state's Medicaid State Plan and the AR Choices Waiver. Golden's has been providing PCS since September 2010. During FFY 2017, Golden's provided personal care services to approximately 297 beneficiaries, employed approximately 165 PCA staff and two supervisory staff.

Golden's Compliance Officer is the Office Administrator, and the Compliance Committee is the Professional Advisory Committee (PAC), which consists of the Office Administrator, a RN, a PCA, and the file clerk. The PAC reports quarterly to the Board, which consists of the President, Vice President, and the Secretary of the company. The Office Administrator is responsible for organizing and directing the agency's ongoing functions, acting as a liaison to the Board and agency personnel, ensuring only qualified and properly trained individuals are providing services, ensuring the accuracy of public information materials and activities, implementing a budgeting and accounting system, and ensuring there is a properly trained backup administrator to serve in their absence. The duties of the PAC are fulfilled through audits. A random sample of 20 percent of total beneficiary cases (ten percent active and ten percent closed cases) are selected for audit each quarter. In addition, monthly meetings are held to evaluate and implement a plan of action. The plan of action will then be followed until the next meeting when the current plan is assessed for viability. Concerns are collected from beneficiaries and family input, employee suggestions, and surveys. The purpose of the PAC is to promote home health in the community, review and approve admission, discharge, clinical record policies, and personnel qualifications, and to participate in an annual review of the agency's personal care program which includes administrative, governing, and personnel areas.

Golden's has a process in place to ensure PCAs manage their time and accurately document the services provided on a Weekly Time/Visit Report. All time/visit reports are turned in to the time sheet auditor who audits the records to ensure time sheets are legible, are not copies, do not exceed the number of physician ordered hours, are signed and dated by both the PCA and the beneficiary and matches the plan of care. Once the weekly time/visit reports are verified they are submitted to the billing and payroll departments for processing and are sent to the RN for approval

The Compliance Policy and Standards of Conduct are reviewed with each employee during agency orientation in addition to required in-service training, which includes but is not limited to job description, state regulations, and a physical examination. Prior to rendering PCS a PCA must pass the Skills Checklist which is administered during orientation by the agency's RN. Copies of In-Service Tracking Sheets are maintained in each employees personnel file to document training. The supervising RN keeps track of training to ensure all required training has been completed. Training topics are determined by the Office Administrator based on issues noted during evaluations and audits. The agency uses In the Know, Inc. Caregiver Training

Solutions to provide training. The RN conducts a home visit at least every 62 days to supervise the PCA.

Office staff are responsible for ensuring all PCA licenses are up to date and that background checks are in place. All applicants must pass a state criminal background check through the Arkansas State Police, complete a drug screening prior to employment and periodically thereafter. If an applicant has not been a resident of the state of Arkansas continually for the past five years, then a federal background check with fingerprinting is required (the five year requirement is a legislative requirement for the state of Arkansas). It appears the agency does not check any of the federal exclusion/termination lists before hiring, only the state exclusion list through the vendor Prometrics. Felony and/or abuse registry checks are completed every three years.

Golden's does not currently utilize an EVV system, however, they assert that they are awaiting guidance from the state, and will fully comply with the regulations set forth.

Home Instead Senior Care

Home Instead Senior Care (HISC) provides in-home senior care services. The HISC has been providing PCS since approximately January 2001. During FFY 2017 HISC has provided personal care services to approximately 79 beneficiaries, employed approximately 303 PCA staff and 14 supervisory staff.

HISC enlists the Human Resources Manager as its Compliance Officer. The HISC implements controls and protocols that assure compliance with federal and state regulations. An advisory council reviews, develops, and implements policies and procedures. HISC keeps updated revisions of regulations through the DHS as well as receiving updates on Medicaid regulations through the MMIS system on Frontline. HISC has a copy of Arkansas Rules and Regulations for private care agencies and Medicaid policies on site and available for all provider care team members.

All applicants are subject to a seven year county level background check, Social Security verification, a Motor Vehicle and State Police Criminal record check, a public data search, reference checks, and pre-employment drug screening. If an applicant has not been a resident of the state of Arkansas continually for the past five years, then a federal background check with fingerprinting is required (the five year requirement is a legislative requirement for the state of Arkansas).

