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Center for Program Integrity

Iowa 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 Iowa Medicaid personal care services (PCS). The objective of the review was to assess the level of program integrity oversight of Medicaid PCS at the state level. A secondary objective of the review was to provide the state with useful feedback, discussions, and technical assistance resources that may be used to advance the program integrity in the delivery of these services.

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

Background

Medicaid PCS is categorized as a range of human assistance services provided to persons with disabilities and chronic conditions which enables them to accomplish activities of daily living (ADLs) or instrumental activities of daily living. It is a Medicaid benefit furnished to eligible beneficiaries according to a state's approved plan, waiver, or demonstration. These services are provided in the beneficiary's home setting or at other locations. Services offered under Medicaid PCS are optional, except when they are medically necessary for children who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment benefit that provides comprehensive and preventive health care services.

Services must be approved by a physician or by some other authority recognized by the state. Personal care beneficiaries cannot be inpatients or residents of a hospital, nursing facility, intermediate care facility for the developmentally disabled, or institution for mental disease; services can only be rendered by qualified individuals, as designated by each state.

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

Pursuant to the regulations found at 42 CFR 440.167 and 42 CFR 441.303(f)(8), Medicaid PCS (sometimes referred to as personal attendant or personal assistance services) includes a range of assistance services provided to beneficiaries with disabilities and chronic conditions of all ages. Provision of these services in the beneficiary's home is intended to serve as an alternative to institutionalization. Assistance may either be in the form of direct provision of a task by the personal care attendant (PCA) or cuing/prompting by the PCA so that the beneficiary may perform the task. Such assistance most often involves ADLs, such as eating and drinking, bathing, dressing, grooming, toileting, transferring, and mobility.

Also, the regulation at 42 CFR 441.450 provides 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.

The Iowa Medicaid Enterprise (IME) is the division of the Iowa Department of Human Services (DHS) responsible for the administration of the Iowa Medicaid program. On April 1, 2016, the DHS transitioned most of the existing Iowa Medicaid members to a managed care program known as IA Health Link. In addition, most new members eligible after April 1, 2016, were also enrolled in IA Health Link; however, some Medicaid members will continue to be served through the Medicaid fee-for-service (FFS) delivery system. The IA Health Link program is administered by three contracted managed care organizations (MCOs) which provide members with comprehensive health care services, including physical, behavioral, and long-term care services and support. Those MCOs are Amerigroup, AmeriHealth Caritas, and United Healthcare.

The state administers home and community-based services (HCBS) PCS under the following 1915(c) waiver authorities: Physical Disabilities (PD), Brain Injury (BI), Health and Disability (HD), Intellectual Disabilities (ID), Human Immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome (AIDS/ HIV), and Elderly (EW). The DHS provides PCS under Consumer Directed Attendant Care (CDAC) or Consumer Choice Options (CCO) waiver provider types; they are not necessarily home health agencies or hospice providers.

Methodology of the Review

In advance of the onsite visit, CMS requested that Iowa complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. In addition, questionnaires and review guide modules were sent to PCS providers and/or provider agencies in order to gain an understanding of their role in program integrity. A three-person review team has reviewed these responses and materials in advance of the onsite visit.

During the week of June 26, 2017, the CMS review team visited DHS. They conducted interviews with numerous state staff involved in program integrity and administration of PCS. The CMS review team also conducted interviews with three provider agencies. 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

Iowa's CDAC delivery model allows members to receive services through a Medicaid enrolled agency or individual provider. The IME conducts all background checks for CDAC providers. The CCO delivery model allows members to self-direct their care by hiring their own attendants directly. An independent support broker (ISB) and a financial management service (FMS) assist the member with employee management and budgeting; however, the member continues to maintain budget and employer authority. The state emphasizes offering its beneficiaries self-directed services, in an effort to promote personal choice and control over the delivery of waiver services.

The CDAC is an option intended for people in an HCBS waiver program who require PCS to remain in their own homes. The PCS under the CDAC model are provided by either a Medicaid enrolled agency or individual providers which are enrolled with the Medicaid program. The beneficiary has the choice of who will provide their CDAC services within the agency. The PCS agency is responsible for both credentialing and scheduling. The MCOs are responsible for training providers, processing payments, and providing oversight.

The CCO is an option available under the HCBS waivers and gives the beneficiary control over a targeted amount of Medicaid dollars, so they may develop a plan to meet their needs by directly hiring employees, and/or purchasing other goods and services. The CCO model offers more choice, control, and flexibility over services as well as more responsibility. The PCS under the CCO delivery model are provided by individuals hired directly by the Medicaid recipients; the recipient functions as the personal care attendant's (PCA's) common law employer. The beneficiary is responsible for all employer activities under the CCO delivery model. In addition, the CCO offers three tools to members to help make important decisions and to support with follow-up actions: ISB services, an individualized budget, and FMS. The beneficiary will choose an ISB who will help develop the individual's budget and assist in recruiting employees. The beneficiary will also work with a FMS that will manage their budget and pay workers on their behalf.

