HB 315

<TARGET><BILL>HB 315</BILL><SUBJECT>HB 315</SUBJECT><COMM>HHSS29</COMM></TARGET>

ALASKA STATE LEGISLATURE

Session:
State Capitol, Room 428
Juneau, AK 99801

Phone: 1 (907) 465-3892
Toll-free: 1 (800) 773-3892
Fax 1 (907) 465-6595

Interim:
716 West Fourth Avenue
Anchorage, AK 99501

Phone: 1 (907) 269-0234
Toll-free: 1 (800) 773-3892
Fax: 1 (907) 269-0238

Email: Rep.Liz.Vazquez@akleg.gov

REPRESENTATIVE LIZ VAZQUEZ
District 22 - Jewel Lake, Sand Lake, Kincaid, Dimond & N. Campbell

MEMORANDUM

Date: Tuesday, March 08, 2016

To: Rep. Paul Seaton

From: Rep. Liz Vazquez LV

Re: HB 315 "Electronic Visit Verification: Medicaid"

Please consider this memorandum as a request for House Bill 315 "Electronic Visit Verification: Medicaid" to be heard in the House Health and Social Services Committee.

Accompanying this memo are the following documents:

- Sponsor Statement,
- HB 315,
- HB 315 Work Draft Committee Substitute,
- Three Press Releases from the State of Alaska, Department of Law (each pertaining to Personal Care Attendant cases),
- An Alaska PCA Providers Association Program overview,
- A Final EVV Alaska PCA Association White Paper titled "Electronic Visit Verification systems for Personal Care Program Accountability,
- Alaska EVV Overview with Pricing and ROI samples,
- Sandata EVV presentation,
- A Brownsville Herald article on Electronic Visit Verification (EVV) for Texas,
- A Dallas Morning News Article,
- A vendor document: "How Will CareWatch Impact Your Agency?",
- Five Facts about Electronic Visit Verification (EVV) for Home Health Agencies,
- A Healthcare article from Information Week,
- Electronic Visit Documentation article from Caring - dated July 2011,
- Three United States Department of Labor documents; an Administrators Interpretation No 2014-2; and two Fact Sheets,

- An Alaska KTVA article titled "State Continues Crackdown on Medicaid Fraud",
- Santrax Payer Management document,
- A Care Embrace document,
- An Experience Outcomes One Pager,
- A Fraud Brochure,
- Florida Clarke Final Evaluation Report,
- An Illinois Home Services Program 2014 Year End Review document,
- A Medicaid Fraud Strike Force 2011 Annual Report, and
- A PCA flow chart.

Thank you for considering our request for a hearing on HB 315. Please contact my Chief of Staff, Anita Halterman, at 465-8422 with any questions.

Explanation of Changes from 29-LS1287\A to 29-LS1287\W

Version W addressed one main change.

1. Upon reviewing the bill as it had been written, I'd realized that home and community based and personal care attendant services are NOT always provided in the home but that sometimes they are provided in other settings. The language change on version W addresses the need for more flexibility with language to accommodate the various settings where services may be provided. The addition of language to allow for "other approved settings" addressed that issue.

Changes from 29-LS1287\W to 29-LS1287\E

Version E keeps the change made in version W and adds a few others as follows:

1. Prior to requesting a hearing over this bill, SDS inquired of our office about the development of the new system they appear to have thought they were to develop in light of language used in versions A and W of this bill. The changes to version H make it clear that the Department shall procure an electronic visit verification system and not develop one of their own. The development of a system would be costly and the Department alerted me on March 16, 2016 that this bill would likely have a $5 million dollar fiscal note, this lead us to understand that they had not understood the intent of this bill. In addition, the changes in version H also add a stipulation that the system must allow providers to electronically document the service in near real-time where it is technically feasible. This will allow us to address allowing more flexibility in remote areas with no telephone, cell phone or computer access. It has been discovered that vendors appear to offer another solution for those settings that actually is entered after the visit occurs. These vendors offer a unique number to assure that the above information is collected and stored when technology solutions are not feasible. The bill ensures that any vendor must be capable of meeting these requirements.
2. The PCA providers have raised issues with a third party employment relationship concern that has been addressed by the Federal Department of Labor and our office felt the need to place assurances in the bill that address this issue. We do not intend to replace the role of the PCA provider or Home and Community based provider agencies in the role of employer. In order to address that concern, we changed the language of the bill in order to ensure the providers still have the ability to be alerted to concerns that need to be managed by the agency. Therefore it seems advisable to add language that requires the vendor to alert the provider agency of any gaps or missed appointments in order for them to remediate the issue. The state also should have the option to receive these alerts and the new CS addresses that issue.
3. The final change addresses integration concerns that agencies raised. Some claim to have proprietary systems that they feel will no longer be usable with a vendor based EVV system. The final version E adds a new section that addresses this by requiring the vendor to integrate any existing EVV systems into the vendor solution.
4. We had leg legal define "real time" as "within a couple of minutes of the occurrence". This was done in order to identify any gaps in service or to allow adult protective service issues to be identified as early as possible for the most vulnerable beneficiaries.

CS FOR HOUSE BILL NO. 315(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES VAZQUEZ, Reinbold

A BILL

FOR AN ACT ENTITLED

"An Act relating to an electronic visit verification system pilot project for providers of personal care services or home and community-based services under the state medical assistance program."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE INTENT. It is the intent of the legislature to

(1) protect vulnerable Alaskans and the integrity of the medical assistance program by reducing the number of fraudulent claims and ensuring that services are provided to medical assistance recipients; and

(2) use technology to improve accountability for personal care services and home and community-based services delivered to medical assistance recipients.

* **Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to read:

ELECTRONIC VISIT VERIFICATION SYSTEM PILOT PROJECT FOR SPECIFIED MEDICAL ASSISTANCE SERVICES. (a) An electronic visit verification system pilot project is established for the purpose of improving accountability for care provided through the state medical assistance program described under AS 47.07. The Department of Health and Social Services shall adopt guidelines for the use of electronic visit verification systems under the pilot project to verify visits conducted to provide personal care services in the home of a medical assistance recipient or other approved setting or visits conducted to provide home and community-based services. In the guidelines adopted under this section, the Department of Health and Social Services shall

(1) establish eligibility guidelines for providers to participate in the pilot project;

(2) require an electronic visit verification system to document, at a minimum, the

(A) name of the provider and the employee or contractor providing the service on behalf of the medical assistance provider;

(B) recipient's name;

(C) date and time the employee or contractor begins and ends the delivery of services; and

(D) location of the delivery of services.

(b) The Department of Health and Social Services may consider a third-party vendor system for the pilot project under this section.

(c) The Department of Health and Social Services shall review the electronic visit verification system or systems implemented under this section and prepare a report making recommendations for the potential statewide application of electronic visit verification systems. On or before July 1, 2018, the Department of Health and Social Services shall deliver the report to the senate secretary and the chief clerk of the house of representatives and notify the legislature that the report is available.

29-LS1287\W
Glover
2/18/16

CS FOR HOUSE BILL NO. 315( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE VAZQUEZ

A BILL

FOR AN ACT ENTITLED

"An Act relating to an electronic visit verification system for providers of personal care services or home and community-based services under the state medical assistance program."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** AS 47.07 is amended by adding a new section to read:

Sec. 47.07.047. Electronic visit verification system. The department shall establish an electronic visit verification system that requires medical assistance providers to verify visits conducted to provide personal care services in a recipient's home or other approved setting or to provide home and community-based services to a recipient. The system must allow providers to electronically document the

(1) provider's name;

(2) recipient's name;

(3) date and time the provider begins and ends the delivery of services; and

(4) location of the delivery of services.

29-LS1287\E
Glover
3/21/16

CS FOR HOUSE BILL NO. 315( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES VAZQUEZ, Reinbold

A BILL

FOR AN ACT ENTITLED

"An Act relating to an electronic visit verification system for providers of personal care services or home and community-based services under the state medical assistance program."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 47.07 is amended by adding a new section to read:

Sec. 47.07.047. Electronic visit verification system. (a) The department shall contract with a vendor to implement an electronic visit verification system that requires medical assistance providers to verify visits conducted to provide personal care services in a recipient's home or other approved setting or to provide home and community-based services to a recipient. The electronic visit verification system must

(1) allow providers to document and transmit information to the vendor in real-time to the extent feasible;

(2) be integrated, to the extent feasible, with electronic visit verification systems currently used by providers;

(3) allow a provider to electronically document the

(A) provider's name;

(B) recipient's name;

(C) date and time the provider begins and ends the delivery of services; and

(D) location of the delivery of services; and

(4) procedures to notify a provider and the department when a vendor identifies a missed appointment or a failure to provide scheduled services.

(b) In this section, "real-time" means concurrent with or within a few minutes of the occurrence of an event.

29-LS1287\E.1
Glover
3/23/16

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE VAZQUEZ

TO: CSHB 315( ), Draft Version "E"

Page 2, line 7, following "(4)":

Insert "include"

29-LS1287\E.2
Glover
3/25/16

A M E N D M E N T

OFFERED IN THE HOUSE BY REPRESENTATIVE VAZQUEZ

TO: CSHB 315( ), Draft Version "E"

Page 2, line 7:

Delete "procedures to notify a provider and the department"

Insert "include procedures to notify a provider"

29-LS1287\N
Glover
4/1/16

CS FOR HOUSE BILL NO. 315( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES VAZQUEZ, Reinbold

A BILL

FOR AN ACT ENTITLED

"An Act relating to an electronic visit verification system pilot project for providers of personal care services or home and community-based services under the state medical assistance program."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE INTENT. It is the intent of the legislature to

(1) protect vulnerable Alaskans and the integrity of the medical assistance program by reducing the number of fraudulent claims and ensuring that services are provided to medical assistance recipients; and

(2) use technology to improve accountability for personal care services and home and community-based services delivered to medical assistance recipients.

* **Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to read:

ELECTRONIC VISIT VERIFICATION SYSTEM PILOT PROJECT FOR SPECIFIED MEDICAL ASSISTANCE SERVICES. (a) An electronic visit verification system pilot project is established for the purpose of improving accountability for care provided through the state medical assistance program described under AS 47.07. The Department of Health and Social Services shall adopt standards for the use of electronic visit verification systems under the pilot project to verify visits conducted to provide personal care services in the home of a medical assistance recipient or other approved setting and visits conducted to provide home and community-based services. In the standards adopted under this section, the Department of Health and Social Services shall

(1) establish eligibility standards for providers to participate in the pilot project;

(2) require an electronic visit verification system to document, at a minimum, the

(A) name of the provider and the employee or contractor providing the service on behalf of the medical assistance provider;

(B) recipient's name;

(C) date and time the employee or contractor begins and ends the delivery of services; and

(D) location of the delivery of services.

(b) The Department of Health and Social Services shall review the electronic visit verification system or systems implemented under this section and prepare a report making recommendations for the potential statewide application of electronic visit verification systems. On or before January 1, 2018, the Department of Health and Social Services shall deliver the report to the senate secretary and the chief clerk of the house of representatives and notify the legislature that the report is available.

29-LS1287\N.5
Glover
4/5/16

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE SEATON

TO: CSHB 315( ), Draft Version "N"

Page 2, following line 19:

Insert a new subsection to read:

"(b) The Department of Health and Social Services may consider a third-party vendor system for the pilot project under this section."

Reletter the following subsection accordingly.

HOUSE BILL NO. 315

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - SECOND SESSION

BY REPRESENTATIVES VAZQUEZ, Reinbold

Introduced: 2/17/16
Referred: Health and Social Services

A BILL

FOR AN ACT ENTITLED

"An Act relating to an electronic visit verification system for providers of certain medical assistance services."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** AS 47.07 is amended by adding a new section to read:

Sec. 47.07.047. Electronic visit verification system. The department shall establish an electronic visit verification system that requires medical assistance providers to verify visits conducted to provide personal care services in a recipient's home or to provide home and community-based services to a recipient. The system must allow providers to electronically document the

(1) provider's name;

(2) recipient's name;

(3) date and time the provider begins and ends the delivery of services; and

(4) location of the delivery of services.

