Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

South Dakota Personal Care Services

Focused Program Integrity Review

Final Report

February 2018

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of the South Dakota 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.

Background

Medicaid PCS is categorized as a range of human assistance services 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 the opportunity for participants (or their representatives) to exercise choice and control over services. Beneficiaries are afforded the decision-making authority to recruit, hire, train, and supervise the individuals who furnish their services under self-directed care models. Beneficiaries may also have decision-making authority over how the Medicaid funds in their service budget are spent.

Methodology of the Review

In advance of the onsite visit, CMS requested that South Dakota 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 July 31, 2017, the CMS review team visited South Dakota's Department of Social Services. They conducted interviews with numerous state staff involved in program integrity and administration of PCS. In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the state's program integrity practices with regard to PCS.

Results of the Review

The CMS team identified areas of concern with the state's PCS program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible. These issues and CMS's recommendations for improvement are described in detail in this report. In addition, CMS has included technical assistance resources for the state to consider utilizing in its provision of PCS.

Section 1: Personal Care Services

Overview of the State's PCS

South Dakota covers PCS through both Medicaid state plan and 1915 (c) waiver authorities using the fee for service (FFS) reimbursement methodology. The state's PCS can be delivered through provider managed service delivery model (agency directed) and participant directed. Several state agencies are responsible for the provision and oversight of PCS.

The Department of Social Services (DSS) is the designated single state Medicaid agency for South Dakota. The following state agencies also administer programs funded by Medicaid in South Dakota: Department of Human Services (DHS), Department of Corrections, Department of Education, and Department of Health (DOH). The DHS is responsible for administering the home and community-based services (HCBS) waivers under DSS guidance. The DHS operates independently of DSS; however, DSS maintains an oversight role, and reviews and submits waiver applications, waiver amendments, State Plan amendments, and the annual CMS 372 reports for each 1915(c) waiver in coordination with DHS. The DSS maintains a cooperative relationship with DHS with staff frequently meeting or corresponding regarding issues affecting both agencies.

The DHS Division of Developmental Disabilities (DDD) is responsible for administering the CHOICES and Family Support 360 waivers, while the Division of Rehabilitation Services (DRS) is responsible for administering the Assistive Daily Living Services (ADLS) Waiver. The DSS Division of Adult Services and Aging (ASA) was responsible for administering the Home and Community-Based Options for Person Centered Excellence (HOPE) waiver until the transition of ASA from DSS to DHS occurred in April 2017. On July 1, 2017, ASA's transition from DSS to the DHS resulted in the creation of the Division of Long Term Services and Supports (LTSS)

within DHS. The LTSS is responsible for administering PCS under the State Plan to beneficiaries participating in the HOPE waiver.

There is a memorandum of understanding (MOU) in existence between DSS and DHS. However, a new MOU is being drafted to address the changes occurring in the organizational relationship between DSS and DHS as a result of creating the new LTSS division. Both DHS and DSS also anticipate updating the existing MOU to be inclusive of the HOPE waiver's transition to DHS. The Internal Waiver Review Committee (IWRC) is comprised of the waiver managers for each waiver and representatives from the DSS Division of Medical Services. The IWRC meets quarterly to review each waiver's performance measures. The executive leadership of both DHS and DSS also meet quarterly to discuss issues affecting both agencies. The staff of both the DSS and DHS also meet on a monthly basis to discuss claims issues; waiver and Medicaid updates; provider and staff training; and other items introduced by either agency. Although meetings occur between DSS and DHS, there is no formal interagency agreement between divisions outlining job responsibilities within DSS or DHS.

The PCAs employed by PCS providers are required to be competent in certain skill areas, however, there is no formal requirement for competency evaluation. The Family Support 360 and ADLS waivers offer participant-directed services under the "Agency With Choice" model. The "Agency With Choice" model is a co-employment arrangement between a provider and a participant. The provider is the employer of record and the participant is the managing employer. The participant and the participant's family (or guardian) may play an active role in the recruitment, interviewing, selection, training, and supervising of employees providing the service, however the provider does the actual hiring. In the Family Support 360 waiver, training for PCAs is at the discretion of the participant and the plan of care must outline who is responsible for providing the training in each necessary skill area. In the ADLS waiver, training for PCAs is the responsibility of the participant.

Summary Information of the State Plan Services and Waivers Reviewed

Currently, South Dakota offers personal care services under the Medicaid state plan and the following three Medicaid HCBS waiver authorities: HOPE, Family Support 360, and ADLS. The provision of PCS 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
State Plan PCS Implemented 12/11/2003	State plan authority	Provider managed service delivery model	South Dakota Medicaid
HCBS Implemented 10/01/1988 Implemented 10/01/1998 Implemented 06/01/1994	Section 1915(c) Section 1915(c) Section 1915(c)	Waivers HOPE Family Support 360 ADLS	DHS-LTSS DHS-DDD DHS-DRS

State plan PCS is provided in the recipient's home or recipient's place of employment, as prescribed in accordance with a plan of treatment. Also, these services are provided by a qualified individual who is not a member of the recipient's family.