Summary Information of Waivers Reviewed

Iowa provides Medicaid PCS to eligible beneficiaries under the following 1915(c) waiver authorities: PD, BI, HD, ID, AIDS/ HIV, and EW. As previously mentioned, provision of these

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

Table 1.

Program Name/ Year Implemented	State Plan or Waiver Type	Service or Program	Administered By
HCBS – CDAC Implemented 08/01/1990 Implemented 03/01/1991 Implemented 08/01/1992 Implemented 07/01/1995 Implemented 10/01/1996 Implemented 08/01/1999	Section 1915(c) Section 1915(c) Section 1915(c) Section 1915(c) Section 1915(c) Section 1915(c)	EW ID HD AIDS/ HIV BI PD	Prior to 04/01/2016: • State Medicaid agency After 04/01/2016: • Amerigroup • AmeriHealth Caritas • United Healthcare
HCBS – CCO Implemented 07/01/2007	Section 1915(c)	EW ID HD AIDS/ HIV BI PD	Prior to 04/01/2016: • State Medicaid agency After 04/01/2016: • Amerigroup • AmeriHealth Caritas • United Healthcare

Iowa currently has six Medicaid HCBS waivers that provide service funding and individualized supports to eligible members. The PD waiver provides PCS for persons who are physically disabled; an applicant must be at least 18 years of age, but less than 65 years of age. The BI waiver provides PCS for those who have been diagnosed with a brain injury due to an accident or illness. The HD waiver provides PCS for persons who are blind or disabled; an applicant must be less than 65 years of age to qualify for this waiver. The ID waiver provides PCS for persons who have been diagnosed by a psychologist or psychologist with an intellectual disability. The AIDS/ HIV waiver provides PCS for those who have been diagnosed with either an AIDS or HIV infection. The EW waiver provides PCS for elderly persons; an applicant must be at least 65 years of age to qualify. The state does offer self-directed services promoting personal choice and control over the delivery of waiver and state plan services.

Iowa's total Medicaid expenditures in federal fiscal year (FFY) 2016 were approximately $4.9 billion and covered nearly 600,000 beneficiaries per month. Iowa's total Medicaid expenditures for PCS in FFY 2016 were approximately $24.7 million. The unduplicated number of beneficiaries who received PCS in FFY 2016 was 3,056 in the CDAC delivery model and 3,094 in the CCO delivery model. Total unduplicated beneficiaries represents the count of unique individuals receiving PCS during a specified time period. The number of PCS providers enrolled in FFY 2016 was 494.

Table 2-A.

1915(c) Waiver Authority Service/Program	**FFY 2014**	**FFY 2015**	**FFY 2016***
PD	$889,203	$734,615	$367,492
BI	$1.1 million	$1.1 million	$533,835
HD	$1.1 million	$933,411	$433,573
ID	$1.7 million	$1.7 million	$735,887
AIDS/HIV	$34,659	$39,440	$20,665
EW	$12.1 million	$12.2 million	$5.7 million
Total CDAC Expenditures	**$16.9 million**	**$16.7 million**	**$7.8 million**

*The CDAC's decrease in PD, BI, HD, ID, AIDS/ HIV, and EW waiver expenditures was attributed to the state's transition to managed care long-term care and support services (LTSS) during the second half of FFY 2016. The FFY16 total does not include managed care expenditures, as expenditure data for the managed care program is not reported by service type.

Table 2-B.

1915(c) Waiver Authority Service/Program	**FFY 2014**	**FFY 2015**	**FFY 2016***
PD	$3.0 million	$2.7 million	$1.2 million
BI	$2.3 million	$2.1 million	$1.1 million
HD	$5.2 million	$4.7 million	$2.3 million
ID	$5.0 million	$4.8 million	$2.3 million
AIDS/ HIV	$211,541	$206,502	$88,456
EW	$21.3 million	$20.5 million	$9.8 million
Total CCO Expenditures	**$37.0 million**	**$35.0 million**	**$17.6 million**

*The CCO's decrease in PD, BI, HD, ID, AIDS/ HIV and EW waiver expenditures was also attributed to the transition to managed care LTSS during the second half of FFY 2016. The FFY16 total does not include managed care expenditures, as expenditure data for the managed care program is not reported by service type.

Table 3.