ALASKA STATE LEGISLATURE

Session:
State Capitol, Room 432
Juneau, AK 99801

Phone: 1 (907) 465-3892
Toll-free: 1 (800) 773-3892
Fax: 1 (907) 465-6595

Interim:
716 West Fourth Avenue
Anchorage, AK 99501

Phone: 1 (907) 269-0234
Toll-free: 1 (800) 773-3892
Fax: 1 (907) 269-0238

Email: Rep.Liz.Vazquez@akleg.gov

REPRESENTATIVE LIZ VAZQUEZ
District 22 – Jewel Lake, Sand Lake, Kincaid, West Dimond & N. Campbell Lake

---

House Bill 315

Sponsor Statement

"An Act related to an electronic visit verification system for providers of certain medical assistance services."

The Home and Community Based Personal Care Assistant Services ("PCA") is a vital Medicaid service that provides hands-on assistance to seniors and individuals who have disabilities. PCA services are provided through the Department of Health and Social Services, Senior & Disability Services. In Fiscal Year 2015 Alaska spent approximately 87 million dollars on this Medicaid service. PCA services can provide savings to the state by keeping recipients of this service from living in more expensive facilities such as assisted living homes. However, there is waste, abuse, and sometimes, fraud in delivering home care or personal care services. As a result, millions of dollars are lost. This bill will provide more accountability for PCA services and has the potential to save the state millions of dollars, **between $15 million and $37 million.**

During Fiscal Year 2015 there were 130 criminal convictions for Medicaid fraud in Alaska, 120 of these convictions were related to the PCA program. For example, in December, 2015, Agnes Francisco, a PCA agency owner, was convicted of Medicaid fraud because she authorized employees to submit false timesheets, valued at $529,000, for services not provided to Medicaid recipients. Additionally, she billed Medicaid another $1.03 million for services provided by employees who were not legally authorized to bill the Medicaid program. Fifty other individuals were also convicted of criminal offenses associated with the same PCA agency and seven individuals agreed to civil sanctions for similar conduct.

This bill requires the implementation and use of EVV systems for PCA services in Alaska. The EVV systems monitor and verify home health services delivered by PCAs by tracking whether home visits occurred and the time spent in the home. The EVV system will verify in real time the physical location of the provider (PCA) and the recipient after they both "sign in" and "sign out" of the EVV system. The "sign in" and "sign out" is usually done by land-line or cell phone and the location is verified by the EVV program. Thus, the EVV system reduces waste, abuse and fraud by capturing and reporting actual time worked by the PCA or home care provider.

The goal of HB 315 is to ensure the State only pays providers for approved services rendered by appropriate home health agency personnel while within the recipients' home or other authorized setting. This ensures that Medicaid recipients receive services as authorized. It is anticipated that billing errors, fraud, and abuse will be reduced significantly through verification of home visits through these efforts.

In an effort to address waste, billing errors and fraud in PCA programs, at least 11 states have implemented or are in the process of implementing Electronic Visit Verification ("EVV") systems for PCA or home care services. Several states have realized substantial savings after implementing the use of an EVV system. Below are some specific examples of savings realized in other jurisdictions by implementing an EVV system for PCA or home care services.

- Florida's Agency for Health Care Administration saved $19 million in savings for Miami-Dade County alone in the first year of use and an additional $3.5 million in savings in the second year. Thus, a total savings of $22.5 million were realized during the first two years of implementing the EVV system.
- The Texas Department of Aging and Disability Services reported a 5% to 7.75% gross savings in the first four months of operation, a 5% decrease in hours delivered, and generated about a 3.6% net savings.
- Oklahoma conducted an electronic visit verification pilot and showed an 8% decline in visits each month, reporting a decrease in reimbursed units, and a decrease in per member monthly costs.

As Alaska's population is aging, the demand for PCA and home care services will increase. Accordingly, it is will become increasingly more important to ensure that home care is delivered properly and that publicly funded resources are being managed and spent appropriately. It is anticipated that Alaska has the **potential to realize savings of between $15 million and $37 million dollars.**

Fiscal Note

State of Alaska
2016 Legislative Session

Bill Version: HB 315
Fiscal Note Number:
() Publish Date:

Identifier: HB315-DHSS-SDSA-3-18-16
Title: ELECTRONIC VISIT VERIFICATION: MEDICAID
Sponsor: VAZQUEZ
Requester: House HSS

Department: Department of Health and Social Services
Appropriation: Senior and Disabilities Services
Allocation: Senior and Disabilities Services Administration
OMB Component Number: 2663

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services	212.2		212.2	212.2	212.2	212.2	212.2
Travel							
Services	7.0		7.0	7.0	7.0	7.0	7.0
Commodities	5.0		5.0	5.0	5.0	5.0	5.0
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**224.2**	**0.0**	**224.2**	**224.2**	**224.2**	**224.2**	**224.2**
Fund Source (Operating Only)							
1002 Fed Rcpts	112.1		112.1	112.1	112.1	112.1	112.1
1003 G/F Match	112.1		112.1	112.1	112.1	112.1	112.1
Total	**224.2**	**0.0**	**224.2**	**224.2**	**224.2**	**224.2**	**224.2**
Positions							
Full-time	2.0		2.0	2.0	2.0	2.0	2.0
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes
If yes, by what date are the regulations to be adopted, amended or repealed? 01/01/18

Why this fiscal note differs from previous version:

Not applicable; initial version.

Prepared By: Duane Mayes, Director — Phone: (907)269-2083
Division: Senior and Disabilities Services — Date: 03/18/2016 10:00 AM
Approved By: Sana Efird, Asst. Commissioner, Finance and Management Services — Date: 03/18/16
Agency: Health and Social Services

FISCAL NOTE ANALYSIS

STATE OF ALASKA **BILL NO.** HB315
2016 LEGISLATIVE SESSION

Analysis

The Bill requires the department to implement an Electronic Visit Verification (EVV) System for Medicaid personal care services (PCS) providers to verify services provided to recipients of personal care services. As introduced, the bill places system and administrative costs on the Department.

Three States have passed legislation to implement an EVV system. Two are fully implemented (Texas and Illinois) and one (Ohio) is currently in the procurement process with EVV providers. The Department has consulted with Texas and Ohio. Both indicate that costs for implementation to the State are significant. Ohio reported an initial cost for implementation of $13,000.0 (state share).

The Department's anticipated timeline for system implementation is 24 months. Regulations changes are required.

States indicate that dedicated staffs are required to implement and manage the ongoing operations of an EVV system. SDS will require two full time Health Program Manager II positions for system implementation, internal operational design, the writing of new regulations and policies, and the establishment of sound quality assurances and controls in the management of the EVV system

For the FY2017-2018 start-up period and ongoing:
Two GGU Health Program Manager II positions (range 19 step C) located in Anchroage: Annual Cost per FTE $106.1 Total: $212.2 (50% Federal/50% General Fund)
Commodities: Annual cost per FTE $2.5 Total $5.0 (50% Federal/50% General Fund)
Services: Annual cost per FTE $3.5 Total $7.0 (50% Federal/50% General Fund)

Fiscal impacts for the Senior and Disabilities Medicaid Services component's implementation and maintenance of an EVV system cannot be determined at this time. Based on the Department's conversations with Texas and Ohio, we understand there to be considerable associated fixed costs (operating systems) and variable costs (assumptions on numbers of devices; service of EVV-initial and ongoing; transitions costs; training; 24/7 support), while Texas reports that cost savings from identification of potential fraud and abuse have not materialized to the degree anticipated.

Other states' experience is new enough and limited enough that there is inadequate data for DHSS to estimate costs and savings for the Medicaid Program.

FISCAL NOTE

STATE OF ALASKA
2016 LEGISLATIVE SESSION

Bill Version: **CSHB315**
Fiscal Note Number:
() Publish Date:

Identifier (file name): HB315CS-DHSS-SDSA draft-4-1-16
Title: Electronic Visit Verification
Sponsor: Rep Vazquez
Requester: House HSS

Dept. Affected: Health and Social Services
Appropriation: Senior and Disabilities Services
Allocation: Senior and Disabilities Services Administration
OMB Component Number: 2663

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY17 Appropriation Requested	Included in Governor's FY17 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY17**	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**
Personal Services				106.1	499.9	499.9	499.9
Travel							
Services				3.5	17.5	17.5	17.5
Commodities				2.5	12.5	12.5	12.5
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**112.1**	**529.9**	**529.9**	**529.9**
FUND SOURCE				(Thousands of Dollars)			
1002 Federal Receipts				56.1	265.0	265.0	265.0
1003 GF Match				56.1	264.9	264.9	264.9
1004 GF							
1005 GF/Prgm (DGF)							
1007 I/A Rcpts (Other)							
1178 temp code (UGF)							
	0.0	**0.0**	**0.0**	**112.1**	**529.9**	**529.9**	**529.9**
POSITIONS							
Full-time				1	5	5	5
Part-time							
Temporary							
CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY16) operating costs 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY17) costs 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes
If yes, by what date are the regulations to be adopted, amended, or repealed? 7/1/2018 Discuss details in analysis section.

Why this fiscal note differs from previous version (if initial version, please note as such)

Committee Substitute requires the State to contract with single vendor to implement Electronic Verification.

Prepared by: Duane Mayes, Director — Phone 907-269-2083
Division: Senior and Disabilities Services — Date/Time 4/1/2016 5:30pm
Approved by: Sana Efird, Asst. Commissioner, Finance and Management Services — Date 4/1/2016
Agency: Health and Social Services

FISCAL NOTE ANALYSIS

STATE OF ALASKA **BILL NO.** CSHB315
2016 LEGISLATIVE SESSION

Analysis

As amended, the bill requires the department to contract with a single vendor to implement an Electronic Visit Verification (EVV) System for Medicaid personal care services (PCS) and Home and Community Based Services providers to verify services provided to recipients of these services. The bill also requires that the department receive real-time data on missed appointments.

Dedicated staff is required to implement and manage the ongoing operations of an EVV system. Management of the EVV system inlcudes system implementation, internal operational design, the writing of new regulations and policies, and the establishment of sound quality assurances and controls in the management of the EVV system. This position will also ensure provider compliance with EVV system. SDS will require one full time Health Program Manger II position.

6,500 individuals receive services each day for a total of over 6,289,300 units of service annually. Current practice requires the agencies to remediate when there is a missed appointment or failure to provide services. Receipt of this information at the department obligates the department to take an action to remediate. Over 98% of personal care services are consumer directed. The schedules are often changed and agencies may or may not be notified so the department anticipates receiving hundreds of reports daily. SDS will require one full-time Health Program Manager II and three full time Health Program Manager I positions to receive and remediate reports of missed appointments or a failure to provide scheduled services.

For the FY2019 start-up period and ongoing:
One GGU Health Program Manager II positions (range 19 step C) located in Anchorage: annual cost per position $106.1
Total: $106.1 (50% federal/50% general fund)

For FY2020 and ongoing:
One SU Health Program Manager II position (range 19 step C) located in Anchorage: annual cost $109.3 (50% federal/50% general fund)
Three GGU Health Program Manager I positions (range 17 step C) located in Anchorage: annual cost per position $94.8
Total: $284.5 (50% federal/50% general fund)

Commodities: annual cost per position $2.5 Total $15.0 (50% federal/50% general fund)
Services: annual cost per position $3.5 Total $21.0 (50% federal/50% general fund)

Other changes to MMIS necessary to implement existing state and federal requirements must be completed prior to beginning the system development for an EVV system. The Department anticipates that it will be able to initiate the development and implementation of EVV in FY 19, with a start date of July 1, 2019.

Regulations changes are required.

FISCAL NOTE

STATE OF ALASKA
2016 LEGISLATIVE SESSION

Bill Version **CSHB315**
Fiscal Note Number
() Publish Date

Identifier (file name) HB315CS-DHSS-SDMS draft-4-1-16
Title Electronic Visit Verification
Sponsor Rep Vazquez
Requester House HSS

Dept. Affected Health and Social Services
Appropriation Senior and Disabilities Services
Allocation Senior and Disabilities Medicaid Services
OMB Component Number 2662

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY17 Appropriation Requested	Included in Governor's FY17 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY17**	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**
Personal Services							
Travel							
Services				508.5			
Commodities							
Capital Outlay							
Grants, Benefits				74.9	(2,653.7)	(2,653.7)	(2,653.7)
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**583.4**	**(2,653.7)**	**(2,653.7)**	**(2,653.7)**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts				525.1	(1,326.8)	(1,326.8)	(1,326.8)
1003	GF Match				58.3	(1,326.9)	(1,326.9)	(1,326.9)
1004	GF							
1005	GF/Prgm (DGF)							
1007	I/A Rcpts (Other)							
1178	temp code (UGF)							
		0.0	**0.0**	**0.0**	**583.4**	**(2,653.7)**	**(2,653.7)**	**(2,653.7)**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY16) operating costs 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY17) costs 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes
If yes, by what date are the regulations to be adopted, amended, or repealed? 7/1/2018 Discuss details in analysis section.