South Dakota requires its PCAs to be competent in certain skill areas; however, there are no defined state standards existing for PCA certifications. The DOH is the regulatory agency for PCAs and it currently does not license or set certification standards for PCAs or agencies providing PCS. Home health agencies referenced by DSS are providers that are recognized as a Medicare-certified home health agency (HHA). Recognition as a Medicare-certified HHA is a condition of participation in the South Dakota Medicaid program for HHA providers. Outside of the Medicare-certified HHAs, the standards for PCAs for other providers of PCS such as in home supportive care, Family 360, and ADLS providers have been left to the discretion of each provider.

The HOPE PCS waiver is delivered under a provider managed service delivery model. This waiver was previously administered by the ASA in the DSS. As previously mentioned, the ASA moved from DSS to DHS in April 2017 and became LTSS. The HOPE waiver provides services to adults age 65 and older, and also to adults with a qualifying disability over the age of 18; the PCS is delivered to the recipients in their homes or the least restrictive community environment available to them.

The HOPE waiver is intended to reduce unnecessary nursing facility care by providing individuals with community-based services to remain at home or in their communities as long as they remain safe and/or choose to live there. The beneficiary must reside in his or her own home, or live with a family member. To prevent duplication of services and to ensure that the beneficiary's comprehensive needs are met, the home health service (HHS) or PCS plan of care (POC) must include all services and unpaid supports provided to the beneficiary regardless of the funding source. The HHS or PCS provider is required to coordinate and communicate with caregivers, legal representatives or unpaid sources, providers of other services, and/or a state service worker or case manager assigned to the beneficiary. The HHS or PCS providers are reimbursed for services in units of time, with each unit equaling 15 minutes.
Family Support 360 PCS waiver is delivered via both participant-directed and provider managed delivery models. Services in the waiver are predominately delivered through participant

direction and are administered by the DDD in the DHS. The South Dakota Family Support 360 waiver is for participants with intellectual or developmental disabilities, and is utilized by participants who self-direct their services and supports. When used in conjunction with non-waiver Medicaid services and other generic services and natural supports, the Family Support 360 waiver services provides for the health and developmental needs of participants to allow them to remain in their homes and communities.

The ADLS PCS waiver PCS is predominately delivered through participant direction, but in specific circumstances, the provider managed delivery option is utilized to supplement participant direction. The waiver is administered by the DRS in the DHS. The ADLS Waiver Program is intended to support eligible individuals with quadriplegia, and assist them to live independently in their homes and in the communities of their choice as an alternative to living in a nursing home.

PCS Expenditure Information

South Dakota's total Medicaid expenditures in federal fiscal year (FFY) 2016 were approximately $841.0 million and covered almost 149,026 beneficiaries as of July 2017. South Dakota's total Medicaid expenditures for PCS in FFY 2016 was approximately $7.7 million. The unduplicated number of beneficiaries who received PCS in FFY 2016 was 1,559. 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 125. South Dakota does not participate in Medicaid expansion. The Federal Medical Assistance Percentage for South Dakota for FFY 2016 was 51.61 percent.

Table 2.

State Plan and 1915(c) Waiver Authority Service/Program	**FFY 2014**	**FFY 2015**	**FFY 2016**
State Plan Authority PCS model	**$130,101**	**$149,573**	**$158,692**
HOPE	**$3.3 million**	**$3.8 million**	**$3.7 million**
Family Support 360	**$101,761**	**$76,864**	**$102,810**
ADLS	**$2.9 million**	**$2.7million**	**$3.8 million**
Total Expenditures	**$6.3 million**	**$6.5 million**	**$7.7 million**

The PCS expenditures overall remained consistent with some gradual increase demonstrated during the three FFYs reviewed. However, the ADLS waiver experienced an almost 41 percent increase in expenditures from FFY 2015 to FFY 2016. This was attributed to the level of care needed for beneficiaries receiving PCS under this waiver. Specifically, in calendar year 2015 the ADLS waiver providers were permitted to utilize the higher end of the per unit rate for PCAs. This was an increase from $5.04 per unit to $5.88 per unit (or $3.36 per hour increase). This was done to enable providers to attract and retain PCAs with skill sets necessary to meet the unique needs of participants in the ADLS waiver.

Table 3.

	FFY 2014	FFY 2015	FFY 2016
Total PCS Expenditures	**$6.3 million**	**$6.5 million**	**$7.7 million**
% Agency-Directed PCS Expenditures	53.4%	57.0%	49.4%
% Self-Directed PCS Expenditures*	46.6%	43.0%	50.6%

*Self-directed PCS is provided under the Family Support 360 and ADLS waivers only.

A larger portion of PCS expenditures were allocated to agency-directed services in South Dakota during two of the three FFYs reviewed. The trend in self-directed PCS expenditures was slightly less for two FFYs than the monies expended on agency-directed PCS delivered. Overall, the trend in the percentage of expenditures attributed to each of the PCS delivery models demonstrated little variance during the time periods reviewed. As previously mentioned, 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.

Table 4.