	FFY 2014	**FFY 2015**	**FFY 2016**
Total PCS Expenditures	$54.0 million	$51.8 million	$24.7 million
% Agency-Directed PCS Expenditures (CDAC)	31.39%	32.34%	31.65%
% Self-Directed PCS Expenditures (CCO)	68.61%	67.66%	68.35%

Overall, CCO (self-directed) PCS expenditures in Iowa are more than twice the number of CDAC (self-directed) PCS. Although there was a significant decrease in the total expenditures for both the agency-directed and self-directed waiver provider types during the transition to the managed care delivery system in the second half of FFY 2016, the overall percentages demonstrated little variance when compared to the prior FFYs.

Table 4-A.

1915(c) Waiver Authority Service/Program	FFY 2014	FFY 2015	FFY 2016
PD	250	222	184
BI	170	168	150
HD	203	181	149
ID	280	266	213
AIDS/ HIV	4	4	4
EW	3,567	3,447	2,806
Total Unduplicated Beneficiaries for All CDAC	**4,474**	**4,288**	**3,506**

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

Table 4-B.

1915(c) Waiver Authority Service/Program	FFY 2014	FFY 2015	FFY 2016
PD	37	46	33
BI	331	322	343
HD	400	390	435
ID	2,059	2,000	2,062
AIDS/ HIV	0	1	0
EW	215	285	221
Total Unduplicated Beneficiaries for All CCO	**3,042**	**3,044**	**3,094**

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

State Oversight of Personal Care Services

As previously mentioned, prior to April 1, 2016, the state Medicaid agency was responsible for the administration and oversight of all CDAC and CCO PCS waiver programs under the traditional state FFS delivery model. Since April 1, 2016, the state Medicaid agency contracted with the three MCOs, delegating program administration and oversight responsibilities for PCS under the CDAC and CCO models. The state reported that oversight of the CDAC and CCO PCS programs is a collaborative effort between the Medical and LTSS Policy Unit, IME's PIU, and the three MCOs.

The IME's Medical and LTSS Policy Unit is responsible for oversight of PCS expenditures, and is also responsible for programmatic oversight of the MCOs' CDAC and CCO services. Although the Medical and LTSS Policy Unit's responsibilities do not include fraud and abuse-related activities, the unit works closely with the IME's PIU. The state's Medical and LTSS Policy Unit develops PCS rules and policies for the CDAC and CCO model. The policy managers within the Medical and LTSS Policy Unit are individually responsible for oversight of the PCS program under each CDAC and CCO waiver type that they manage.

Iowa's PIU consists of 18 full-time employees, including three state employees and a contracted vendor, Truven Health Analytics (THA), which is managed by state employees. The IME's PIU is responsible for all program integrity, audit, and fraud investigation activities including: surveillance and utilization review services; data analytics; medical necessity reviews; investigations/audits; oversight of provider enrollment; implementation and oversight of adverse

actions against providers; coordination with state and federal partners; ensuring accurate reporting of MCO overpayments; ensuring MCOs are actively identifying and reporting fraud, waste, and abuse; ensuring MCOs are actively identifying and reporting any excluded individuals employed within their networks; and ensuring MCO contract compliance.

The IME and its contracted entities have an established audit work plan which includes billing for CDAC providers, personal care agency providers, and CCO providers. Additionally, the audit work plan is aligned with the level of risk assigned to providers during the provider enrollment process. The state's audit work plan establishes a strategy stating that the PIU will provide MCO oversight; identify targets for review and investigation; conduct audits; and generate recoveries and other provider actions according to the state's Medicaid program integrity contract. The state's PIU and THA are required to meet annually to discuss and approve the algorithms to be included on the following year's annual analytic work plan. The IME's program integrity requirements, output from the previous year, provider type risk/focus, economic impact, the strength of Iowa policy, overall complexity, and required follow-up are among the considerations and factors that are used in developing the audit work plan. The THA data analysis team will also create expectations for the quantity of algorithms per year.

The MCOs administer and ensure service delivery within state and federal guidelines. Each MCO oversees the CDAC and CCO models through case managers who are responsible for ensuring that the provision of services are appropriate and delivered according to the beneficiary's plan of care. The MCO contract compliance, quality, and other contractual monitoring activities are overseen by Medical and LTSS Policy Unit and the states Managed Care Oversight and Supports Bureau. The state's PIU conducts PCS monitoring for the CDAC and CCO models in the areas of fraud, waste, and abuse which include: a fraud hotline; explanation of medical benefits (EOMB) review; complaints mailed to IME, the Unified Program Integrity Contractor, and internally within other departments at IME. In addition, the IME's PIU meets monthly with the state's HCBS Quality Oversight Unit to collaborate and discuss ongoing issues with HCBS providers.