Why this fiscal note differs from previous version (if initial version, please note as such)

Committee Substitute requires the State to contract with single vendor to implement Electronic Verification.

Prepared by Duane Mayes, Director
Division Senior and Disabilities Services
Phone 907-269-2083
Date/Time 4/1/2016 5:30pm

Approved by Sana Efird, Asst. Commissioner, Finance and Management Services
Agency Health and Social Services
Date 4/1/2016

(Revised 9/9/15 OMB/LFD)

FISCAL NOTE ANALYSIS

STATE OF ALASKA **BILL NO.** CSHB315
2016 LEGISLATIVE SESSION

Analysis

As amended, the bill requires the department to contract with a single vendor to implement an Electronic Visit Verification (EVV) System for Medicaid personal care services (PCS) and Home and Community Based Services providers to verify services provided to recipients of these services.
EVV requires a provider to record electronically when they arrive and leave. This technology requires the recipient to have a phone or the provider to have a device that can confirm that they are located in the recipient's home when they call in to report their time. If a person does not have a phone or connectivity then the EVV provider can provide a solution at an additional cost to the state. The following assumptions were made to develop the estimated costs for implementation and ongoing maintenance of the EVV system.

Services subject to the requirement for Electronic Visit Verification (EVV): Personal Care Services, Respite, Residential Habilitation, Chore, Intensive Active Treatment (IAT), Nursing Service oversight and care management, Day Habilitation, Specialized Private Duty Nursing.
FY2015 6,472 Individuals receive one or more services listed above.
Estimated Annual Expenditures:
975 individuals (15%) would require an EVV device solution in their home due to no home phone or connectivity. Device solution cost equals $7.00 per member per month.
Estimated annual expenditure for EVV device solution to serve 975 individuals: $ 82.0
Estimated annual expenditure for access fee: $ 40.0
Estimated cost per transaction: $.15 (phone call) each visit totals two transactions. Total transaction fee per visit: $0.30.
Recipients receive multiple visits per day depending upon the service needs of that individual. For example, personal care services can be delivered in the morning and then in the evening. That same person on that same day may also receive Day Habilitation. The state does not monitor actual visits per day per service. To estimate the transactions costs for the EVV the state makes the following assumptions: Each individual receives 2 visits per day ($.60 per day transaction fee), 20 days per month, 12 months a year
Estimated annual transaction fees to serve 6,500 individuals: $ 936.0
FY2020 and ongoing total annual expenditures: $ 1,058.0 (50% federal /50% general fund)
Estimated one-time fees:
Access fee to use vendor software (does not include any custom development) and exchange configuration and testing estimated costs: $ 275.0 (this estimate may increase if system configuration and testing are impacted by the implementation of an interface)
Implementation fee including provider deployment (technical assistance from EVV provider: $ 200.0 lump sum, plus $330.00 per provider times 227 providers = $74.9, for total of $274.9
Training material development, train the trainer instruction and training system set up estimated cost: $33.5
FY2019 total estimated costs for one time fees: $ 583.4 (90% federal/10% general fund)

Other states' experience is varied and there is inadequate data for DHSS to adequately estimate costs and savings for the Medicaid Program. In the State of Texas when implemented to a select group the State realized initially realized an 8% savings however once implemented Statewide the State has realized no cost savings. The State of Washington reports an initial 1.5% decrease in Medicaid claims however billing rates have since returned typical pre-implementation levels. The department assumes that there may be some efficiency in Medicaid claiming and due to those efficiencies estimates approximately a 1.5% savings from the estimated annual expenditures $247,445.3.
FY2010 Total Estimated Savings: $ 3,711.7 (50% federal /50% general fund)

Other changes to MMIS necessary to implement existing state and federal requirements must be completed prior to beginning system development for an EVV system. The Department anticipates being able to initiate development and implementation of EVV in FY 19, with a start date of July 1, 2019. Regulations are required to implement.

FISCAL NOTE

STATE OF ALASKA
2016 LEGISLATIVE SESSION

Bill Version: **CSHB315**
Fiscal Note Number:
() Publish Date:

Identifier (file name): HB315CS-DHSS-HCMS draft-4-1-16
Title: Electronic Visit Verification
Sponsor: Rep Vazquez
Requester: House HSS

Dept. Affected: Health and Social Services
Appropriation: Medicaid Services
Allocation: Health Care Medicaid Services
OMB Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY17 Appropriation Requested	Included in Governor's FY17 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY17**	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**
Personal Services							
Travel							
Services					50.0	50.0	50.0
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**50.0**	**50.0**	**50.0**
FUND SOURCE			(Thousands of Dollars)				
1002 Federal Receipts					37.5	37.5	37.5
1003 GF Match					12.5	12.5	12.5
1004 GF							
1005 GF/Prgm (DGF)							
1007 I/A Rcpts (Other)							
1178 temp code (UGF)							
	0.0	**0.0**	**0.0**	**0.0**	**50.0**	**50.0**	**50.0**
POSITIONS							
Full-time							
Part-time							
Temporary							
CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY16) operating costs 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY17) costs $ 550.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended, or repealed? n/s Discuss details in analysis section.

Why this fiscal note differs from previous version (if initial version, please note as such)

Committee Substitute requires the State to contract with single vendor to implement Electronic Verification.

Prepared by: Margaret Brodie, Director — Phone: 907-334-2520
Division: Health Care Services — Date/Time: 4/1/2016 5pm
Approved by: Sana Efird, Asst. Commissioner, Finance and Management Services — Date: 4/1/2016
Agency: Health and Social Services

(Revised 9/9/15 OMB/LFD)

FISCAL NOTE ANALYSIS

STATE OF ALASKA **BILL NO.** CSHB315
2016 LEGISLATIVE SESSION

Analysis

As amended, this bill requires the department to contract with a single vendor to implement an Electronic Visit Verification (EVV) System for Medicaid personal care services (PCS) and Home and Community Based Services providers to verify services provided to recipients of these services.

The bill also requires the provider and department to receive reports of missed appointments or a failure to provide scheduled services. The EVV System must interface with the Department's Medicaid Management Information System (MMIS) to receive service authorizations and to process Medicaid claims. The following assumptions were made to develop the estimated costs for implementation and ongoing maintenance of the EVV system.

Services subject to the requirement for Electronic Visit Verification (EVV): Personal Care Services, Respite, Residential Habilitation, Chore, Intensive Active Treatment (IAT), Nursing Service oversight and care management, Day Habilitation, Specialized Private Duty Nursing.

FY2015: 6,472 individuals received one or more services listed above.

Estimated one-time capital costs:

Service authorization data transmitted to a EVV system from MMIS and claims data transmitted from an EVV system to MMIS would require an interface between the two systems. Costs to develop the interface are estimated to be $550.0 (4,400 hours x $125/hr = $550.0) at 90% federal/10% GF
Total Capital Costs for FY2017: $550.0 90% federal/10% GF

Estimated annual operating expenditures:
Estimated annual maintenance expenditure for Electronic Visit Verification = $ 50.0
Estimated cost per transaction = $7.69 ($50.0/6,500 client services per year)
FY2020 and ongoing total annual expenditures: $50.0 at 75% federal/25% GF

Other changes to MMIS necessary to implement existing state and federal requirements must be completed prior to beginning the system development for an EVV system. The Department anticipates that it will be able to initiate the development and implementation of EVV in FY 19, with a start date of July 1, 2019.

THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Health and Social Services
GOVERNOR'S COUNCIL ON DISABILITIES & SPECIAL EDUCATION
Patrick Reinhart, Executive Director

3601 C Street, Suite 740
Anchorage, Alaska 99503-5924
Main: 907.269.8990
Toll Free: 1.888.269.8990
Fax: 907.269.8995

April 5, 2016

RE: HB 315 - Electronic Visit Verification for providers of certain medical assistance services

Dear Representatives Seaton, Vazquez, and Reinbold,

The Governor's Council on Disabilities and Special Education (the "Council") fills a variety of federal and state roles, including serving as the State Council on Developmental Disabilities (SCDD) under the Developmental Disabilities Assistance and Bill of Rights Act. As the State DD Council, we work with Senior and Disabilities Services (SDS) and other State agencies to ensure that people with intellectual and developmental disabilities and their families receive the services and supports that they need, as well as participate in the planning and design of those services. One of the duties of the State DD Council is providing comments on proposed recommendations that may have an impact on individuals with intellectual and/or developmental disabilities and their families.

The Council has some concerns with the current version of HB 315 to require an electronic visit verification (EVV) system for personal care assistance (PCA) and home and community-based services (HCBS) providers in Alaska. Although this may work for consumer-directed PCA services, the very nature of HCB services is that they can be provided anywhere, making an EVV system extremely costly and impractical to implement. Although the Council agrees with efforts to reduce Medicaid fraud, abuse, and waste, we feel that EVV systems may not have the desired outcomes the State is looking for and may be far too expensive to implement in Alaska at this time. We believe that there are too many other systemwide Medicaid changes occurring in Alaska, most notably the implementation of conflict-free care coordination and possible transition to the 1915 (i) and (k) state plans. The Council especially wishes to express concern over the service recipient's quality of life, which can be significantly altered by EVV systems.

May impact recipient quality of life

There are a number of quality of life issues that arise when requiring HCBS providers to comply with an EVV system. Firstly, EVV systems require the consumer to have a landline telephone or installation of a device in their home, in order for the provider to clock in and out. People with landlines must allow their care provider to use the telephone, something they currently do not have to do. Since landlines are falling out of use and people are relying solely on cellular phones these days, many service recipients will need to consent to installation of a device in their home. However, such devices might be regarded with

suspicion by consumers, who feel that their homes should be secure and safe spaces free from surveillance devices. The very nature of person-centered, home and community-based services is that recipients are to be treated like everyone else in the community, not forcing them into a decision; either install tracking devices in their homes or pay for a landline. Newer options include global positioning system (GPS) tracking in the caregiver's cellular phone, another incredibly invasive option that does not sit well with Council members. Would the state purchase these phone trackers? Can the state legally require they be installed onto someone's personal property? What if caregivers do not have a cellular phone? Will the state be paying the employee's phone bill?

Service recipients in Texas and Illinois have reported negative experiences with EVVs. For example, community forums conducted by the Texas Department of Aging and Disability Services indicated that both consumers and their families have found the system to be bothersome. Individuals are witnessing the State track the movements of their care providers as if they are inherently untrustworthy and should be regarded with skepticism, which has changed the nature of the relationships between recipients, families, and their attendants. Since many service provider agencies already had their own EVV systems set up in these states, implementation of a statewide EVV has also resulted in residents maintaining multiple tracking systems for their various care providers, depending on what services they receive from which agencies and when. Since Alaska's service provider agencies already have their own electronic record-keeping systems in place, this issue would put undue burden on Alaskans to maintain several systems for various providers.

Lastly, most HCB services are not actually provided in the home, such as day habilitation where recipients learn skills for independence and employability in community settings. Since these services are provided in job centers, libraries, recreation centers, and other community-based locations, an HCB provider could not utilize an EVV system that is tied to an individual's landline or home address. Since an EVV system would only serve those home-bound individuals, it would not save the State money as keeping people in the home is not the preferred service delivery model for HCBS.

Will be costly to the State of Alaska

There are also several factors that would drive up the cost to the State if such an EVV system were implemented. Research on the EVV implementation in Texas has revealed similar billing and paycheck delays as to what Alaska has already experienced with Xerox, an issue that is still ongoing. There have been several suspensions of the system in Texas while bugs were fixed, resulting in additional costs to the state who needed to "provide relief" to providers for system downtimes. Alaskan providers wish to avoid such a possibility, as the Xerox issues were significant and long-lasting.