State Plan and 1915(c) Waiver Authority Service/Program	FFY 2014	FFY 2015	FFY 2016
State Plan Authority PCS model	308	361	358
HOPE	950	1,068	1,055
Family Support 360	43	43	43
ADLS	106	107	103
Total Unduplicated Beneficiaries*	**1,407**	**1,579**	**1,559**

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

The CMS review team noted that the ADLS waiver had a lower number of unduplicated beneficiaries receiving services and the highest overall expenditures. This was attributed to the level of care needed for beneficiaries receiving PCS under this waiver. The ADLS waiver supports eligible individuals with quadriplegia to live independently in their homes.

Overall, PCS expenditures and the number of unduplicated beneficiaries receiving PCS services remained constant with some gradual changes during the three FFYs reviewed. As previously mentioned, correlation between expenditures and the number of beneficiaries varies. This was noted for the ADLS waiver which had a lower number of unduplicated beneficiaries receiving services and the highest amount of overall expenditures, due to the level of care that its beneficiaries require.

State Oversight of PCS Expenditures

During the onsite review, a written MOU or contract between DSS and DHS to support oversight responsibilities did not exist; however, there is limited collaborative and coordinated effort between the agencies that have administrative responsibilities over the state plan services and waivers, largely due to the newly created LTSS unit. The interagency oversight structure and

business processes are currently being redefined in the new MOU. In addition, during the interview with the CMS review team, the DHS staff acknowledged that the PCS expenditure oversight function was the responsibility of the DSS's Surveillance and Utilization Review Services (SURS) unit until the processes between these two entities can be defined in an MOU. The SURS audit plan is currently under development.

The post-payment data analytics toolkit contains six reports pertinent to medical care provided through the waiver programs, including PCS. These reports are run at designated intervals by the state Medicaid agency's program integrity staff and are a central component of the audit plan. The data analytics toolkit is paired with a case investigation tracking form that is integrated into the current program integrity log or case tracking system. These tools provide surveillance of claims data, which leads to deeper levels of auditing based on trends and patterns observed in the claims data. Auditing may also be elicited in response to investigations stemming from complaints that the agency receives regarding fraud, waste, and abuse. Both PCS and self-directed care programs are subject to the audit plan, since all South Dakota Medicaid providers submitting claims for payment are included in this plan.

Table 5.

	FFY 2014	FFY 2015	FFY 2016
Findings	0	0	1*
Identified Overpayments	$0	$0	$500
Recovered Overpayments	$0	$0	$500
Corrective Action Plans	0	0	0
Terminated Providers	0	0	1
Suspected Fraud Referrals	0	0	1
# of Fraud Referrals to Medicaid Fraud Control Unit (MFCU)	0	0	1

*The state successfully prosecuted one provider during FFY 2016

Overall, South Dakota's activity regarding post payment actions taken was low. During FFYs 2014 and 2015, there were no findings, overpayments identified or recovered, corrective action plans, provider terminations, suspected fraud referrals, or fraud referrals made to the MFCU related to PCS. This was the result of not conducting any provider reviews. The only investigative activity noted occurred during FFY 2016. During this time period, the state reported one finding, an overpayment identified and recovery of $500 and minimal post payment actions taken.

Section 2: Personal Care Services 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.

The DSS Division of Medical Services' Provider Enrollment section is responsible for enrolling providers into Medicaid through an online application process. Provider Enrollment reviews and processes the applications to enroll or add modifications to existing providers, and includes DHS when appropriate. In addition to the online application, certain supporting documentation must be sent via email, fax, or mail following application completion. Applications and accompanying documentation not completed and received within 30 days of the application start date will be rejected or denied. Providers may not proceed with the process utilizing applications that have been either rejected or denied. Provider Enrollment will require the provider to begin the application process again. Medicaid enrollment in South Dakota is centered upon utilization of the unique ten digit identification number issued by CMS to health care providers known as the National Provider Identifier (NPI) and there may be multiple locations noted on a single application.

Summary of Information Reviewed

Providers of PCS other than HHAs are not required to be licensed or certified to provide services. All entities providing PCS are required to have an NPI and be enrolled, however PCAs employed by those entities are not enrolled or provided with a unique numerical identifier. While onsite visits to verify location are always completed as a condition of enrollment, the visits are not always conducted by DSS Provider Enrollment staff. Onsite visits may be completed by DSS Provider Enrollment staff, DHS staff, or DSS staff acting at the direction of the DSS Provider Enrollment unit. The DSS conducts ongoing monthly U.S. Health and Human Services-Office of the Inspector General (HHS-OIG) and System for Award Management (SAM) database checks for owners and managing employees.
The LTSS staff (under the HOPE waiver) determines what conditions specific to the program are met and documented, such as those outlined in the In-Home Supplemental Agreement. The LTSS requires the provider to complete the following forms: *Provider Self-Assessment, Business Associates Agreement, Private Pay Rate Verification, Provider Questionnaire, Supplemental Agreement, W-9,* and *Health Insurance Attestation*. In addition, DHS staff determines what conditions specific to the ADLS and Family Support 360 waiver programs and outlined in the contract are met, such as the qualifications of any individual acting as the consumer preparation specialist.