Prior to April 1, 2016, fraud and abuse cases originated from and were reviewed by the state's PIU to determine if they should be referred to the MFCU as credible allegations of fraud. All tips received by an MCO must be reported to the IME PIU and the Medicaid Fraud Control Unit (MFCU) via the 2-day tip form within 2 business days of receipt of the tip. When the IME PIU receives a tip, it is also sent to the MFCU via the 2-day tip form. Each tip is vetted by the MCO or IME PIU that received it. If the tip is unfounded, it is closed and reported on the monthly report. If the tip is founded, a case is opened for investigation by the MCO or IME PIU that received it. An investigation may result in administrative recovery of an overpayment, or if possible fraud is suspected, a referral is made to the MFCU. A referral from an MCO is sent to the MFCU and the IME PIU simultaneously. At that time, the IME PIU determines if a credible allegation of fraud exists. If a credible allegation of fraud exists, the IME PIU notifies the MCO and asks if they will be requesting a good cause exception due to network adequacy issues if the provider is suspended. During this time, the MFCU is evaluating the referral and must accept or decline the case within 14 calendar days. If the MFCU accepts the case, they indicate at that time if they are requesting a good cause exception. If the MFCU opens the case and no good cause exception has been requested, the credible allegation of fraud payment suspension letter is

sent to the provider. Investigations and referrals are also reported on the monthly report. The IME PIU compiles a report which lists all cases opened by either the MFCU, the IME PIU, or an MCO which is then shared with all parties on a monthly. However, the IME's PIU has not been suspending payments nor has it invoked any good cause exceptions not to suspend payments immediately upon referral to the MFCU.

Iowa endeavors to ensure that client services are verified in both the CDAC and CCO models. On a monthly basis, verification is accomplished by mailing EOMBs to a sample size of between 50 to 60 percent of paid claims. In addition, the state's CORE unit who manages the claims processing, payment, and the technical coding and configurations of the Medicaid Management Information System (MMIS) conducts 25 to 30 telephone quality checks on a monthly basis. Prior to April 1, 2016, a sample size selection of between 65 to 75 percent of paid claims was used.

The IME routinely conducts policy team meetings to discuss issues relating to waiver administration and oversight activities. The meeting convenes weekly and is attended by staff from the Medical and LTSS Policy Unit. The PCS topics are included in the agenda as the need arises. In addition, the state's HCBS Quality Oversight Unit and PIU meet monthly to discuss program integrity and quality-related issues. These meetings are attended by HCBS program managers, quality assurance team members, and the PIU staff. The team discusses specific cases where program integrity and quality concerns may be present. The policy team determines the course of action needed to address each of the issues presented by the members. Any issue discussed requiring leadership input will be summarized and presented to leadership for review and advisement. In addition, the IME's PIU, the Managed Care Bureau and LTSS Policy Unit, and the MCOs conduct monthly meetings and ad hoc meetings with the MFCU to present all referrals and PCS cases. Additionally, the state Medicaid agency makes available various information on the IME website, including CDAC and CCO information and forms that are accessible to providers and members to be utilized as training tools.

The state's HCBS quality team conducts routine certification and reviews provider annual self-assessments for any potential quality of care concerns. In addition, the HCBS quality team conducts a passive monitoring process utilizing an incident reporting system as a tool to review for indicators of potential quality issues. The state Medicaid agency may impose monetary or provider probation, sanctions, corrective actions, and/or training/education if findings are discovered.

The IME's PIU tracks the recovery of provider overpayments. The senior financial analyst verifies the recovery of provider overpayments reflected in the MMIS data, and reconciles the documentation of these recoveries between the MMIS and the PIU's accounts receivable (A/R) database on a monthly basis. In addition, the PIU staff monitors the progress of all overpayment recoveries both within the PIU's A/R database and contained on the MMIS.

Iowa does conduct data mining by employing specific analytics to capture HCBS/PCS information at both the agency and at the attendant levels, and reported to the CMS review team that is does receive all of the certified data that Iowa requires to perform data mining activities.

Also, the IME applies edits to the system to prevent inaccurate or double billing of claims. The Medical and LTSS Policy Unit initiates the request for change; the change request is presented to the state's claims and benefits committee and, if approved by the committee, the Medical Services Unit submits a change management request or system action memo. The state's Provider Services Unit will then revise the provider manual, and develop an information letter to communicate the system edits and claim submission instructions.

The CMS review team selected samples of five network provider investigations conducted by Iowa during the past four FFYs. Upon review of the case files, the CMS review team found that a provider appealed the allegations of fraud; a provider was suspended on one count of tampering with records; a provider was under current investigation by the MFCU to determine if a credible allegation of fraud exists; a provider case was declined by the county attorney's office; and a provider case resulted in unfounded allegations of fraud. In addition, the CMS review team identified two of the cases where a beneficiary was receiving services provided by both members of a married couple using the same identifier, although this was not the reported cause of the fraud investigation.