EVV systems have extensive training requirements for the State to implement, including training of consumers, employees, and agencies on the system that will be expensive. States that are currently using EVVs have done so through their managed-care organizations, an infrastructure that Alaska is lacking. For example, Illinois' EVV training manual for providers is 27 pages/slides long, the agency manual is 31 pages long, and the training for the recipient/consumer is a whopping 43 pages long. Not only is this undue burden to our most vulnerable population and lowest paid caregivers in Alaska, but

SDS does not have the funding to provide such robust training to all consumers, employees, and agencies. The State would need to hire costly consultants to implement an EVV system. Additionally, states that are utilizing EVVs have had to create a new technical support division and help desk unit for the system. In the current budget crisis that has already required SDS to lay-off staff and remove vacant positions, the Council believes that the State does not currently have the funds to implement such a system, as the fiscal note will be significant.

The American Recovery and Reinvestment Act of 2009 required HCB providers to maintain electronic medical records (EMR). To achieve compliance, Alaskan agencies have invested significant resources in their own electronic record-keeping and workforce management systems; however, research from other states suggests that EVV systems do not integrate easily with various EMR systems, increasing the cost of incorporating many different electronic systems into something Alaska can use.

Lastly, smaller HCB providers, especially in rural and remote regions, will bear the brunt of the expense. Such providers will be extremely burdened by a system which requires significant costs, infrastructure, and training to implement and maintain, in regions that are already scarce on resources.

Suggested changes and recommendations

In order to reduce Medicaid fraud, it is better for the recipients and their families when provider agencies are given the opportunity to develop their own record-keeping systems that work best in their unique environments. Additionally, there are cheaper alternatives to EVVs that can have the same effect, such as providing the Explanation of Benefits (EOB) documentation to the recipient. This way, consumers can play a more active role in fraud reduction. The Council also recommends changes to HB 315 that removes home and community-based services from the EVV requirement, and changes the intent of the bill from a PCA requirement to a pilot project. We suggest amendments to lines 6-8, as follows (*changes in red*):

"Sec. 47.07.047. Electronic visit verification system. The department shall establish a pilot electronic visit verification system so that ~~requires~~ medical assistance providers may test a system to verify visits conducted to provide personal care services in a recipient's home ~~or to provide home and community-based services to a recipient~~."

The Council thanks the legislature very much for the opportunity to express our concerns regarding HB 315. Please let us know if you have questions or need further information.

Sincerely,

Jeanne Gerhardt-Cyrus

Jeanne Gerhardt-Cyrus, Chair
Developmental Disabilities Committee
FASD Workgroup

AADD
ALASKA ASSOCIATION ON DEVELOPMENTAL DISABILITIES
P.O. Box 241742
Anchorage, Alaska 99524

To facilitate a united provider voice for best practices, advocacy, partnerships and networking.

March 30, 2016

Dear Representative Vasquez and Representative Seaton,

The Alaska Association on Developmental Disabilities (AADD) is the voice of over 30 providers offering developmental disability services through the Home and Community Based waiver system. The members of this association offer services to individuals of all ages in communities throughout Alaska.

AADD has serious concerns related to HB315 which would require electronic visit verification (EVV) for providers of personal care services and home and community-based services. We strongly feel this requirement would increase the cost of providing services without demonstrating cost savings to the State of Alaska or service providers. While HB 315 may be a logical direction for consumer-directed PCA services, we do not agree that this a logical requirement for Home and Community-Based Services.

To be compliant with the requirements of American Recovery and Reinvestment Act 2009, Home and Community Based providers were required to maintain electronic health records. Agencies have invested in different forms of electronic record-keeping and workforce management systems at a significant cost, not just in the initial purchase but the ongoing operational cost, including staff training and quality assurance systems. The Division of Senior and Disabilities Services (SDS) has indicated that there are sufficient controls in monitoring the agency-based service records available for compliance purposes. If a separate EVV system were required by the Department, the agency electronic records systems could not be simply replaced as they also provide HR and other agency support modules. Requiring duplicative systems would be a hardship across the system, especially on SDS which has experienced significant staffing reductions during the past year. Duplicative reporting processes will escalate administrative burden for the State of Alaska and medical assistance providers as they attempt to reconcile multiple systems. For small providers, particularly for those in rural and remote areas, real-time access to an EVV would be extremely difficult and possibly result in agency closures. This requirement will undoubtedly increase the cost of doing business.

The requirement for HCB service providers to document each visit with both the agency's electronic record and at the EVV site (as Texas required) is unreasonably demanding in a time of all of us having to "do less with less". Additionally, the increased cost to providers of EVV compliance will require a rate of reimbursement enhancement through the Office of Rate Review, and will therefore, increase the overall Medicaid costs for the State of Alaska.

Examples of fiscal "costs" requiring Medicaid rate enhancement are:

1. Training for a new data system
2. Who pays the providers for that additional training time that is not billable?
3. Must each employee have his/her own portable electronic device or telephone? If so, will the State of Alaska reimburse a portion of their bill? Who pays if they don't already have one?
4. Who purchases the new system and at what cost?
5. Administrative time required to reconcile differences between dual systems.
6. If SDS receives notification of missed visits in real time how are they to respond? Additionally administrative time would be required of providers to respond to SDS research.
7. If a visit is missed and SDS responds with the direct service worker are they a joint employer?

8. Would every individual direct support provider have to be enrolled with Medicaid with their own provider number? If so, additional provider enrollment costs and administrative time incurred by agency based providers.

The Association recommends that the requirement for "home and community based services" be removed from the bill, and a pilot project limited to consumer-directed services, such as PCA or chore services.

Sincerely,

Lizette Stiehr

Lizette Stiehr
Executive Director, AADD

Supported by:
Access Alaska
The Arc of Anchorage
Alzheimer's Resource of Alaska
Assets, Inc.
Catholic Social Services
Center for Community
Center for Human Development
Cindy & Vic's
Challenge Alaska
Community Connections
Connecting Ties
Christine, Inc.
Crossroads
CSI
South Peninsula Behavioral Health
Eagle Crest
Fairbanks Resource Agency
Focus, Inc.
Frontier Community Services
Hope Community Resources
Independent care Coordination
Maniilaq Association
Mat- Su Services for Children and Adults
West care
Norton Sound Health Corporations
REACH, Inc.
ResCare
Serendipity/Salvation Army
Seaview Community Services
Stone Soup Group
Tanana Chiefs Conference
YKHC
Effective Health Design

Alaska PCA Providers Association

c/o Allison Lee, ResCare Alaska, or Connie Sipe, Center for Community
700 Katlian Street, Suite B, Sitka, Alaska 99835

April 5, 2016

Representative Liz Vasquez, Co-Chair, and
Representative Paul Seaton, Co-Chair
Health & Social Services Committee
House of Representatives
State Capitol
Juneau, AK 99801

Re: Committee Substitute for House Bill 315 (4/1/16)

Dear Committee Chairs Vasquez and Seaton:

Thank you for continued and productive discussions with both of you and your staffs, and for the introduction of the Committee Substitute of April 1, 2016 for House Bill 315.

The Alaska PCA Providers Association wishes to go on the record as supporting this committee substitute, as it applies to Medicaid personal care services. We believe that a standards-based system for Electronic Visit Verification will best improve public accountability while still promoting operating efficiencies within PCA provider businesses.

Thank you again for your efforts and for hearing and working with our association's concerns.

Allison Lee, Rescare, Chair, Alaska PCA Providers Association
allisonlee@rescare.com 907-978-2556

Connie Sipe, Center for Community, Co-Chair, Alaska PCA Providers Association
csipe@cfc.org 907-966-4232

Sincerely,

Allison Lee, Chair Connie J. Sipe, Co-Chair

Sandata TECHNOLOGIES

Electronic Visit Verification Technologies

Solutions to help reduce Fraud, Waste and Abuse and increase visibility

Prepared for:

Anita Halterman
Chief of Staff for Representative Liz Vazquez

December 27, 2015

Prepared by:

Brian Lawson
Vice President, Business Development
516.484.4400 x 3131
blawson@sandata.com

Table of Contents

Solution Overview

For over 36 years, Sandata has been and remains 100% focused on delivering solutions for the home care industry. Sandata's core focus is innovation in technology to support all key stakeholders in home care. Where many of our competitors focus only on single components of the home care and/or government markets, Sandata is the only company that provides solutions and value for all of the constituents in the home care continuum including recipients, caregivers, home care providers and payers.

Sandata's comprehensive solution suite benefits all stakeholders in the HCBS continuum.

Recipients: Sandata maximizes the value of every in-home touch via:

- Supporting Plan of Care connection and verification;
- Triggering pre-emptive alerts for recipient condition changes;
- Supporting fulfillment of 'care alerts' or 'gaps in care';
- Facilitating comprehensive care that includes personal and clinical services; and
- Ensuring the Five Rights of Care™ - the right recipient, the right caregiver, the right services, the right location, and the right time.

Providers: Sandata maximizes the efficiency of home care providers via:

- Offering all-payer, multi-state solutions supporting comprehensive business models;
- Creating efficient management processes for clinical and non-clinical services;
- Reducing paper and administrative overhead through the implementation of automated workflows and best practices; and
- Supporting staff management and credentialing.

Payers: Through seamless integration, Sandata maximizes connectivity and improves the provider-payer experience via:

- Supporting care plan integration with automated data feeds;
- Establishing efficient methods for accurate, streamlined bilateral financial transactions including billing and payment;
- Supporting provider network profiling and best practices; and
- Providing impact analysis to reduce fraud while maximizing savings and health outcomes.

Sandata's Electronic Visit Verification technology suite can be deployed quickly and easily on a statewide scale. Once live, our technology immediately begins generating savings as demonstrated in our third party outcomes studies.

Sandata offers a flexible and configurable set of solution modules designed to help payers create a personalized program that meets the needs of all stakeholders. Each component of our recommended suite of solutions is described in detail below.

1. ***Electronic Visit Verification™*** - multiple technology options to capture caregiver time and tasks at the point of care in near real-time;
2. ***Agency Management*** - a powerful scheduling and billing engine designed to maximize efficiency for providers;
3. ***Claims Validation*** – validates claims data against authorizations and EVV-captured data before claims are submitted and adjudicated;
4. ***Reporting***, including Standard, Jurisdictional Views, and Data Extracts – detailed reporting and near-real time oversight over service delivery for the Payer's entire network.

ELECTRONIC VISIT VERIFICATION

EVV is the keystone of the solution and allows for remote collection of HCBS visit data improving accuracy and processing timeframes that are often caused by human error associated with manual paper processes. The data that is collected is available in near-real time for analysis and reporting. Our powerful combination of patented solutions for visit verification is called our Assured Coverage™ program and includes:

- Telephone Visit Verification™ ("TVV™") – TVV uses Automatic Number Identification ("ANI") technology to validate telephone calls to log in and log out, recording time and location and tasks performed in near real time.
- Mobile Visit Verification™ ("MVV") – near real time GPS technology, verifying caregiver location and visits via GPS enabled devices (mobile phones and tablets).
- Fixed Visit Verification™ ("FVV™") - patented technology to verify visits when no landline or cellular service is available. Caregivers press a button for a system generated number at the start and end of each visit. The number is then entered into the EVV system when a phone line is available and translated to an exact date and time stamp for the visit.

Through our "Assured Coverage" Program, Alaska DHSS can feel confident that multiple technologies ensure visit verification is occurring at the point-of-care; helping to guard against allegations of fraud and abuse, while improving care. Sandata works with each payer

hand in hand to provide the right set of visit verification technologies to meet the specific needs of your home care programs.

AGENCY MANAGEMENT

Agency Management is software for home care scheduling and billing, used by the providers to manage their business. Sandata offers flexible options to incorporate advanced, automated scheduling and billing tools for home care providers. Scheduling and billing functionality options include:

- *Santrax® Agency Management* – our Agency Management system is proven to improve accuracy in both the delivery of service as well as the billing for those services, ensuring higher standards of care delivery, program and cost efficiencies, and transparency among all stakeholders in the chain of care (See detailed description below); or

- *Third-Party Agency Management Integration* – an optional integration of EVV data with third-party scheduling and billing vendors.

Our Santrax Agency Management module is a powerful billing and scheduling engine designed to maximize efficiency for providers. Santrax Agency Management incorporates creation of schedules from authorizations with real time validation. The Advanced Scheduling Module provides proximity and attributes searching, with real-time validation of staff compliance. Schedules can be viewed in a calendar, weekly or detailed format. A configurable alert system provides enhanced visibility and compliance tracking for administrators of schedule variances.