State Oversight

As required by 42 CFR 455.450, the state has implemented the screening level provisions, based on the assigned level of risk for directly enrolled PCS providers. During onsite interviews with the state, the CMS review team confirmed that the implementation of the fingerprinting-based criminal background check requirement was not fully implemented, as required, by July 1, 2017. However, the State provided correspondence to the review team from CMS's Provider Enrollment and Oversight Group, extending the deadline of implementation to July 1, 2018. In addition, the state has implemented the federal database checks for 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 HHS-OIG's List of Excluded Individuals and Entities (LEIE) and the SAM monthly after enrollment/reenrollment as required at 42 CFR 455.436(c)(2).
The DSS relies on DHS to ensure PCS provider agencies do not employ individual PCA or PCS providers who have been terminated by Medicaid, revoked by Medicare, or convicted of a health

care-related criminal offense. The DHS conducts random agency checks to confirm that the PCS agencies are performing the required database checks to ensure that PCS provider agencies do not employ individual PCA or PCS providers who have been terminated or denied enrollment. The DSS staff acknowledged that checks conducted through the TIBCO Managed File Transfer Internet Server Web Interface (TIBCO MFT) were not occurring and has attempted to get the situation resolved through CMS. CMS is currently working with the state to remedy the technical difficulties with the TIBCO MFT system, which would help the state become compliant.

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

Summary of Information Reviewed

As previously mentioned, South Dakota's Medicaid self-directed PCS program operates under the two HCBS waivers authorities; those waivers are ADLS and Family Support 360. The ADLS waiver utilizes the standard Medicaid payment mechanism. Only the Family Support 360 waiver program utilizes qualified financial management services (FMS) providers. The qualified FMS provider employs support coordinators who work with participants to authorize payment of goods and services in the approved service plan via the *FOCoS Innovation* (*FOCoS*) software. The qualified provider also serves as the "Agency With Choice". This model encourages consumers and their advocates to be directly involved in the planning, scheduling, hiring, and maintenance of their support workers. These services are authorized through *FOCoS* which allows the participant or support coordinator with access to all employment-related forms required for signature/submission. The *FOCoS* software also computes payroll deductions which are downloaded into the accounting system of the "Agency With Choice"; this facilitates the issuance of payroll checks, and performs other necessary bookkeeping and audit functions. The "Agency With Choice" then bills the Medicaid Management Information System (MMIS) utilizing a *FOCoS*-generated electronic billing based on the authorized services paid.

State Oversight of Self-Directed Services

The DSS conducts quarterly reviews of POCs and performance matrix for recipients in the self-directed program. Qualified waiver providers are required to conduct and submit an annual independent audit and undergo a DHS billing review. Independent audit firms conduct the annual audit according to generally accepted accounting practices and procedures. Audits must be submitted to the DHS by the first day of November annually, and are reviewed by DHS fiscal staff to ensure compliance and identify any irregularities which are reported to the DSS. Each provider is required to participate in a biennial billing review conducted by a DHS auditor during which a random sample of claims is examined to ensure and validate the accuracy of record keeping, supporting documentation, and claim submission. The auditor reports the findings to the DHS waiver manager and the findings report is forwarded to the DSS. The DHS waiver manager may require a plan of corrective action to address identified issues. This plan is also submitted to the DSS for review/approval.

In addition, all claims adjudicated through the MMIS are under the authority of the SURS unit. The SURS unit is staffed with investigators who review paid claims for inappropriate or incorrect payments to providers, and implement any required corrective actions. Financial

transactions and claim submissions are also monitored as a component of the Payment Error Rate Measurement (PERM) process required by CMS. Waiver claims are included in the sample population for PERM and are also reviewed for accuracy. The DHS monitors the *FOCoS* (formerly Greystone Consumer Empowerment Systems) contractual obligations annually upon contract renewal and reports any negative findings to the DSS.

Participants recruit, screen, train, and direct their PCAs delivered under the ADLS waiver authority, which is not the case with state plan PCS. The ADLS waiver encourages the employment of spouses, parents or adult children to provide services. Participants are not able to access both state plan services and waiver services for PCS simultaneously. If a participant chooses not to or is unable to self-direct, the participant may appoint someone to act on their behalf. Otherwise, they are directed to LTSS waiver staff. In specific circumstances, the ADLS participant is allowed to utilize PCS through an in-home services provider agency. Participants may also choose to utilize in-home services providers where the agency manages the attendant care employee, and retains responsibility for hiring and fiscal responsibilities. This option supplements the self-directed hiring of their PCAs through a contracted provider agency.

Reviews are conducted under the ADLS waiver authority with each qualified provider receiving an annual claims audit. The ADLS waiver manager evaluates the volume of provider claims reviewed to ensure the required number of claim reviews have been completed. The DHS service coordinators and ADLS participants retain the responsibility for monitoring the service plan to ensure that the PCA provider is skilled and that training has been provided. The participant is expected to direct their own care and to participate in the training of their PCA. The home health agency supports the participant throughout this process by providing consumer preparation services.

There are two DHS service coordinators and both positions are supervised by the ADLS waiver manager. The Family Support 360 support coordinator is responsible for assisting participants within the self-directed program along with family members, under the direction of the waiver manager. The DSS SURS unit is responsible for conducting audits on PCS providers participating in the self-directed program.