Table 5.

CDAC and CCO Combined	FFY 2014	FFY 2015	FFY 2016
Identified Overpayments*	$272,920	$176,144	$137,857
Recovered Overpayments*	$172,073	$71,783	$3,405
Terminated Providers	37	48	17
Suspected Fraud Referrals	102	90	50
# of Fraud Referrals Made to MFCU	18	49	36

*Overpayments identified and recovered in FFY 2014, FFY 2015, and FFY 2016 include fraud, waste, and abuse.

During onsite interviews, the decrease in identified overpayments from FFY 2014 to FFY 2015 was attributed to the retirement of the prior program integrity contractor's fully dedicated investigator who was knowledgeable in HCBS's CDAC and CCO models. The loss of key personnel experienced with PCS and dedicated to reviewing these providers resulted in a decline in identified overpayments during this time period. Also, the decrease in identified overpayments between FFY 2015 to FFY 2016 was due to the change in program integrity contractors and the state's transition to the managed care delivery system. During the change in contractors, investigations were being completed and no additional cases were opened. In addition, the CDAC and CCO FFS population significantly decreased as a result of the transition to the managed care delivery system, as the majority of these providers were enrolled into one of the three MCOs.

There was a decrease in the number of terminated providers from FFY 2015 to FFY 2016, due to an organizational transitions at the state; the number of providers terminated during this time period decreased from 48 to 17. Some of the changes in the state's Medicaid program included the state's award of a program integrity contract to a new contractor and the transition from a FFS to a managed care delivery system. Between December 2015 and May 2016, the IME's PIU went from three to one full time equivalent (FTE) employee. Throughout the summer of 2016, there was only one FTE overseeing the IME's entire PIU while permission to obtain additional staff was pursued. During late August 2016, two FTEs were hired. Additionally, due to the

managed care transition, the IME PIU was working with a much smaller population (FFS only) and the MCOs were ramping up their PI efforts during this time, which resulted in fewer cases going to prosecution, which is the main cause of terminations.

The number of fraud referrals made to the MFCU increased from 18 in FFY 2014 to 49 in FFY 2015, due to implementation of corrective actions resulting from the previous CMS review; the prior CMS review noted a lack of collaboration between the IME and the its PIU. Also, other initiatives resulting from the previous CMS finding were implemented to facilitate better working relationships, collaboration, and improve communications between both state entities. As a result, there was an increase in the number of referrals to MFCU from Iowa Medicaid program integrity between these two FFYs.

Section 2: PCS Provider Enrollment

Overview of PCS Provider Enrollment

States pay PCS providers for furnishing services to eligible beneficiaries on either a FFS basis or through risk-based managed care arrangements. However, Medicaid funds are diverted from their intended purpose and beneficiaries who need PCS may not receive them, when state Medicaid agencies pay fraudulent providers for services either not furnished or for services rendered to beneficiaries that were unnecessary.
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.

In Iowa, it is the responsibility of the Provider Services Unit to screen all CDAC provider applications. It is the responsibility of the FMS to screen all CCO provider applications, including initial enrollment and re-enrollment.

Summary of Information Reviewed

The CDAC option is a public or private agency or an individual working independently as a PCS provider of consumer-directed attendant care and must be enrolled to provide waiver services. An individual who contracts with the member to provide attendant care service under the CDAC option is:

- At least 18 years of age;
- Qualified by training or experience to carry out the member's plan of care pursuant to the department approved service plan;
- Not the spouse of the member, or a parent or stepparent of a member aged 17 or under; and
- Not the recipient of respite services paid through HCBS on behalf of a member who receives HCBS waiver services.

Agencies are authorized to provide similar services through a contract with the Iowa Department of Public Health (IDPH) for local public health services. The agency must provide a current

IDPH local public health services contract number. Under the CDAC option, agencies providing PCS are:

- Home health agencies that are certified to participate in the Medicare program.
- Chore providers subcontracting with the Department on Aging.
- Community action agencies as designated in Iowa Code Section 216A.93.
- Providers certified under an HCBS waiver for supported community living.
- Assisted living programs that are voluntarily accredited or certified by the Department of Inspections and Appeals under chapters 69 and 70.

Also, the member or the legal representative of the member is responsible for selecting the person or agency that will provide the components of the attendant care services to be provided.

The CDAC providers must demonstrate proficiency in delivery of the services included in a member's service plan. Proficiency must be demonstrated through documentation of prior training and experience, or a certificate of formal training. After the interdisciplinary team and member determine the adequacy of the training and experience, the member and provider complete the HCBS/CDAC agreement. The case manager approves the HCBS/CDAC agreement before the provision of services. This agreement becomes an attachment to and part of the service plan. Providers must also document the delivery of services.