CLAIMS VALIDATION

Unfortunately, billing errors and fraud are widespread in home care. Millions of dollars are lost through fraud, waste and abuse. One of the most powerful tools available to combat billing fraud is claims validation. With claims validation, the only claims that are paid are claims that are supported with or linked to properly validated visits. Sandata offers multiple processes that ensure a claim is valid and matches against EVV data. Claims validation options include:

- *Pre Submission Claims Validation* – our fully integrated EVV-Agency Management system automates the remote acquisition of service data, the processing of service data against authorizations, and the automatic generation of 837 claims for those

services that match the submission criteria as defined by the Department. This ensures that any claim that is submitted has proper visit verification, meets the requirements of the authorization and is directly submitted as a clean claim to the payer (described in detail below).

- *Post Submission Claims Validation* – for Agencies that have their own Agency Management and Billing process, integration of EVV visit data with Payer's claims adjudication systems.

Sandata's integrated Agency Management solution includes our comprehensive claims validation process; ensuring the only claims that are transmitted for payment are clean claims (claims that have been verified against the authorization as well as matched to a properly electronically verified visit). Providers generate electronic billing files once the visit is properly verified. Electronic 837 claims files are transmitted directly to the Payer for adjudication and payment. This reduces the number of incorrect claims that get to the Payer, putting the burden on the Provider to bill correctly the first time. The result is less work effort for all and improved accuracy in billing.

Figure 1 provides a visual representation of the end to end solution set available for payers.

Figure 1: Sandata provides an end-to-end solution to control costs and manage care for HCBS Members.

Value Proposition

Sandata assists the Payer by providing innovative, cost effective, and time savings solutions for improving the accuracy, quality and oversight of HCBS waiver programs. The table below summarizes the benefits of implementing Santrax Payer Management.

Detailed Value Proposition	
Issue	**Santrax Payer Management**
Maintaining HCBS Program Information	• Automatically collects, stores, and maintains HCBS visit data from the point of care; • Helps to ensure the integrity of visit information by reducing manual data entry/paper forms; • Ensures all visits match an authorization; and • Allows for direct transmission of data (members, providers, authorizations, claims) between EVV system and Payer
Fraud, waste and abuse	• Helps to ensure that only visits electronically verified against authorized services and limits are paid, mitigating the potential for fraudulent claims and reducing the workload for claims adjudicators and program integrity staff; • Supports existing program integrity resources through the ability to efficiently audit and investigate service records via jurisdictional oversight and reporting; and • Provides accountability and additional controls for HCBS agency and self-directed programs – high risk areas for fraud, waste and abuse.
Quality of Care	• Supports HCBS members through improved coordination, monitoring, and management of service delivery; • Allows for provider oversight and compliance and supports provider/member auditing via Jurisdictional Views; • Provides real-time alerts to provider agencies for late or missed visits that can be immediately addressed by home care agency management improving the client experience and allowing members to safely remain in their homes; and • Ensures visits are happening as expected and that members are receiving care as authorized - reducing gaps in care.
Claims Processing	• Helps to expedite the claims submission–payment cycle resulting in improved provider satisfaction; and • Helps to prevent the submission of services that do not match the authorization and have not been properly verified.
Data Quality, Analytics, and Availability	• Provides access to real time home care service delivery data, monitoring tools, and comprehensive reporting on utilization giving care coordinators / administrative stakeholders full oversight to ensure the quality of your HCBS Programs, improve service delivery and monitor agency trends; and

Detailed Value Proposition	
	• Provides a tool for payers to manage and compare provider agencies and establish benchmarks for care delivery to implement Pay for Performance (P4P) programs and/or assess penalties thus improving the overall quality of the program.
Budget Neutrality	• Automates manual and paper-based processes, removing potential human error or time sheet 'rounding' by caregivers, thus reducing overall claims cost; and • Reduces claims costs through automated visit validation, increased efficiencies, and the application of consistent business rules (e.g. payment rounding rules) across provider networks.

Outcomes

Sandata can provide **proven, independent, third-party** outcomes for customers who use our solution sets. We have summarized our outcomes below and included Appendix A which has more detailed information about outcomes from our deployments.

FLORIDA'S AGENCY FOR HEALTH CARE ADMINISTRATION

In 2009, the Florida Legislature passed Senate Bill 1986, which authorized the Agency for Health Care Administration to implement pilot projects in Miami-Dade Payer to prevent the overutilization of home care services and to control, verify and monitor the delivery of home care services. The state issued an RFP on December 7, 2009, which was subsequently awarded to Sandata. The program launched March 1, 2010, on schedule. The state expanded the program statewide for additional services; the expansion launched October 1, 2012, on time and on budget.

Results

The program reduced claims costs by $5M in the first seven months of operation, representing a 50% drop in claims volume as shown in Figure 2.

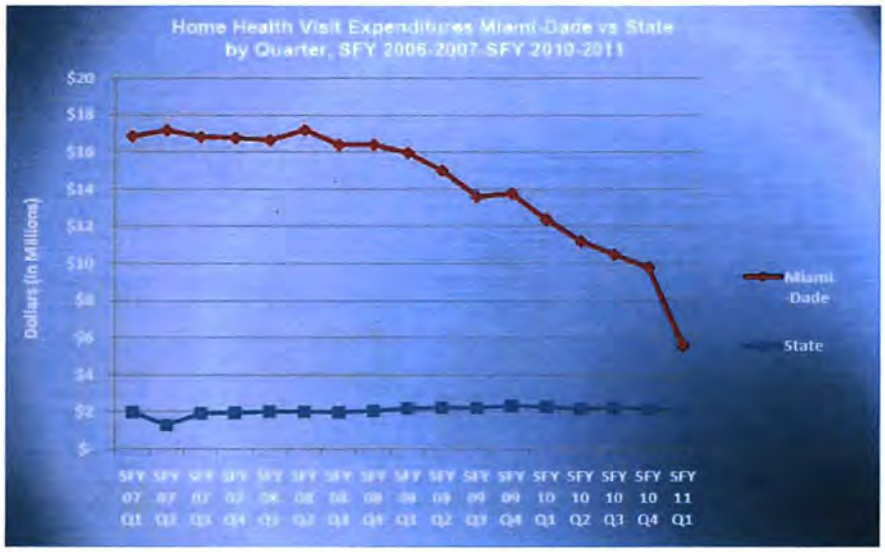


Figure 2: Miami-Dade realized a 50% drop in claims volume and $5M reduction in claims cost in less than a year.

For more details on AHCA's study, the complete report can be found by clicking on this link: Florida DMV Report.

Further, the 2011 Annual report of Florida's Medicaid and Public Assistance Strike Force Report states that AHCA reported a decrease of 50% in claims paid for home care visits in

SFY 2010-2011 when compared to the prior year and that the program also resulted in a reduction in home care visits by 51% during the same time period.

The second evaluation year, 2012, fared just as well. According to the 2012 Strike Force Annual Report, year two of the Delivery Monitoring and Verification ("*DMV*") program is expected to have generated substantial additional savings for Medicaid expenditure in Miami-Dade Payer. Preliminary statistics show that ***the dollar amount of claims paid in year two of the program was 15% lower than in year one, resulting in an estimated additional savings of $3.5M. The second year's savings are in addition to the $19M cost reduction achieved in the programs first year.***[1]

TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES ("DADS")

On March 1, 2011, the Texas DADS launched a pilot program for EVV in Region 9. The program has since expanded and over 700 Texas providers use Sandata's EVV solution.

Results

Results showed the following:

- 5% - 7.75% gross savings in the first four months of operations;
- 5% decrease in hours delivered to authorized hours; and
- 3.6% net savings.

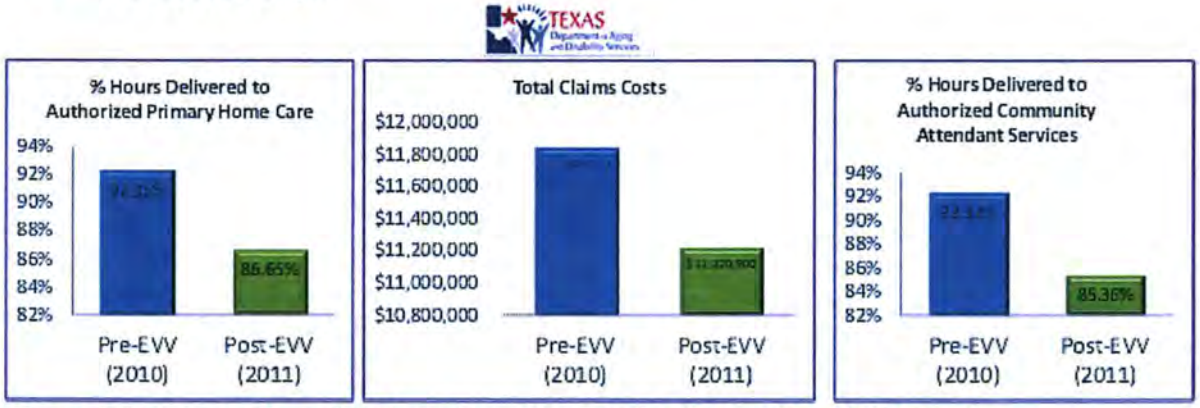


Figure 3: Outcomes from the Texas Department of Aging and Disability Services.

TENNCARE PROGRAM

As Tennessee moved their Medicaid members to Managed Care, TennCare required their MCOs to choose an EVV Vendor. All three TennCare MCOs independently selected Sandata as their EVV vendor. This is the first and only successful deployment of EVV in a member

[1] Note: AHCA uses Sandata's fully integrated EVV and Agency Management system, Santrax® Payer Management, which combines EVV, scheduling, payroll and billing in one system.

preferred scheduling environment. Member Preferred scheduling allows the recipients to specify when their visits should start, either through a specific time or a window of time. The MCOs are then required to authorize and ensure that care is delivered at that specific time or liquidated damages are assessed.

Tennessee's EVV program goal was to ensure care was delivered and reduce gaps in care. Analysis of EVV data shows that of the visits that were missed, 32% were successfully made up; preventing gaps in care and ultimately reducing overall claims costs for non-home and community based care and the results below demonstrate the program's success.

Results

The TennCare MCO EVV program was launched in August 2010. According to their presentation for the National Association of Medicaid Directors on October 29, 2012, TennCare stated that their Electronic Visit Verification system helps ensure fiscal accountability and provides immediate notification/resolution of potential gaps in care. In just two years, TennCare has achieved the following results using Sandata's EVV system:

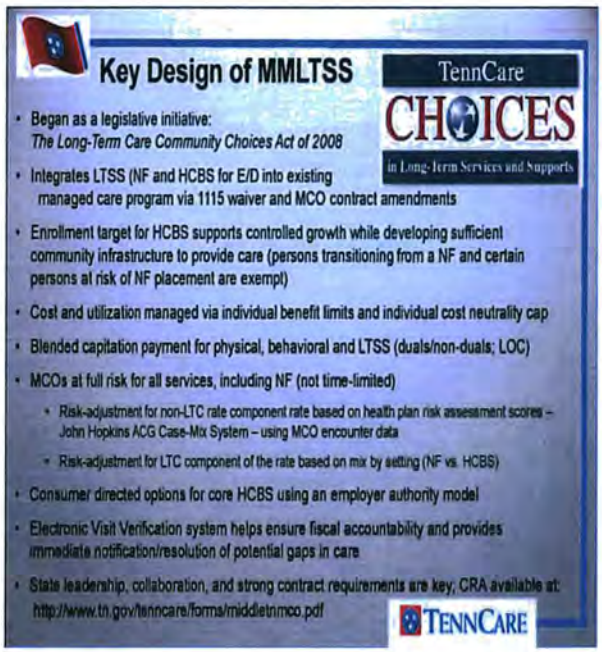


Figure 4: Design of the Managed Care Choices Program by TennCare.

- 97% of all in-home services scheduled over the last year were provided; of those visits that did not occur as scheduled, the overwhelming majority (roughly 75%) were initiated by the member (not the provider); back-up plans are required in either case; and
- > 99.75% of all scheduled in-home services provided over the last year were on time.

STATE OF OKLAHOMA

In 2008, the Oklahoma Department of Human Services published a study from a pilot of Interactive Voice Response/Authentication using all of Sandata's modules.[1]

Evaluation Methodology

The pilot analyzed the following measures:

- Service delivery and service reimbursements:
- Service visits per member per month;
- Reimbursed units per member per month;
- Reimbursed units per visit per member per month;
- Total reimbursement per member per month;
- Operational efficiency; and
- Number of lag time days from date of service delivery to date of claim payment.