During the onsite interview, the states disclosed that there have been no direct findings or recoveries resulting from these audits in the three FFYs reviewed. The DSS staff also stated that there were approximately ten claims identified as errors in the state's FFY 2013 PERM for self-directed providers. It was determined that claims were submitted on the *UB-04* claim form and omitted the attending/rendering provider. The state changed their billing guidance and began utilizing a professional claim form as of October 1, 2016 to correct this error.

Both DSS and DHS staff disclosed that they have not issued any Recipient Explanation of Medical Benefits (REOMBs) to verify PCS rendered by the individual PCAs participating in self-directed programs under the state plan or waiver. However, the state did provide documentation that other beneficiary services are being verified outside of the PCS program.

Section 4: Electronic Visit Verification

Overview of the State's Electronic Visit Verification 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 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.

South Dakota does not utilize electronic visit verification (EVV) for in-home scheduling, tracking and billing of PCS. However, some PCS providers had an EVV system at this time of this review. The state anticipates DHS having a system in place by the end of 2018. Pursuant to Section 12006 of the 21st Century Cures Act all states are required to implement an EVV system for PCS by January 1, 2019.

Section 5: Personal Care Service Providers

Overview of the State's PCS Providers

Providers of PCS deliver supports to Medicaid eligible beneficiaries in their own home or communities who would otherwise require care in a medical institution. These non-medical services assist beneficiaries who have limited ability to care for themselves because of physical, developmental, or intellectual disabilities or conditions. These non-medical services also assist beneficiaries with ADLs. During the time of the onsite review there were 125 providers contracted directly with the state as PCS providers.

Provider Oversight of PCS

Avera at Home

Avera at Home (Avera) is an integrated health system based in Sioux Falls, South Dakota and has been providing PCS services since November 1, 2013. Avera provides Medicaid PCS to eligible beneficiaries under the HOPE waiver, and State Plan Avera serves South Dakota through five regional centers located in the cities of Aberdeen, Mitchell, Pierre, Sioux Falls, and Yankton. Avera served 199 Medicaid beneficiaries and had approximately 79 PCA staff members during FFY 2016. Avera has maintained 23 supervisory personnel for the last three FFYs.

Avera does have a compliance officer, compliance program, and compliance policies and procedures in place. Avera does not have a compliance committee; however, the Avera at Home Health and Hospice Operations Council serves as the compliance committee, and receives a quarterly report of all audits and actionable quarterly. Also, the Council is responsible to approve the yearly compliance plan, and provide direction to relative to all audits and findings the director of quality and quality specialists.

Avera's compliance department establishes goals and defines the actions to achieve those goals. Avera does implement internal audits of client and personnel files. Avera conducts mandatory fraud, waste, and abuse trainings upon hire, and yearly thereafter. Avera ensures employees and PCAs are receiving training on Medicaid PCS fraud and abuse by utilizing an online training tracking system.

Avera utilizes a contractor to perform pre-employment background checks. Employment is contingent upon successful completion of the background investigation process. All applicants are screened and interviewed. In addition, all applicants offered employment, in addition to any individuals entering into contracts with Avera, are screened to ensure they are not on the HHS-OIG's LEIE, SAM, and the National Sex Offender Registry. All employment offers and contracts are contingent upon the successful completion of these registry checks. In addition, all applicants offered employment must sign the appropriate consent forms and undergo a national criminal background check along with any applicable state-conducted background investigation required by state law. The LEIE and SAM screenings will be completed by Avera for all employees on a monthly basis thereafter.

Avera performs both announced and unannounced site visits with the PCAs and beneficiaries at 60-day intervals. Avera does not utilize EVV for in-home scheduling, tracking, and billing of PCS. Instead, Avera uses a copy of the client's *Services Task List* sign-off sheet to monitor tasks performed by the PCA, which is then signed by the client.

Interim HealthCare of the Black Hills

Interim HealthCare of the Black Hills (Interim HealthCare) is a locally owned and operated Medicare and Medicaid certified home health agency provider with three locations within South Dakota. Established in 1993 and headquartered in the state, Interim HealthCare has offices located in Rapid City, and Spearfish. Services are delivered in-home and centered on individual needs; achieving the care needed utilizing nursing; personal care and home health aide services; and physical, occupational, and speech therapies. Interim HealthCare served 118 Medicaid beneficiaries, and employed approximately 63 PCA staff and 20 supervisory staff during FFY 2016. Interim HealthCare provides Medicaid PCS services to eligible beneficiaries under the State Plan and HOPE waiver.

Interim HealthCare does have a compliance officer, compliance program, and compliance policies and procedures in place. Interim HealthCare does not have a compliance committee. Interim HealthCare does implement internal audits of client and personnel files. These internal audits are conducted by corporate staff, however, they do not maintain records. Interim HealthCare conducts mandatory fraud, waste, and abuse trainings upon hire, and yearly trainings thereafter. Interim HealthCare ensures employees and PCAs are receiving training on Medicaid PCS fraud and abuse, and maintains documentation in their employees' files.