The Provider Services Unit verifies these CDAC provider requirements by tracking with a personnel records report. Iowa confirmed that it does have policies and procedures for the verification process. Additionally, the Provider Services Unit is responsible for monitoring providers who are enrolled, but subsequently lose their license. The IME receives licensing information from various licensure or accreditation boards, and takes action on received notifications.

The CCO model members must work with an Iowa Medicaid enrolled Financial Management Service (FMS) provider. The FMS must either:

- Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration, or by the Credit Union Division of the Iowa Department of Commerce; or
- Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation

Members who elect the CCO model must work with an ISB who meets the following qualifications:

- The broker must be at least 18 years of age.
- The broker must not be the legal representative under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.
- The broker must not provide any other paid service to the member.
- The broker must not work for an individual or entity that is providing services to the member.
- The broker must consent to a criminal background check, and child and dependent adult abuse checks.

- The broker must complete an independent support brokerage training approved by the department.

Members who elect the CCO model may choose to purchase self-directed PCS from an individual or business. A business providing self-directed PCS must:

- Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations;
- Have current liability and workers' compensation coverage; and
- An individual providing self-directed PCS must have all the necessary licenses required by federal, state, and local laws including a valid driver's license, if providing transportation.

All personnel providing CCO self-directed PCS must:

- Be at least 16 years of age;
- Be able to communicate successfully with the member;
- Not be the recipient of respite services paid through HCBS on behalf of a member who receives HCBS;
- Not be the recipient of respite services paid through the CCO on behalf of a member who receives the CCO; and
- Not be the parent or stepparent of a minor child member or the spouse of a member.

The provider of CCO PCS must:

- Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided; and
- Submit invoices and timesheets to the FMS no later than 30 calendar days from the date when the last service in the billing period was provided, and payment will not be made if invoices and timesheets are received after this 30-day period.

State Oversight

As required by 42 CFR 455.450, the state has implemented the screening level provisions, including fingerprinting, based on the assigned level of risk for directly enrolled PCS providers. In addition, the state has implemented the federal database checks on any person with an ownership interest or who is an agent or managing employee of the provider as required. Also, the state does check all parties against the List of Excluded Individuals and Entities and the Excluded Parties List System monthly after enrollment/reenrollment as required at 42 CFR 455.436(c)(2).

The IME requires that all Medicaid enrolled providers, or provider agencies which hire or arrange for PCS service providers reimbursed by the Medicaid program, meet all background check and enrollment screening requirements required by the Affordable Care Act. As previously mentioned, it is the responsibility of the FMS to screen all CCO provider applications, including initial enrollment and re-enrollment. It is the responsibility of Iowa's Provider Services Unit to screen and enroll PCS providers in the CDAC option. It is also the responsibility of the state's Provider Services Unit to perform all of the required federal database checks for the PCS providers in the CDAC option as well as collecting and storing all required

disclosure information for enrolled providers during the enrollment process. In addition, the IME's PIU conducts monthly provider surveillance to ensure that enrolled providers maintain clear background checks for CDAC PCS providers. The onsite review team confirmed that the Provider Services Unit is performing all required federal database checks for the PCS providers as well as collecting and storing all required disclosure information.

When the IME receives notification, identifies, or is made aware of a provider entity that has been terminated by Medicaid or convicted of a health care-related criminal offense, the IME will issue a sanction to either suspend or terminate the provider from participation. A copy of the sanction is posted on the IME website. The state, when issuing a sanction may send a courtesy notice to the employer of the sanctioned individual and, if applicable, other state departments, licensing boards, managed care health plans, the U.S. Department of Health and Human Services-Office of the Inspector General (HHS-OIG), and any additional relevant parties. The provider entity's name is added to the state sanction list on the IME's website which is available to the public. The PCS provider agencies are prohibited from employing individuals who have been convicted of a health care-related crimes and have been sanctioned by IME.

Section 3: Electronic Visit Verification

Overview of the State's Electronic Visit Verification System

Iowa does not currently use an EVV system, however, Iowa is currently in the process of implementing EVV and are working with the MCOs, providers, and other stakeholders to determine how the system will work. 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 care-givers right at the point of care. Some of the benefits of utilizing an EVV system include ensuring quality of care and monitoring costs and expenditures. As part of the onsite review, the CMS review team interviewed three provider agencies. Those agencies were Iowa Family Assistants (IFA), Accessible Home Health Care (AHHC), and Trumark Home Care (THC). However, only two of the three PCS provider agencies interviewed do utilize EVV; those agencies were IFA and THC. The AHHC does not utilize an EVV system.