All measures are based upon MMIS claims paid data records organized by month of service delivery. Measures were assessed for 1,724 unduplicated individuals served by two provider agencies participating in the pilot. Measures were compared for Pre and Post EVV periods during the five-month period immediately prior to EVV introduction and the five-month period of EVV use.

Results

The EVV pilot produced the following impacts:

- Visits per month declined on average, by 8% (about 1 visit less per month);
- Units reimbursed per visit increased slightly on average, 0.5 more visits per member per month;
- Total reimbursed units decreased;
- Cost per member per month decreased; and
- The average days lag between dates of service delivery to receipt of payment decreased significantly (an average 12-day decrease in lag time per claim payment per month). The provider experiencing the longest payment lag time in the Pre EVV period experienced the greatest improvement in payment lag from Pre to Post EVV representing a decrease of 18 days (almost a 2.5-week improvement in performance).

Based upon these analyses, Oklahoma concluded that "***the implementation of an EVV system appears to offer potential benefits to providers and to the state. Specifically, providers may benefit from improved efficiency of operation including more timely claims payment from the state.***" The EVV system provides a verifiable means to assure the public that tax dollars are expended only for services delivered. The EVV system reduced the average number of reimbursed units and thus the average state expenditure per member per month.

Pricing Proposal

Sandata is pleased to provide pricing information and return on investment analysis per your request. Sandata's solution, and therefore our pricing, is offered in a modular format.

We have included the following sample estimates for your review:

- Personal Care Attendant Pricing Sample and ROI Estimate
- Multiple Program Pricing Sample and ROI Estimate

For the ROI estimates, we are using conservative numbers of 5%, 8% and 12% projected savings. As reflected in the outcomes sections, we have shown savings of 8% to 50% throughout our deployments.

WHAT DRIVES ROI?

Sandata directly impacts fraud, waste and abuse by capturing and reporting actual time worked by the caregiver. This improved accuracy drives savings as shown below:

- Improved accuracy
  - Direct reporting of time: After working 54 minutes, most people will round up their timesheet to report 60 minutes of work. By removing the provider's ability to "round up", Sandata drives 10% savings for every visit where the provider started late and/or left early.
  - Unit based services using a 7/8 rule: For a schedule of one hour where 45 minutes are actually worked, workers often report a full hour which leads to 4 units billed instead of the 3 units that were actually worked. In this example, restricting the provider to only billing 3 unites instead of 4 results in a 25% savings on every visit where this occurs.

Figure 1: Example of savings by using EVV over manual entry.

- Fictitious visits cannot be billed as there is no corresponding visit verification;
- Billing limited to proper authorization limits – no overbilling of the authorization is allowed;
- Disciplines are tracked to ensure the proper service level (and appropriate rate) is being billed based on the work delivered (i.e. if a personal care attendant performs the service, the provider cannot bill at a higher RN rate).

PRICING SAMPLE – ONE-TIME FEES. [2]

This sample will walk through what a pricing model would look like for an implementation for two different population sets in Alaska. This pricing is broken this down into 3 main sections. The first section will focus on One-Time Fees. The second and third sections will focus on reoccurring transactional fees for PCA only and All HCBS population implementations, respectively. The one-time fee section applies to either model assuming one implementation date. Please note that all sample pricing is based on volume estimates pulled from the Kaiser Family Foundation Website and is for informational purposes only. Actual pricing will vary depending on program specifics and data provided by the Alaska DHSS.

Sample One Time Program Access Fee[2]				
Payer level	Average	Price Input	Quantity	Extended Price
Access Fee (with Agency Management)	$150,000 - $300,000	$150,000	1	$150,000
Santrax Jurisdictional View		$50,000	1	$ 50,000
Pricing Notes				
Access Fee: Fee for utilizing Sandata's SaaS (Software as a Service) solutions and does not include any custom development.				
Technical Implementation: The technical implementation fee includes business rule definition, data exchange configuration and testing, reporting, and system configuration and testing.				
The initial access fee is payable in full upon contract execution.				

Sample One Time Program Implementation Fees[2]				
Payer level	Average	Price Input	Quantity	Extended Price
Technical Implementation	$150,000 - $300,000 per program	$200,000	1	$200,000
Technical Implementation (Provider deployment per account)	$330 per provider agency	$330	100[3]	$33,000
Speaker Verification Enrollments (Optional)	$3.00 per registered caregiver at each provider	$3.00	TBD	-
Pricing Notes				
Technical Implementation: The technical implementation fee includes business rule definition, data exchange configuration and testing, reporting, and system configuration and testing.				
Per Provider: A per provider account implementation fee for provider Agency Management/EVV database deployment.				
Speaker Verification: One time set up of speaker verification recording.				
All one-time fees are payable 25% at contract signing, 50% at project kick off date, and 25% at project go live.				

[2] All stated numbers are samples; true pricing would be built as part of a proposal process
[3] Forecasted number of providers; true pricing would be built as part of a proposal process

Training				
Training Material Development	$10,000 per program	$10,000	1	$10,000
Instructor-led Train-the-Trainer session	$7,500 per session	$7,500	1	$7,500
Training system set up	$16,000 per training environment	$16,000	1	$16,000
Pricing Notes				
To help ensure the Payer's project success, Sandata's experienced implementation team develops a custom training program to ensure program success. This includes all documentation creation and training environment configuration. Training can be handled a number of ways including: train-the-trainer, classroom sessions, and/or webinars.				

Total Estimated One-time Fees $466,500

PRICING SAMPLE 1 –ANNUAL FEES (PCA ONLY) [4]

The Annual fees are calculated based on total number of visits, and for purposes of this sample, we have forecasted 20 visits per member per month. There is also a yearly access fee.

~Recipients [4]	3,598
~Visits/Month [5]	20

Pricing Sample 1 Annual Fees[1]				
Yearly Service Fees		Price	Quantity	Ext. Price
Yearly Access Fee		$ 40,000	1	$40,000
EVV Transaction Fee- Base Fee		$ 0.12	1,727,040	$207,245
EVV Transaction Fee – Speaker Verification (Optional)		$ 0.03	1,727,040	$51,811

Total Estimated Annual Fees $299,056

[4] All stated numbers are samples; true pricing would be built as part of a proposal process

[4] Kaiser Commission on Medicaid and the Uninsured: Medicaid Home and Community-Based Services Programs: 2012 Data Update

[5] Forecasted visits per month based on typical program volume

PRICING SAMPLE 2 –ANNUAL FEES (ALL HCBS) [7]

The Annual fees are calculated based on total number of visits, and for purposes of this sample, we have forecasted 20 visits per member per month. There is also a yearly access fee.

PCA	3,598
Home Health	281
I/DD	1,624
Aged	1,819
PD	1,390
Children	270
Totals:	**8,982**

~ Recipients[8]	8,982
~Visits/Month[9]	20

Pricing Sample 2 Annual Fees				
Yearly Service Fees		Price	Quantity	Ext. Price
Yearly Access Fee		$ 40,000	1	$40,000
EVV Transaction Fee – Base Fee		$ 0.12	4,311,360	$517,363
EVV Transaction Fee – Speaker Verification (Optional)		$ 0.03	4,311,360	$129,341

Total Estimated Annual Fees $686,704

[7] All stated numbers are samples; true pricing would be built as part of a proposal process

[8] Kaiser Commission on Medicaid and the Uninsured: Medicaid Home and Community-Based Services Programs: 2012 Data Update

[9] Forecasted visits per month based on typical program volume

Return on Investment

ROI Sample – Personal Care Attendant[6]

This first example focuses on the potential savings Alaska DHSS could see using conservative savings calculations and factoring in the costs in Pricing Sample 1. You'll note the ~3,600 recipient population used in the pricing sample as well as the total expenditures for these recipients which is approximately $92 million dollars.

	Recipients[11]	Expenditures
Personal Care Attendant program	3,598	$91,921,000

The fees below come directly from Pricing Sample 1 and are first year costs only. Note that after the first year, the ROI increases as only the reoccurring fees continue. T***hese fees can also be further reduced using Federal Medical Assistance Percentages at up to 90% for one time fees and up to 75% for reoccurring fees.***

SPM Fees (from Pricing)	
One Time Fees	$466,500
Reoccurring Fees	$299,056
Total OTR + Year 1 Fees	***$ 765,556***

We have used conservative savings calculations starting off at 5% and netted the fees out of the gross savings to give a net savings and total ROI.

	Cost Containment		
Percentage Savings	5%	8%	12%
Gross Savings	$ 4,596,050	$ 7,353,680	$ 11,030,520
Sandata Fees	$ 765,556	$ 765,556	$ 765,556
Net Savings:	**$ 3,830,494**	**$ 6,588,124**	**$ 10,264,964**
ROI:	5.00	8.61	13.41

As you can see, Alaska **DHSS *could see savings from roughly $4 million to over $10 million dollars for a cost of roughly $750,000 dollars*** by implementing EVV. After the first year, those costs would drop to a little under $300,000 dollars a year *before federal matching*.

[6] All stated numbers are samples; true pricing would be built as part of a proposal process

[11] Kaiser Commission on Medicaid and the Uninsured: Medicaid Home and Community-Based Services Programs: 2012 Data Update - Includes Personal Care Participants and Expenditures

ROI SAMPLE – ALL HCBS[12]

This final example focuses on the potential savings Alaska DHSS could see if implemented for all HCBS populations using conservative savings calculations and factoring in the costs from Pricing Sample 2. You will note the ~9,000 recipient population used in the pricing sample as well as the total expenditures for these recipients which is just over $300 million dollars.

	Recipients[13]	Expenditures
PCA	3,598	$91,921,000
Home Health	281	$319,000
I/DD	1,624	$117,200,000
Aged	1,819	$47,393,000
PD	1,390	$36,365,000
Children	270	$11,737,000
TOTAL	**8,982**	**$304,935,000**

The fees below come directly from Pricing Sample 2 and are first year costs only. Note that after the first year, the ROI increases as only the reoccurring fees continue. ***These fees can also be further reduced using Federal Medical Assistance Percentages at up to 90% for one time fees and up to 75% for reoccurring fees.***

SPM Fees (from Pricing)	
One Time Fees	$466,500
Reoccurring Fees	$686,704
Total OTR + Year 1 Fees	***$ 1,153,204***

We have again used conservative savings calculations starting off at 5% and netted the fees out of the gross savings to give a net savings and total ROI.

	Cost Containment		
Percentage Savings	5%	8%	12%
Gross Savings	$ 15,246,750	$ 24,394,800	$ 36,592,200
Sandata Fees	$ 1,153,204	$ 1,153,204	$ 1,153,204
Net savings:	**$ 14,093,546**	**$ 23,241,596**	**$ 35,438,996**
ROI:	12.22	20.15	30.73

[12] All stated numbers are samples; true pricing would be built as part of a proposal process

[13] Kaiser Commission on Medicaid and the Uninsured: Medicaid Home and Community-Based Services Programs: 2012 Data Update - Includes Personal Care, Home Health, and Waiver Participants and Expenditures

As you can see, Alaska DHSS ***could see savings from roughly $14 million to over $35 million dollars for a cost of roughly $1.15 million dollars*** by implementing EVV. After the first year, those costs would drop to under $700,000 dollars a year *before federal matching*.

Thank you for the opportunity to provide an overview of our solution as well as sample pricing and ROI information. We look forward to demonstrating our EVV capabilities for you and assisting you with anything you might need as you go through your process!

Sincerely,

Brian Lawson
Vice President, Business Development
Sandata Technologies, LLC
516.484.4400 x 3131
blawson@sandata.com

Care Embrace
Powered by Sandata Technologies

SEE CARE HAPPEN

Insights Into the Care Continuum

Sandata Technologies, LLC brings you the first-of-its-kind Home Care system, Care Embrace. Combining Electronic Visit Verification and Remote Care Management into a single patient-centric device.

Care Embrace puts participants first, with modular health and visit features that empower caregivers and revolutionize the claim system.

VISIBILITY
Into the home care experience

ACCOUNTABILITY
Across home care

EFFICIENCY
In delivering and paying for care

TRANSPARENCY
Into the care being provided

Deliver the right care to the right person at the right time:

sandata.com info@sandata.com 800.544.7263

By facilitating better engagement and communication between participants, providers, and payers; Care Embrace provides better management and better outcomes.