Interim HealthCare utilizes contractors to perform pre-employment background checks. Prospective Interim HealthCare employees are required to sign an authorization form agreeing to background checks. In addition, Interim HealthCare conducts an HHS-OIG exclusion check upon hire and monthly thereafter utilizing their Riversoft Data System. Interim HealthCare does perform both announced and unannounced site visits for the PCAs and beneficiaries monthly. Interim HealthCare does not utilize EVV for in-home scheduling, tracking, or billing of PCS.

Spectrum Home Care

Spectrum Home Care (Spectrum) is an in-home care provider serving two locations, Fargo, North Dakota and Sioux Falls, South Dakota. Spectrum Health Care provides either skilled medical or non-medical, or home maker support services. Spectrum has provided PCS in the state of South Dakota for 17 years. Spectrum served 28 Medicaid beneficiaries, and employed

approximately 45 PCAs and two supervisory personnel during the three FFYs reviewed. Spectrum provides Medicaid PCS services to eligible beneficiaries under the State Plan and HOPE waiver.

Spectrum does not have a compliance officer, compliance program, or compliance committee. Spectrum's two-person management team fulfills the responsibility of the compliance committee. Spectrum's policy handbook serves as the compliance policies and procedures. The areas of compliance focused on within the handbook are: hiring, timekeeping, ethical behavior, and training protocols.

Spectrum mentioned to the review team that they do not conduct routine monitoring and auditing; however, Spectrum provided the CMS review team with documentation stating that it performs quarterly drop-in visits on each employee while they are performing PCS at the consumer's residence. A telephonic audit of each consumer is also conducted at least quarterly. The results are documented in a spreadsheet and placed in the employees' files to reflect drop-in visits. Spectrum also indicated that they are moving toward an electronic filing system.

New hires at Spectrum receive two hours of orientation initially and, thereafter, adhere to DHS's annual training requirements of six hours. Policies and procedures are reviewed as part of each prospective employee's orientation. Spectrum ensures that its employees and PCAs receive training on Medicaid PCS fraud and abuse. Routine monitoring and auditing of timesheets are conducted.

Spectrum does not utilize an EVV system. The PCA is provided a data sheet for each consumer. These datasheets indicate services that are to be provided, units allowed, arrival and departure times, and services provided. Management completes the billing and timesheets are not signed by beneficiaries. Timesheets are compared with data sheets and calendars to ensure compliance. Management reviews the logs and timesheets.

Spectrum does not use an outside source to conduct background checks prior to PCA employment. Instead, Spectrum utilizes HHS-OIG exclusion databases, in conjunction with the South Dakota Unified Judicial System, to search for any criminal convictions. These checks are performed upon hire and during annual evaluations. An employee signs an attestation statement indicating that they have not been involved in any type of criminal activity. During the interview with Spectrum, they disclosed that their criminal history checks on employees were conducted utilizing the South Dakota Unified Judicial System. The CMS review team determined that the scope of these criminal history background checks had limitations. The checks contained information pertaining to activities occurring within state alone and did not capture any information regarding activities that may have occurred elsewhere.

Homecare Services of South Dakota, Inc.

Homecare Services of South Dakota, Inc., (Homecare Services) is a private agency providing specialized care to clients who wish to live independently at home. Homecare Services provides a full range of in-home support services throughout South Dakota and into Minnesota. They have nine locations across South Dakota including the cities of: Pierre, Huron, Mobridge,

Brookings, Spearfish, Watertown, Waubay, Madison, and Sioux Falls; in addition, the agency has an office located in Lyon, Minnesota. Homecare Services served 101 Medicaid beneficiaries, and had approximately 375 PCA staff and 47 supervisory personnel during FFY 2016. Homecare Services provides Medicaid PCS services to eligible beneficiaries under the State Plan and HOPE and ADLS waivers.

Homecare Services does not have a formal compliance officer or a compliance committee. However, the agency has identified the following staff positions as fulfilling the job responsibilities of a compliance officer/committee: assistant agency director, regional support coordinator, agency operations manager, agency operations manager-administrative assistant, branch coordinators, and assistant branch coordinators. Although Homecare Services does not have a formal compliance program, the agency identified the following documents as meeting the requirements of a compliance program: *Ethical Standards, Employee Selection Policy, Employee Hiring How To, Employment Application, Authorization to Verify Information for Background Checks, Employee Performance and Appraisal Policy, Employee Performance Review How To, Employee Evaluation Form, Staff Orientation and In-Service Policy, Training Policy Outline, Homecare Billing and Payroll System Guide, T19 and ADLS Billing Procedure, List of Preferred Practices, Quality Assurance Policy,* and *Risk Management Guide*.

Homecare Services does perform internal audits of client and personnel files. The Pierre office has the primary responsibility of implementing the risk management objectives of the agency to ensure its operations are not impaired by loss. At the agency's branch offices, management conducts loss control audits. Once these audits are completed, agency administration is provided with a written report outlining any findings and recommendations. The branch coordinator reports directly to the agency head and serves as the liaison between the branch office and the Pierre office. Timesheets are monitored on a weekly basis by the branch coordinator or assistant branch coordinator. The visit reports are compared to each PCA's timesheet and schedule. This process is outlined in the agency's guidelines for processing timesheets and documentation policy.