The HISC has established minimum requirements for PCA training. Per state guidelines, a minimum of 40 hours of training is required. All caregivers are given further training on updated policies and/or regulations during quarterly caregiver meetings if pertaining to job duties. The training and education is formulated from state regulations and policies. The education is also pertinent to the HISC licensure and regulations from the DHS.

The HISC has quality assurance protocols and audit procedures in place. Care logs are checked daily by the Provider Care Team and PCA and beneficiary quality assurance visits are

conducted. PCS are reviewed by the Beneficiary Care team and billing department for any discrepancies that may have taken place during shifts. HISC uses a double check system that is activated before billing is completed. HISC also has a beneficiary care process that is completed when a beneficiary is placed in a hospital or other care facility. The Beneficiary Care team and the billing department are notified of admission to a hospital or other care facility in order to prevent unauthorized in-home services.

The HISC does not currently utilize an EVV system and is awaiting further guidance from the state.

PremierChoice, LLC

PremierChoice provides in-home care services in Arkansas through the state's Medicaid State Plan and the AR Choices Waiver. PremierChoice has been providing PCS since approximately 2014. During FFY 2017 PremierChoice provided personal care services to approximately 134 beneficiaries and employed approximately 113 PCA staff and three supervisory staff.

PremierChoice has an acting Compliance Officer and the Governing Board acts as the Compliance Committee. The purpose of the Compliance Program is to develop effective internal controls to promote compliance with applicable federal, state and local laws and regulations, to establish and maintain the commitment to ethical operating practices, and to ensure that false or inaccurate claims are not submitted.

The Compliance Policy and Standards of Conduct are reviewed with employees during orientation and also during their annual reviews. PremierChoice follows the 40 hour annual training guidelines established by the state.

All applicants must pass a background check, drug screening, have reliable transportation, and auto insurance. Background checks include a check of the Arkansas State Police Criminal History/Background report and a nationwide FBI check. Fingerprint cards are submitted for individuals who have lived outside of the state for any period in the last five years (the five-year requirement is a legislative requirement for the state of Arkansas). Residency is determined via the resume, work history and verbally during the interview process. PremierChoice does not check any of the federal exclusion/termination lists before hiring, only the state exclusion list through their vendor Prometrics. This check is completed every five years at a minimum, with some random checks.

PremierChoice does not currently utilize an EVV system. However, they are narrowing their search for a vendor and anticipate having an EVV system in place by late summer of 2018.

Silver Lining Senior Care

Silver Lining Senior Care (hereinafter referred to as Silver Lining) provides in-home care services in Arkansas through the state's Medicaid State Plan and the AR Choices Waiver. Silver Lining has been providing PCS since January 2016. During FFY 2017 Silver Lining provided

personal care services to approximately 232 beneficiaries, employed approximately 166 PCA staff and three supervisory staff.

Silver Lining has an acting Compliance Officer and the Governing Board acts as the Compliance Committee. The purpose of the Compliance Program is to develop effective internal controls to promote compliance with applicable federal, state and local laws and regulations, to establish and maintain the commitment to ethical operating practices, and to ensure that false or inaccurate claims are not submitted.

The Compliance Policy and Standards of Conduct are reviewed with employees during orientation and also during their annual reviews. Silver Lining follows the 40 hour annual training guidelines established by the state.

All applicants must pass a background check, drug screening, have reliable transportation, and auto insurance. Background checks include a check of the Arkansas State Police Criminal History/Background report and a nationwide FBI check. Fingerprint cards are submitted for individuals who have lived outside of the state for any period in the last five years (the five-year requirement is a legislative requirement for the state of Arkansas). Residency is determined via the resume, work history and verbally during the interview process. Silver Lining does not check any of the federal exclusion/termination lists before hiring, only the state exclusion list through their vendor Prometrics. This check is completed every five years at a minimum, with some random checks.

Silver Lining does not currently utilize an EVV system and is awaiting further guidance from the state.

The interviewed agencies voiced some concerns that DHS and OMIG do not provide an annual training and education calendar for courses offered throughout the year. However, it was determined that OMIG does publish an annual training calendar which is available to all providers. The CMS review team recommends that DHS publish information on the availability of training and provide additional training to PCS providers on updated policies, rules and regulations as needed.