PARTICIPANT

Utilize visit information and biometric data to modify participant health plans, collaborate with care team and keep participants at home

Quick access to virtual support system

PROVIDER

Increase productivity of staff and streamline workflows and payments

Building relationships between staff and participants

CAREGIVERS

Verified accountability for compliance and faster payments

Empowering the first line of health care

PAYERS

Access to detailed claims records and participant data results in healthier participants

Reduced costs and improved care

Deliver the right care to the right person at the right time:

Sandata TECHNOLOGIES

Serving Home Care Payers and Providers

Electronic Visit Verification™ Solutions

Sandata Technologies' Unsurpassed Payer Experience and Results

Independent analysis of four payer programs supports the budget savings and program quality improvements from implementing EVV solutions for State and Managed Care Organization's Home and Community Based Programs.

Florida Medicaid and Public Assistance Strike Force Reports show that AHCA realized:

- $19M savings (46%) for Miami-Dade County alone in Year 1
- $3.5M savings (an additional 15%) for Miami-Dade County in Year 2

Within first four months of operations:

- 5% - 7.75% savings
- 5% decrease in hours delivered to authorized hours
- 3.6% net savings

TennCare presentation to National Association of Medical Directors quoted:

- 97% of all scheduled in-home services were provided
- >99.75% of all scheduled in-home services were provided on time

Results from EVV Pilot Project showed:

- 8% decline in visits/month
- Decrease in reimbursed units
- Decrease in per member per month cost
- Average 12-day decrease in lag time per claim payment per month

Improved Program Management and Significant Program Savings.

Sandata's solutions have proven their effectiveness for Payers in the following areas:

- Reduced claims costs
- Improved accuracy of service delivery to HCBS participants
- Increased on-time visits
- Decreased Per Member Per Month costs
- Decreased lag time between service delivery and payment

Sandata is the leading provider of Electronic Visit Verification ("EVV") services for State and Managed Care Medicaid Home and Community Based Programs with documented third party outcomes.

Medicaid FFS Program

- Statewide EVV program for **Agency for Health Care Administration** since 2010

Managed Medical Assistance Program

- EVV services for **Amerigroup** and **Sunshine Health Plan**—programs launched in mid-2014

Medicaid Managed Long Term Care Program

- EVV services for **Sunshine Health Plan** since 2013—

TennCare Medicaid FFS Program

- Statewide EVV program for **United Healthcare Plan of the River Valley, Amerigroup** and **BlueCare Tennessee** — providing EVV services since August 2010 including self-directed populations
- In 2014, launched new Care Embrace™ delivery model which combines Electronic Visit Verification and Remote Care Management through a single Member-centric mobile device

Medicaid FFS Program

- Statewide EVV program for **Department of Human Services** in 2013—launched on time on January 1, 2014

Medicaid FFS Program

- EVV program for **New York City Human Resources Administration** in 1984—saving over $1 Billion due to fraud, waste and abuse

Medicaid FFS Program

- EVV services for **Department of Human Services** to support Advantage Waiver and State Plan Personal Care programs
- Selected to replace existing EVV vendor—program launched on time on September 1, 2014

Medicaid FFS Program

- EVV program for **Department of Aging and Disability Services** in 2010—launched original FFS pilot in Region 9 in 90 days with statewide expansion completed in 2012

National Programs

- Hold national agreements with **Centene Corporation** and **Molina Healthcare, Inc.** to provide EVV services for use in local plan programs

Sandata Technologies, LLC

26 Harbor Park Drive

Port Washington, NY 11050

www.sandata.com

1.800.544.7413

Connect with us:

SPMsales@sandata.com

twitter.com/Sandata_Tech

www.linkedin.com/company/sandata-technologies

www.facebook.com/pages/Sandata-Technologies/147789808570957

www.youtube.com/user/SandataTechnologies

Sandata TECHNOLOGIES

Santrax® Payer Management

Santrax Payer Management (SPM) provides home care payers with near real-time visibility through a jurisdictional view into the operations of their HCBS provider networks enabling payers to audit agency business practices to deliver more cost-effective care.

Santrax Payer Management provides the foundation necessary for greater control and insight into clinical, financial and operational processes within Home and Community Based programs. SPM includes:

- Electronic Visit Verification™ solutions to track participant and direct care provider IDs, location, caregiver arrival and departure times, and tasks performed during a visit
- Scheduling and billing modules to support agency operations
- Advanced visit monitoring and rules-based claims submittal for improved care plan compliance and claims accuracy, virtually eliminating inappropriately billed services
- A single composite view of, services, claims and data collected by all participating providers across a jurisdiction

SPM offers unmatched payer visibility into provider operations and efficient documentation for audits and investigations. The result is improved oversight into HCBS program delivery, streamlined claims, increased provider accountability, and reductions in fraud.

Sandata offers a flexible, modular approach to EVV solutions, allowing our clients to select and deploy the models that best meet your business needs.

Sandata Brings Value To Payers

- Coordination of Care
- Fraud & Abuse Prevention
- Quality Management and Outcomes
- Visibility
- Provider Support and Services
- Participant Safety and Satisfaction

Sandata TECHNOLOGIES

Value Proposition

Sandata's Electronic Visit Verification solutions serve the *entire* post-acute continuum – payers, home care providers, and participants – to enhance transparency, improve service delivery and quality, and optimize outcomes.

Payer Benefits

Quality

- Improves provider accountability and quality of services delivered
- Ensures tight control over authorized services
- Captures valuable real-time patient data at the point-of-care
- Supports timeliness and accuracy of service delivery resulting in improved member satisfaction

Savings

- Decreases incidence of fraud, waste, and abuse
- Provides accuracy and efficiency in payments through automated claims validation and billing processes
- Generates program savings as evidenced by third-party outcomes

Transparency

- Enhances transparency into HCBS provider network
- Provides data and audit trails to support payer/OIG audits
- Provides actionable data through static and near real-time reporting and analytics to better manage provider networks and support provider incentive programs

Process

- Streamlines claims management and services authorization
- Reduces incidence of inappropriately billed services
- Helps facilitate communication with providers

Sandata Technologies, LLC

26 Harbor Park Drive
Port Washington, NY 11050

www.sandata.com
1.800.544.7413

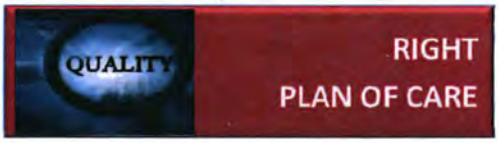
Connect with us:
SPMsales@sandata.com

twitter.com/Sandata_Tech

www.linkedin.com/company/sandata-technologies

www.facebook.com/pages/Sandata-Technologies/147789808570957

www.youtube.com/user/SandataTechnologes



Ensuring the Five Rights of Care™

Sandata TECHNOLOGIES

Sandata TECHNOLOGIES

Electronic Visit Verification Overview

December 17, 2015

Alaska Department of Health and Social Services

Agenda

- Introductions
- What is EVV?
- Sandata Overview
- Solution and Technology Overview
- Questions and Answers
- Wrap Up

Electronic Visit Verification (EVV): What is it?

Electronic Visit Verification validates care delivery by capturing visit information including date and time, member and caregiver ID, services provided, and member health status; ensuring the right care is delivered at the right time to the right person.

- **Focus on Home Care Services**
  - Home Health Aide
  - Homemaker
  - Chore
  - Personal Assistance Attendant
  - Private Duty Nursing
  - Therapy Services
  - Respite
  - Care coordination
  - Provider (Agency) Directed and Self-Directed Services

Electronic Visit Verification (EVV): What is it?

Providers insert scheduled visits into the system

- Scheduler contains data on provider, caregiver, client and care plan
- Adherence to service order is done at the point of scheduling, prior to the service being delivered

Care is delivered and the delivery of service is verified

- When the caregiver arrives on site, they "check-in" via phone or other electronic means
- When they leave, they "check-out" via the same means
- The system more accurately captures visit start/stop and duration
- Verification data is available and reportable in real-time before the claim is submitted

Scheduled visits are tracked

- Missed or late scheduled visits create alerts to inform the provider and payer that the client was not served according to the care plan

Electronic Visit Verification (EVV): What is it?

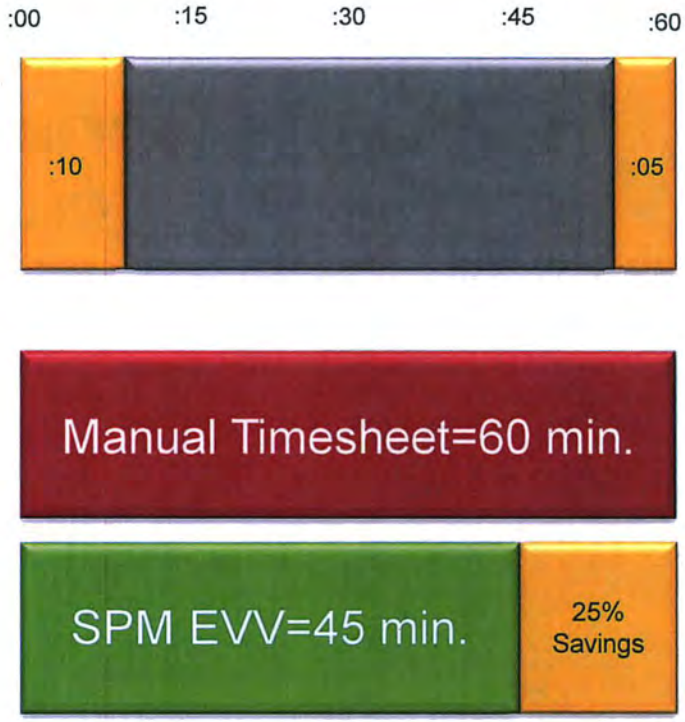
The verified service automatically creates a claim

- A HIPAA compliant 837 claim is created that contains data tracked during the visit, ensuring Medicaid only pays for actual time spent on the service rendered to the client
- Claims for verified visits that align with the scope of the care plan are automatically submitted to MMIS without intervention by the provider
- Claims for unscheduled visits or those that fall outside of the scope of the care plan are held until the issue is resolved
- Claim is automatically released for billing once the issue is resolved
- Visits unable to be verified are prevented from being billed, this front end edit provides immediate savings

EVV Solution - Example

Caregivers are no longer able to pad their time and agencies are unable to bill for visits that did not occur

- In this example, the visit is scheduled for a full hour, but the caregiver checks in at 10 minutes after the hour and checks out at 55 minutes after the hour
- Rather than a standard rounded entry of 60 minutes, EVV tracks that only 45 minutes are spent on site and ensures only 3 units are billed
- The result is program savings, reduced fraud, and understanding of services rendered



Recent Fraud Cases in Alaska

Good Faith Services

- Billed for services that never occurred
  - Caretakers were billing for services when they were out of the country
  - Billing for patients who had died
- The operator and part-owner was sentenced to three years in prison for Medicaid fraud in December 2015
- Charges against 29 employees were filed in July 2014
- Fined $300,000 and ordered to pay $1.2 million in restitution
- Stripped of its authority to bill Medicaid

http://www.adn.com/article/20151211/good-faith-services-owner-gets-3-years-medicaid-fraud

EVV prevents services like these from being fraudulently billed and gives near real-time access into provider activity. This provides front-end fraud prevention as opposed to the typical pay and chase model.