Section 4: Personal Care Service Providers

Overview of the State's Personal Care Service Providers

Providers of PCS deliver supports to Medicaid eligible beneficiaries in their own home or communities who would otherwise require care in a medical institution. These non-medical services assist beneficiaries who have limited ability to care for themselves because of physical, developmental, or intellectual disabilities or conditions. These nonmedical services assist beneficiaries with ADLs.
During FFY 2016, 493 agency PCS providers in the CDAC option and one PCS provider (FMS) in the CCO model 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 three managed care entities operating in Iowa. As previously mentioned, the three provider agencies interviewed during the onsite review were IFA, AHHC, and THC.

Provider Oversight of Personal Care Service

The IFA is a locally owned agency operating since 2010 and specializes in senior in-home care, as well as in-home care for people with mental or physical disabilities and special needs children. During FFY 2016, IFA served 284 Medicaid beneficiaries and employs approximately 140 PCA staff. The IFA provides Medicaid PCS to eligible beneficiaries under the following 1915(c) waiver authorities: PD, BI, HD, ID, AIDS/ HIV, and EW.

The IFA does not have a compliance officer, compliance program, compliance committee, or compliance policies and procedures in place. However, the IFA office staff meet weekly to address complaints relating to suspected PCA fraud or abuse, and to ensure that IFA is meeting the requirements for all federal and state regulations enacted including the research of any new updates to ensure all the proper entities are current and accurate. The IFA office staff consists of two owners, an office manager, a human resources representative, a marketing/intake specialist, a billing specialist, and three office administrators. In addition, meeting minutes are taken at each staff meeting to ensure that responsibilities are outlined and tracked.

The IFA does implement internal audits of both client and personnel files. The IFA uses a quality improvement tracking system to ensure they are in compliance with the findings from previous audits and have incorporated any necessary changes. The IFA verifies the PCS timesheets and service logs twice a month to determine if they are acceptable based on the service plan. In addition, IFA will contact and follow-up with the beneficiary semimonthly. The state reported a five percent error rate of concern or issue for FFY 2016. When a discrepancy is found, IFA will provide education, training, verbal write-up, or terminate the caregiver. The IFA has mandatory fraud, waste, and abuse trainings within 30 days of hire and weekly thereafter. Also, IFA ensures that employees and PCAs are receiving training on Medicaid PCS fraud and abuse using both a paper system and online tracker.

The IFA uses the state's mandated Single Contact Repository (SING) system to perform background checks prior to employment. In addition, IFA runs an HHS-OIG exclusion check upon hire and monthly thereafter. The IFA does perform announced and unannounced site visits with the PCAs and the beneficiaries between two to three times per week. Also, the IFA does utilize an EVV system for in-home scheduling, tracking, and billing of PCS. The IFA utilizes a telephony system to ensure that all shifts can be verified through the consumer's phone number; telephony is the field of telecommunication technology services utilized for the electronic transmission of voice, fax, or data between distant parties.

The AHHC has been locally owned since 2008 and provides both long-term and short-term, in-home senior care services in Polk County, Iowa. The AHHC served 29 Medicaid beneficiaries and approximately 24 PCA staff during FFY 2016. The AHHC provides Medicaid PCS to eligible beneficiaries under the following 1915(c) waiver authorities: PD, HD, ID, and E.

The AHHC does not have a compliance officer, compliance program, compliance committee, or compliance policies and procedures in place. The AHHC's administrator manages all compliance issues. The AHHC's administrator and other designated personnel work together to review and revise policies and procedures; they also collaborate with staff, clients, and families,

as well as other entities, in the detection, prevention, and correction of any potential violations of law or regulations. The AHHC's administrator holds annual meetings with their board of directors which include any compliance issues, improvement activities, and outcomes. The AHHC provides caregiver orientation including fraud, waste, and abuse regulations and reporting requirements, code of conduct, and online academy in-services and education. The AHHC enters caregiver and patient information into an electronic system which is monitored and alerts AHHC office staff regarding any compliance issues. The AHHC periodically reviews state and federal regulations for any changes, and implements revisions, additional policies, and/or documents to maintain compliance.

The AHHC conducts both weekly and monthly record audits to ensure documentation and coding are appropriate for their billing. Reports are generated, addressed, and any corrective actions are completed and reported to the board of directors. The agency's PCS timesheet and the CDAC daily record sheet/service log are compared each week, prior to processing billing, to ensure they agree. If an error is identified, the beneficiary and caregiver are contacted. Once the information is validated and documented, a corrective action is implemented and discussed with the caregiver, if necessary.

During the onsite review, the AHHC representative interviewed also discussed the need for a more inclusive PCA registry with both the CMS review team and the state. When a PCA is fired for misconduct from a position with a home health agency, the agency does not have the ability to report this information in a way that is accessible to other agencies during the hiring process, unless the PCA is criminally charged and a criminal record is created. The AHHC utilizes the state's mandated SING system to perform background checks prior to employment. In addition, AHHC conducts a motor vehicle record check, and runs an HHS-OIG exclusion check upon hire and every two years thereafter. Also, the AHHC does not utilize an EVV system for in-home scheduling, tracking, and billing of PCS.