Section 5: Electronic Visit Verification (EVV)

Overview of the State's Electronic Visit Verification (EVV) System

An EVV system is a telephonic and computer-based in-home scheduling, tracking, and billing system. Specifically, EVV documents the precise time and type of care provided by caregivers at the point of care. Pursuant to Section 12006 of the 21st Century Cures Act, all states are required to implement an EVV system for PCS by January 1, 2020.

Arkansas does not currently use an EVV system. The state is still in the contracting phase for EVV and has yet to select a statewide vendor. The state will use a single vendor, however

individual providers may use any system they wish as long as it properly interfaces with the state's system.

The DHS will oversee the EVV system. Updated policies and procedures will be developed in consultation with the EVV vendor.

Recommendations for Improvement

- The state should consider issuing Explanation of Medicaid Beneficiary Medical Benefits (EOMB) verifications to beneficiaries receiving PCS furnished by individual PCAs in self-directed programs.
- The state should consider establishing a statewide system that captures information on all PCS providers related to the status/results of necessary background checks, federal database checks and licensing requirements that can be accessed to verify PCS providers' ability to provide services.
- The state should consider utilizing data analytics to identify potential improper payments related to PCS claims that may require further investigation for fraud, waste and abuse.
- The state should consider providing regular training opportunities for PCS providers related to topics (including but not limited to) updates related to PCS program rules and/or guidance, PCS billing requirements, PCS fraud, waste and abuse identification and reporting requirements.
- The state should ensure that the contracting occurs in order to secure an EVV system 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.

Section 6: Status of Corrective Action Plan

Arkansas's last CMS program integrity review was in April 2013, and the report for this review was issued in February 2014. The report contained sixteen findings. During the onsite review in March 2018, the CMS review team conducted a thorough review of the corrective actions taken by Arkansas to address all issues reported in calendar 2013 year. The findings of this review are described below.

Findings –

Risk: Inadequate program integrity oversight and activities, including: not having a written work plan, not having adequate policies and procedures, not monitoring False Claims Act education, and not having any Division of Medical Services – Program Integrity Unit (DMS-PI) involvement into decisions regarding Medicaid Management Information System (MMIS) edits.

1. The State does not have a written work plan.

Status at time of the review: Corrected

The OMIG developed a work plan (2014) and published the work plan on its agency website. The OMIG 2014 work plan will identified the Program Integrity audit/review strategy for conducting field audits and desk audits of Medicaid providers. OMIG also worked with Health Integrity, the CMS MIC auditor for Arkansas, to develop a specific review plan to target areas of concern with Medicaid provider types. The 2014 work plan provided specific information to the public and Medicaid providers of the areas where the

MIC audits will focus and the areas and types of field and desk audits that will be targeted by OMIG as well as an opportunity for Medicaid providers to self-report in areas identified by OMIG.

2. The State does not have adequate written policies and procedures for program integrity oversight of the Medicaid program.

Status at time of the review: Corrected

The OMIG developed a Program Integrity audit and review protocol and strategy in order to identify Medicaid providers for audits and reviews to ensure that the OMIG audit and review strategy was consistent with the 2014 work plan. In October 2013, OMIG began a new audit tracking process by holding Pre/Post Audit meetings to review and monitor Program Integrity field audits and desk audits. OMIG administration has weekly meetings with the audit teams that are working on pending audits to review the progress and work to resolve issues and concerns. The audit tracking meetings have been very productive and have helped streamline the audit and review process.

A database is also maintained to ensure that Program Integrity audits and reports are issued in a timely fashion. The Pre/Post Audit meetings also allow OMIG administration to monitor whether personnel have completed audits, to work with the audit teams to ensure that they are prepared for future audit assignments, and to identify new audits or reviews.

3. The State does not comply with its State plan regarding False Claims education monitoring.

Status at time of the review: Corrected

The OMIG and the Department of Human Services, Division of Medical Services worked to develop procedures to ensure that the appropriate providers are meeting the False Claims Act education requirements, including following compliance guidelines set forth in the contract. The provider enrollment verification process was modified to achieve the necessary verifications of the False Claims Act education requirements.