Homecare Services' regional support coordinator is responsible for assisting in the development and continued training for staff, monitoring the agency's service delivery mechanism, ensuring branch coordinators are adhering to preferred practices, and following up on consumer complaints. Homecare Services' branch coordinators and assistant coordinators receive and review caregiver and nurse documentation for each visit, and follow up with consumers and/or caregivers regarding all documented issues. Coordinators and assistant coordinators conduct annual visits, at a minimum, to the consumer's home to monitor services. This visit is documented using the *home visit* form. Also, a *first visit* training session is performed at the consumer's home for all caregivers; this includes a coordinator accompanying the caregiver to the home. Formal evaluations are performed on each caregiver and goals are established for the next evaluation period. These evaluations are performed after the first 90 days and annually thereafter.

All applicants offered employment, and any individuals entering in to a contract with Homecare Services, will be screened to ensure they do not appear on the HHS-OIG's LEIE and SAM. After applicants have been hired, random HHS-OIG and GSA screening checks are performed by Homecare Services as time allows, and routinely on an annual basis.

Homecare Services does not utilize an EVV system for in-home scheduling, tracking, and billing of PCS. Instead, Homecare Services uses *visit reports* to monitor tasks performed by the PCAs, which are then signed by the clients for the ADLS waiver services. There is no verification of services rendered for the HOPE waiver or state plan services, other than the first and annual visits, unless there is a complaint received. During the onsite interview with Homecare Services, it was disclosed that they were not aware DSS had a fraud, waste, and abuse hotline; however, this information was posted on the state's website. In addition, the agency were unaware which waiver authority they were providing services under, although the state forwarded an update regarding the name changes for their PCS waivers to all home health agencies.

During the onsite interviews, the CMS review team also observed that the four PCS providers had various compliance programs; however, the state has not established guidance to the PCS providers related to their expectation for a compliance program and to establish continuity.

Recommendations for Improvement

- Modify the MOU between the state and its sister agencies to better address PCS monitoring, strengthen oversight, and improve the lines of communication.
- The state should develop written policies and procedures, or an interagency agreement that outlines which state unit will be responsible for the various program integrity-related oversight functions.
- The state should ensure that the SURS audit plan clearly identifies the program integrity efforts required to both initiate and improve investigations and audits used to identify and recover improper payments related to PCS.
- Develop policies or procedures establishing minimal requirements and/or standards for PCAs to include certification requirements and consider assigning a unique identifier to each PCA to facilitate tracking of each PCA's work.
- 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 DSS should consider the requirement to routinely conduct home health agency visits, during the enrollment process, to verify provider location.
- Implement the provider enrollment provision of fingerprinting based on assigned level of risk to assist with the reduction of improper payments being made to ineligible providers by July 1, 2018.
- Take actions to ensure that PCS provider agencies do not employ individual PCAs who have been terminated by another Medicaid program or convicted of a health-care related criminal offense. Restore TIBCO credential checks and continue utilizing database as required by uploading and downloading terminated providers.
- The state should monitor the delivery of PCS furnished to beneficiaries under both the state plan and waiver authorities through the utilization of the REOMB verification process in effort to improve the return on investment.
- The state should require that both announced and unannounced onsite visits continue to be conducted at appropriate intervals for PCS providers and PCAs.
- Provide additional training to PCS providers on updated rules and regulations, so they are more aware and informed on changes and updates. In addition, the state should establish guidance on the basic requirements for all PCS providers regarding compliance program structure to ensure continuity within its Medicaid PCS program.

Section 6: Status of Corrective Action Plan

South Dakota's last CMS program integrity review was in April 2013, and the report for this review was issued in January 2015. The report contained three vulnerabilities. During the onsite review in July 2017, the CMS review team conducted a thorough review of the corrective actions taken by South Dakota to address all issues reported in calendar year 2013. The findings of this review are described below.

Vulnerabilities –

1. ***Risks were identified in the state's program integrity operations and oversight in the following areas: low staffing levels; lack of dental contractor oversight; lack of written policies and procedures; permissive exclusion authority is underutilized; and the case tracking system has limitations.***

   Status at time of the review: Corrected

   In addition to the staff of four FTEs allocated to the SURS unit, additional resources and other staff members are utilized to assist SURS in its program integrity efforts. The SURS unit has also developed tools to make more efficient use of SURS staff time. Under the National Coding Initiative, South Dakota employs over 500 additional internal MMIS edits designed to deny claims that contain errors or that do not meet service limitations of the Medicaid state plan. The SURS unit runs a weekly systems report which contains a random sampling of claims that appear to have been improperly submitted. The staff is now able to attend all training regarding issues related to Medicaid integrity, fraud detection, and utilization. Data mining training is ongoing.

   The DSS has monthly meetings with the MFCU to discuss cases of suspected fraud. The DSS meets quarterly with the MFCU and other agencies. The DSS also ensures program integrity activities are handled efficiently across Medicaid and establish a formalized agreement to open communications with DHS. The state has exemption to recovery audit contractor requirements. The staff has also been refocused and a stronger emphasis has been placed on investigations.