The THC is a privately owned company serving Des Moines, West Des Moines, Johnston, Urbandale, Waukee, and other surrounding areas of Iowa which provide caregivers, companions, and skilled nursing professionals for any long-term or short-term care need in the home. The THC served 26 Medicaid beneficiaries and 57 PCA staff during FFY 2016. The THC provides Medicaid PCS to eligible beneficiaries under the following 1915(c) waiver authorities: PD, BI, HD, ID, AIDS/ HIV, and E.

The THC does have a compliance officer, compliance program, compliance committee, and compliance policies and procedures in place. The THC's compliance policy is reviewed at least annually, updated as necessary by the compliance officer, and approved by the compliance committee. The THC's policies are distributed to all individuals who are affected by the specific policy at issue along with new, amended, or revised compliance policies; those policies outline best efforts to avoid fraud, waste, and abuse, and to adhere to all guidelines/regulations governing federal and state funded health care programs.

The THC does conduct internal audits of client and personnel files. The THC's recruiting manager conducts periodic checks on PCAs and beneficiaries to ensure services being provided are satisfactory. The THC's compliance officer collects the daily service records, verifies

services rendered with the beneficiary, and compares to the telephony system on a monthly basis or weekly, if necessary. The THC's compliance committee receives annual reports on compliance activities which identifies areas where corrective actions are needed. Subsequent audits are performed to ensure that corrective actions have been successfully implemented.

The THC conducts fraud, waste, and abuse training within 30 days of hire and on as needed basis thereafter. All employees are required to immediately report to the compliance officer any suspected violations of law, regulations, or applicable standards of conduct. If the compliance officer determines that a violation may have occurred, the matter will be referred to outside legal counsel to conduct a more detailed investigation. A log of all reports of possible misconduct is kept indicating the nature of any investigation and its results. The THC uses the state's mandated SING system to perform background checks prior to employment. In addition, THC runs an HHS-OIG exclusion check only upon hire. Also, THC does utilize an EVV system for in-home scheduling, tracking, and billing of PCS.

Recommendations for Improvement

- The state should develop and implement policies and procedures for the MCEs to track and report PCS program expenditure data.
- The state should develop and implement policies and procedures to meet the fraud referral standards for MFCU referrals, and the requirements found at 42 CFR 455.23 which address the suspension of payments to providers upon referrals forwarded to the MFCU.
- The state should strengthen PCS provider regulations to ensure that each PCA is functioning under a unique identifier. Failing to identify each PCA individually increases the opportunity for PCS provider fraud and impedes efforts when investigating potentially fraudulent claims.
- The state should ensure that sufficient resources and staff are allocated to conducting the full range of program integrity functions of fraud prevention, investigation, referral, overpayment recovery, and termination for the providers in its PCS program. In addition, the state should ensure that any MCE with which it contracts has an established and functioning program integrity infrastructure that has adequate systems and staff to prevent, detect and investigate PCS provider fraud.
- The state should require the use of 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.
- The state should consider requiring that any PCS providers participating in their Medicaid program have compliance policies and procedures in place. In addition, PCS providers who are agencies should have designated staff tasked with ensuring that their agencies are in compliance with both internal policies/procedures, and all applicable state and federal regulatory requirements.
- The state should consider additional methods that facilitate the sharing of information regarding PCA providers removed from the PCS program. A more inclusive PCA registry would have the ability to capture and communicate the removal of a PCA for reasons attributed to misconduct with a home health agency and allow the PCS agency to report this information in a way that is accessible to other agencies during their hiring process. This would add a more proactive approach to PCS provider background checks and expand the PCA screening beyond the current scope of criminal record searches.
- The state should ensure that all PCS providers are checking the HHS-OIG exclusion check at the appropriate frequency. This includes checking the PCA upon hire and every two years thereafter.

Section 4: Status of Corrective Action Plan

Iowa did not have a corrective action plan (CAP) to review and allow for the reporting of progression. It has been determined that Iowa made a good faith effort to address all findings and vulnerabilities identified during the previous onsite review in 2013.

Technical Assistance Resources

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

- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute (MII) which can help address the risk areas identified in this report. Courses that may be helpful to (Select State) 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 attached document titled "Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services". This document provides an account of the consensus recommendations developed by MII participants to help states more effectively protect vulnerable beneficiaries and reduce improper payments in PCS.
- 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 Iowa's efforts and encourages it to explore additional opportunities to improve overall program integrity. The CMS focused review identified areas of concern which should be addressed immediately.

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