4. The DMS-PI is not consulted on decisions to implement or revise MMIS edits.

Status at time of the review: Corrected

OMIG worked with the fiscal agent employed to operate the Medicaid Management Information System of the Department of Human Services to optimize the system, including without limitation the ability to add edits and audits in consultation with the Department of Human Services. *Ark. Code Ann. §20-77-2506.* The OMIG has coordinated to ensure that they will have access to recommend edits and changes to the MMIS system when appropriate to identify fraud, waste, and abuse in the Medicaid program.

Risk: Ineffective provider enrollment practices and reporting, including but not limited to, failing to properly capture disclosure information at enrollment or properly notify beneficiaries and the public of provider terminations and reinstatements.

5. ***The State does not capture all required ownership and control disclosures from disclosing entities and the fiscal agent.***

   Status at time of the review: Corrected

   In August, 2014 the State promulgated DMS form DMS 675. This is Arkansas's Ownership and Disclosure form. Since the form's creation, all provider types wishing to enroll in Arkansas Medicaid have been required to submit it.

6. ***The State does not adequately address business transaction disclosure requirements in its provider agreements or contracts.***

   Status at time of the review: Corrected

   In August, 2014 the State promulgated DMS form DMS 689. This is the State's Disclosure of Significant Business Transactions form. Since the form's creation all provider types wishing to enroll in Arkansas Medicaid have been required to submit it.

7. ***The State does not provide notice of exclusion consistent with the regulation at 42 CFR 1002.212.***

   Status at time of the review: Corrected

   Since the Program Integrity functions at DMS were merged with the Office of Medicaid Inspector General, the SMA has not initiated any exclusions. If the SMA were to do so, they would mirror the process currently used by the AR OMIG.

   Risk: Failure to implement key provisions of the Affordable Care Act related to provider screening and enrollment.

8. ***The State does not require all enrolled providers to be screened or all ordering or referring physicians be enrolled as participating providers.***

   Status at time of the review: Corrected

   All providers are screened as required by the ACA. The State's fiscal agent enrolls Medicaid providers and has a contract with LexisNexis. The contract stipulates that all data bases that are required to be screened are searched.

9. ***The State does not have a method for verifying provider licenses nor confirming that the license has not expired.***

Status at time of the review: Corrected

Enrollment analysts are required to verify, electronically or via phone, that all licenses are current and accurate. Plans are currently in place to fully automate medical based licenses through the Arkansas State Medical Board.

10. ***The State is at risk because it does not deny or terminate enrollment of any provider that is terminated under title XVIII of the Act or under the Medicaid program or CHIP of any other State.***

Status at time of the review: Corrected

Any notice received from the federal OMIG and any other state is reviewed to determine if that excluded provider is listed as an Arkansas Medicaid provider. If they are enrolled, they are removed.

11. ***The State does not conduct pre-enrollment or post-enrollment site visits of designated moderate or high risks providers.***

Status at time of the review: Corrected

The State is currently in the planning stages to implement this requirement and hope to go-live with fully implemented site visits by 12/21/18. In the interim, the State has

- Consulted with CMS and received a data compare spreadsheet, for use, that allows the State the ability to attach pertinent information (name, NPI, Medicare #, etc.) and they will share site visit and fingerprint based information from the Medicare enrollment contractor.
- Identified a panel in interchange where this information can be stored.
- For the remaining providers that are not linked to Medicare, I am working with DXC to determine if we can leverage their existing sub contract with AFMC provider representatives and using the two enrollment (2) staff I have here to complete those visits.
- A site visit form has been developed and is attached.

The State has been developing a plan to address newly enrolling providers by

- Completing system edits that will not allow a provider to fully enroll until a site visit has been completed.
- Expand the contracting of provider reps to conduct the site visits and complete and submit the site visit form to provider enrollment to download and complete the enrollment in workflow.
- Query and report daily, all newly enrolled providers, also identifying those that require a site visit.
- Ensure provider reps visit newly enrolled providers within ten days of enrollment.