   Program integrity is now addressed in the state's contract with Delta Dental, and is monitored by the SURS unit and an independent audit firm. The SURS unit and Delta Dental meet on a quarterly basis. These meetings discuss any change to policy and potential fraud cases.

   The DSS has been compiling its policies and procedures related to the permissive exclusion authority into a central location. When deficiencies are noted a policy is researched and created. Providers are terminated/excluded for fraud. All suspected fraud cases are investigated and documented in the program integrity database. Suspected fraud cases are referred to the MFCU from the SURS unit. Database samples and the current policy regarding MFCU referrals were supplied to the CMS review team. The MFCU and DSS work collaboratively to support integrity of Medicaid program. If

MFCU's investigation (or the HHS-OIG) supports a credible allegation of fraud, the provider is terminated/excluded by DSS. The policy for payment suspensions was revised on October 1, 2014.

2. ***Risks were identified in the state's process for suspension of payments in cases with credible allegations of fraud.***

   Status at time of the review: Corrected

   South Dakota Medicaid has created a policy on October 1, 2014, which addresses SURS preliminary investigations, credible fraud referrals, and payment suspensions. Providers have received and continue to receive written notice regarding being placed on suspension. The DSS has developed a standardized provider notification letter for suspension of payment in accordance with the federal regulation.

3. ***Risks were identified in the state's provider enrollment practices and reporting in the following areas: exclusion searches; ownership and disclosures; business transaction disclosure; criminal offense disclosures; notification of adverse actions to HHS-OIG; provider screening and enrollment; verification of provider licenses; National Provider Identifier; screening levels for Medicaid providers; and the application fee.***

   Status at time of the review: Corrected

   Overall, the state has updated and continues to amend the provider agreement to more clearly articulate provider expectations identified from the prior CMS review team's findings as well as those issues recognized by the state. Trading partner agreements are also being reviewed. The state has created forms to supplement their online enrollment process, since they are presently unable to update their web-based system. Also, an MOU has been created regarding site visits for emergency vehicles, which are being conducted by another state agency.

   The state conducts exclusionary checks against the HHS-OIG's LEIE and SAM for all new providers, and their associated owners and managing employees at the time of enrollment. The state reviews monthly files and/or extracts regarding actions taken against existing providers from SAM and the Medicare Exclusion Database. The state has a contract with Truven Health Analytics to automate the exclusionary database searches on HHS-OIG's LEIE and SAM for both new and existing providers, owners, and managing employees. This automated process is currently in "end to end testing" to assess the workflow and functionality of the system. The Truven Health Analytics solution automatically checks all providers, owners, and managing employees monthly, in addition to routine checks in instances where a provider updates the ownership or managing employee data on their electronic enrollment record.

   Currently, the state is unable to modify their web-based system regarding ownership and control disclosure information captured. However, the state have implemented a process requiring the submission of supplementary forms to include the date of birth for a new

enrollment, as well as request the completion of forms by existing owners and managing employees at the time of revalidation. The web-based system modification issue also applied modifications required for issues related to the disclosure of criminal offenses, therefore, the state also implemented a similar process requiring submission of disclosure documentation for provider revalidations. In addition, the state updated the provider directions clarifying that disclosure checklists on new applications apply to the individual practitioners, any owner or controlling interest, and managing employees. Also, the standard vendor contract for Delta Dental is being reviewed and updated by DSS legal staff.

The provider agreement is currently being modified to specify the 30-day timeframe requirement for providers to furnish business transaction information to the DSS and DHHS. In addition to applying to all new providers, this requirement will also pertain to all providers undergoing revalidation.

Adverse actions of waiver providers are reported by the ASA or DHS Waiver Program manager via email to both the Provider Enrollment System (PES) and the SURS Payment Control Officer (PCO). Adverse actions based on dental claim reviews conducted by the dental contractor are reported to the SURS PCO and the PES. The SURS unit provides notice to HHS-OIG and the ALL States Database. Adverse actions during provider enrollment and credentialing are reported to HHS-OIG and ALL States Database by the provider enrollment area through email notification to the SURS PCO. Adverse actions that are the result of MFCU investigations or prosecutions will be reported to by MFCU by forwarding an email to both the SURS PCO and the PES, and copying the HHS-OIG on the correspondence.

In addition, the state is implementing a streamlined enrollment process for ordering, referring, and prescribing providers. The state requires copies of licenses from providers at the time of enrollment. The state also contracts with LexisNexis (Health Market Science was acquired by LexisNexis in 2015) and Truven Health Analytics to ensure that provider licenses are active upon enrollment, as well as ensuring that licenses remain active and in good standing. Also, the state has requested and received approval to be exempt from collecting any application fees.

Technical Assistance Resources

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

- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to South Dakota 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 South Dakota's efforts and encourages the state to explore additional opportunities to improve overall program integrity. The CMS focused review has identified areas of concern which should be addressed immediately.

We require the state to provide a Corrective Action Plan (CAP) for each of the recommendations within 30 calendar days from the date of the report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the weaknesses will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct the compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

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