12. ***The State does not conduct complete database searches for individuals and entities participating in Medicaid.***

Status at time of the review: Corrected

All providers are screened as required by the ACA. The State's fiscal agent enrolls Medicaid providers and has a contract with LexisNexis. The contract stipulates that all data bases that are required to be screened are searched.

13. The State does not collect application fees from institutional providers prior to executing a provider agreement.

Status at time of the review: Corrected

Application fees for institutional provider have been collected since July1, 2013.

Risk: Inadequate attention to fraud and abuse detection and referral, including not referring all suspected provider fraud to the Medicaid Fraud Control Unit (MFCU), not suspending payments in cases of credible allegations of fraud, not making timely referrals to law enforcement, not maintaining proper documentation, and having an ineffective working relationship with the MFCU.

The OMIG took proactive steps in working with the Arkansas Attorney General's Medicaid Fraud Control Unit, (MFCU). An updated agency policy manual was developed to provide procedures and requirements for OMIG personnel to follow relating to suspected provider fraud.

The OMIG Policy Manual included policies and procedures to ensure that referrals to MFCU and other law enforcement are made in writing, referred in a timely manner, and a procedure is in place to check the status of pending referrals.

Significant steps were taken to build a strong working relationship with the Arkansas Attorney General's Medicaid Fraud Control Unit. OMIG has increased communication efforts and interaction and correspondence with the MFCU.

In January 2014, OMIG signed a Memorandum of Understanding with the Arkansas Attorney General in order to comply with federal requirements and to set the protocol and procedures in place for the two agencies to effectively work together to combat Medicaid fraud and abuse.

14. The State does not refer all suspected provider fraud cases to the MFCU.

Status at time of the review: Corrected

OMIG developed a protocol for developing and submitting possible fraud cases to the attention of the MFCU. The outline of the protocol and the general referral process is made available to OMIG staff in the policy and procedures manual.

OMIG has corrected previously noted deficiencies to ensure that all suspected provider fraud is referred to the MFCU within one business day of any temporary payment suspension. The OMIG referral process includes notification letters to the suspended providers, formal referral letters to the Attorney General's Medicaid Fraud Control Unit, and case file submission forms.

OMIG has created and maintains a case and audit referral database to document referrals or case submissions to MFCU. In addition, OMIG tracks all MFCU and law enforcement referrals and requests status information on a quarterly basis. OMIG submits all MFCU submissions and referrals in writing and requests that all MFCU decisions, judicial dispositions or other cases or investigation outcomes, be submitted in writing to OMIG. This process is available to OMIG staff in the policy and procedures manual. A copy of the OMIG referral database and an example of a MFCU disposition letter is included in the corrective action plan.

OMIG hired a full time investigator to prepare cases and audits for referral or submission to the MFCU based on a credible allegation of fraud. One of the primary functions of the investigator is to coordinate efforts and work as a liaison with MFCU investigations.

15. The State does not suspend payments in cases of credible allegations of fraud, make timely referrals to the MFCU, or maintain proper documentation on suspensions of payments.

Status at time of the review: Corrected

OMIG has corrected the noted deficiencies to ensure all provider payments are suspended upon OMIG establishing a credible allegation of fraud. Cases are referred to the MFCU upon the establishment of the credible allegation of fraud and the referral process includes notification letters to the suspended providers, formal referral letters to MFCU, and case file submissions. OMIG maintains a case file for all referrals and requests case updates on a quarterly basis. These updates are documented and discussed during a quarterly meeting. OMIG also meets with MFCU on a monthly basis to discuss active investigations that may result in suspected or a credible allegation of fraud.

16. Referral numbers are not commensurate with the size and staffing of the State Medicaid program.

Status at time of the review: Corrected

Since its creation in 2013, OMIG has averaged 46 referrals to the MFCU per state fiscal year. OMIG has employed a full time fraud investigator since August 2015 and has provided audit staff with Medicaid fraud training. OMIG has also created a data analytics unit which analyzes claims data for potential fraud, waste, and abuse within the Medicaid program.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Arkansas to continue 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 Arkansas 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 Arkansas' efforts and encourages it to look for to additional opportunities to improve overall program integrity. CMS's focused review identified areas of concern which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the weaknesses will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for 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 Arkansas to build an effective and strengthened program integrity function.