Agenda

- Introductions
- What is EVV?
- Sandata Overview
- Solution and Technology Overview
- Questions and Answers
- Wrap Up

Sandata Mission and Vision

Maximize the value of every in-home encounter

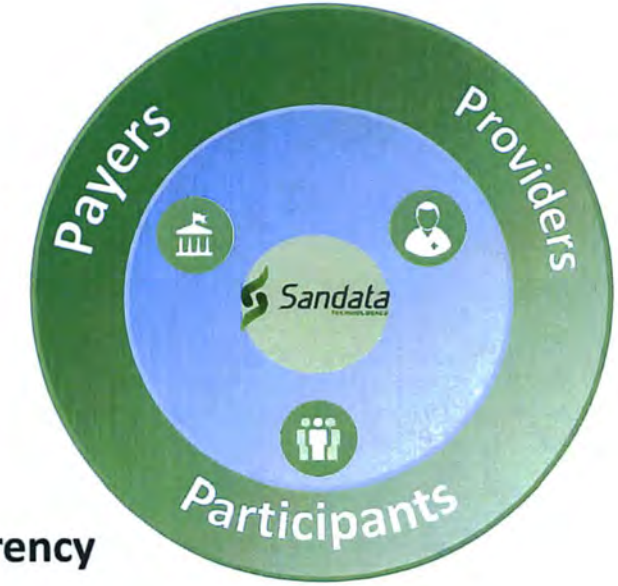
- Plan-of-care connection and verification
- Pre-emptive alerts for participant condition changes
- Fulfillment of "care alerts" or "gaps in care"
- Facilitate comprehensive care that includes personal and clinical services

Maximize efficiency of homecare providers

- All-payer, multi-state solution
- Efficient management of clinical/non-clinical services
- Reduce paper and administrative overhead
- Staff management and credentialing

Integrate providers and payers to drive network transparency

- Referral and authorization management
- Care-plan integration with primary care physicians or care coordinators
- Efficient financial transactions
- Support for network management and visibility
- Measure results and health outcomes



Sandata is uniquely positioned at the center of the homecare network

Sandata Highlights at a Glance

- **Home Care Focus:** Sandata is 100% focused on the Home Care industry, providing solutions at each stakeholder level (Payer, Provider, Participant)
- **Large, Growing Base of Payers and Providers:** 5 MCOs, 5 major Medicaid agencies, and 3,500 homecare agencies across the country
- **Market Leading Scale & Utilization:** 650K+ participants and 200K homecare visits managed each day
- **Experience and Accountability:** Extensive Payer (State and MCO) experience with proven results showing savings of 8% - 50%
- **Innovation:** Industry leading EVV technology processing more than 150 million visit verifications annually implemented using a flexible and modular solution
- **Scalable, Integrated SaaS Solution:** Integrated SaaS platform – agency management, payer management, point-of-care, and EVV – serving the entire post-acute continuum

Home Care Agencies

Daily Visits

Leading SaaS Provider to the Homecare Continuum

Payers / MCOs

- ✓ Reduce Fraud, Waste, and Abuse
- ✓ Provide Visibility into Homecare
- ✓ Reduce Costs
- ✓ Ensure Service Quality
- ✓ Deliver Analytics for Decision Making

Providers

- ✓ Reduce Missed Visits/Optimize Revenue
- ✓ Automate Processes
- ✓ Identify Gaps in Care
- ✓ Manage Compliance
- ✓ Leverage Single Platform

Participants

- ✓ Address Gaps in Care
- ✓ Increase Care Quality
- ✓ Improve Care Timeliness
- ✓ Enable Appointment Scheduling
- ✓ Participant Portal for Online Access

Payer / State Medicaid Agencies and MCOs

AHCA · BlueCare Tennessee · CENTENE Corporation · IDHS · Texas Department of Aging and Disability Services · Oklahoma Department of Human Services · MOLINA HEALTHCARE · AMERIGROUP CORPORATION · UnitedHealthcare

Provider / Homecare Agencies

AID & ASSIST AT HOME Where the heart is · Harden HEALTHCARE · HELP AT HOME INC · Bestcare, Inc · BrightStar · QUALITY CARE SERVICES, INC. · PEOPLE CARE · Unlimited Care, Inc. · Partners in Care®

Third Party Documented Payer Outcomes

	AHCA	Texas Department of Aging and Disability Services	AMERIGROUP CORPORATION / BlueCare Tennessee / UnitedHealthcare	
Program	Miami-Dade County	Texas DADS	Tennessee	Oklahoma
Solution	SPM (EVV and SAM)	EVV	SPM (EVV and SAM)	SPM (EVV and SAM)
Launch	345 providers	900 providers	400 providers	100 providers
ROI	$19M savings (46%) for Miami-Dade County alone in Year 1 $3.5M savings (an additional 15%) for Miami-Dade County in Year 2	8% program savings 5% decrease in hours delivered to authorized hours	97% of all scheduled in-home services were provided	8% decline in visits/mo
Results	Expanded statewide to the Private Duty Nursing and Personal Care Services Programs to more than 750 Providers	Expanding to statewide program – projecting $27M in savings with statewide rollout	>99.75% of all scheduled in-home services were provided on time	Decrease in reimbursed units Decrease in per member per month cost Average 12-day decrease in lag time per claim payment per month

"Since implementing the pilot projects in Miami-Dade, two large home health providers (each serving over 250 Medicaid recipients in the county, with annual reimbursement exceeding $1 million) were terminated from participation in the Medicaid program and one provider was suspended from the program. "

- Agency for Health Care Administration in Florida

Examples of EVV State Legislation

Illinois

Added EVV as part of it's DHS Consumer directed plan under the SMART Act:

https://www2.illinois.gov/hfs/SiteCollectionDocuments/0970689.pdf

(g) For the Home Services Program operated by the Department of Human Services and the Community Care Program operated by the Department on Aging, the Department of Human Services, in cooperation with the Department on Aging, shall implement an electronic service verification based on global positioning systems or other cost-effective technology.

Florida

Added EVV initially as a pilot in Miami-Dade in 2009 (SB 1986) and expanded statewide in 2012 (HB 5031)

http://archive.flsenate.gov/cgi-bin/view_page.pl?Tab=session&Submenu=1&FT=D&File=sb1986er.html&Directory=session/2009/Senate/bills/billtext/html/

SB 1986 - Section 31. Pilot project to monitor home health services. The Agency for Health Care Administration shall develop and implement a home health agency monitoring pilot project in Miami-Dade County by January 1, 2010. The agency shall contract with a vendor to verify the utilization and delivery of home health services and provide an electronic billing interface for home health services. The contract must require the creation of a program to submit claims electronically for the delivery of home health services. The program must verify telephonically visits for the delivery of home health services using voice biometrics. The agency may seek amendments to the Medicaid state plan and waivers of federal laws, as necessary, to implement the pilot project. Notwithstanding s. 287.057(5)(f), Florida Statutes, the agency must award the contract through the competitive solicitation process. The agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives evaluating the pilot project by February 1, 2011.

http://www.flsenate.gov/Session/Bill/2012/5301/BillText/Filed/PDF

HB 5301 - 409.9132 Pilot project to monitor home health services.—The Agency for Health Care Administration may expand the home health agency monitoring pilot project in Miami-Dade County to include Broward, Escambia, Martin, and Palm Beach Counties, effective July 1, 2012. The agency shall contract with a vendor to verify the utilization and delivery of home health services and provide an electronic billing interface for home health services. The contract must require the creation of a program to 698 submit claims electronically for the delivery of home health services. The program must verify telephonically visits for the delivery of home health services using voice biometrics. The agency may seek amendments to the Medicaid state plan and waivers of federal laws, as necessary, to implement or expand the pilot project. Notwithstanding s. 287.057(3)(f), the agency must award the contract through the competitive solicitation process and may use the current contract to expand the home health agency monitoring pilot project to include additional counties as authorized under this section.

Examples of EVV State Legislation (cont.)

Texas

Added EVV as part of it's Department of Aging and Disability Service under SB7 (2011)

https://legiscan.com/TX/text/SB7/id/339584

SECTION 1.07. Subchapter D, Chapter 161, Human Resources Code, is amended by adding Section 161.086 to read as follows:

Sec. 161.086. ELECTRONIC VISIT VERIFICATION SYSTEM. If it is cost-effective, the department shall implement an electronic visit verification system under appropriate programs administered by the department under the Medicaid program that allows providers to electronically verify and document basic information relating to the delivery of services, including:

(1) the provider's name;

(2) the recipient's name;

(3) the date and time the provider begins and ends the delivery of services; and

(4) the location of service delivery.

Agenda

- Introductions
- What is EVV
- Sandata Overview
- Solution and Technology Overview
- Questions and Answers
- Wrap Up

Integrated and Comprehensive Solutions

santrax® PAYOR MANAGEMENT

Jurisdictional View

Quality Oversight and Management

Participants

Authorizations

Providers

santrax® AGENCY MANAGEMENT

- Supports provider agency business process needs
- Real time alerts for Late and Missed Visits
- Restricts Agencies from scheduling outside of authorization limits

santrax® ELECTRONIC VISIT VERIFICATION

- Telephony
- Mobile
- Fixed Visit Device

santrax® CLAIMS VALIDATION

- All claims are validated in the system prior to direct submission
- Solely clean claims can be submitted
- 837 formatted to specifics

Santrax Electronic Visit Verification

- *Santrax Electronic Visit Verification (EVV)* optimizes clinical compliance and reduces fraud, waste, and abuse by enabling homecare agencies and payers to monitor homecare caregivers in real-time
- Multi-modal solution that leverages telephonic, fixed-device (FVV) and GPS enabled mobile (MVV) visit verification to monitor field activity and schedule compliance

Solution Benefits

Payer Benefits

- Ensures tight control over authorized services and service delivery
- Increases transparency into homecare provider network
- Reduces fraud, waste, and abuse

Provider Benefits

- Ensures clinical compliance
- Maximizes reimbursement by reducing missed and late visits
- Protects against allegations of fraud
- Improves caregiver accountability

Participant Benefits

- Increases care timeliness and quality by ensuring the right caregiver is delivering the right plan of care

Solution Functionality

- Multiple verification modalities
- Time and Attendance
- Configurable Alert
- Speaker Verification
- Plan-of-Care Prompting
- Task Entry

Santrax Agency Management

- *Santrax Agency Management* provides a platform for automating all clinical, financial, and operational elements of agency management, including scheduling, billing, and payroll
- *Santrax Agency management* is fully integrated with *Santrax EVV*, enabling agencies to automatically access real-time visit data

Solution Benefits

Payer Benefits

- Ensures compliance via no show alerts
- Claim validation ensures only verified visits are sent to adjudication vendor
- Improves communication with provider and increases transparency

Provider Benefits

- Maximizes productivity and efficiency
- Increases cash flow through billing automation
- Preserves revenue through reduced missed and late visits

Participant Benefits

- Ensures necessary care occurs and improves care timeliness

Solution Functionality

- Participant & Staff Management
- Compliance Tracking and Documentation
- Advanced Scheduling
- Electronic Billing and Accounts Receivable
- Electronic Health Records
- Analytics

Santrax Participant Portal

- *Santrax Participant Portal* is an ADA 508 Compliant web portal that allows participants to manage home care delivery, utilization, and payroll for consumer directed care programs
- *Santrax Participant Portal* is fully integrated with *Santrax EVV*, enabling participants to automatically access real-time visit data

Solution Benefits

Payer Benefits

- Provides visibility to consumer directed care programs
- Increases transparency into homecare provider network
- Reduces fraud, waste, and abuse

Participant Benefits

- Empowers participants to effectively manage care delivery, budgets, and employee payroll
- Automates the paper timesheet process

Solution Functionality

- ADA 508 Compliant
- Consumer Directed Programs
- Review and Approve Visits
- View Authorized Services
- Payroll Integration

Santrax Payer Management

- *Santrax Payer Management (SPM)* provides homecare payers with near real-time visibility and a jurisdictional view into the operations of their provider networks
- *SPM* enables payers to audit agency business practices to deliver more cost-effective, efficacious care

Solution Benefits

Payer Benefits

- Improves provider accountability and quality of service delivered in the home
- Streamlines claims management and services authorization
- Ensures tight control over authorized services
- Enhances transparency into provider network
- Reduces incidence of inappropriately billed services
- Decreases fraud, waste, and abuse

Provider Benefits

- Improves communication with payer

Participant Benefits

- Improves care quality and timeliness

Solution Functionality

- Alerts
- Analytics
- Visit Verification
- Auditing
- Claims Processing

Implementation Process

Preparation	Requirements	Design and Development	Testing and Training	Live/ Post Live
• Contract completion • Kick-off meeting(s) • PMO and logistics • PR Outreach planning • PMO Planning: Phases, Resources, Scope, Budget	• Business Rules definition • Functional requirements definition • Data exchange needs • Reporting needs • Technical environments • Connectivity	• Database schema • Data dictionaries • Navigation tabs • Data imports • Views and security • Report setup	• Unit Testing • Integrated Testing • Stress/Volume, UAT • Training materials • Super user training • End user training • Proficiency tests	• Import verification • Prod schedule review • Sign-offs • PR/Communication • Go Live • Post Go-Live support

Continuous project monitoring, progress reporting, scope and timeline management

EVV: Value to Alaska

RIGHT MEMBER

RIGHT LOCATION

RIGHT TIME

RIGHT CAREGIVER

RIGHT PLAN OF CARE

The Sandata Solution:

- **Validates Visits** - at the point of care to guard against allegations of Fraud and Abuse
- **Improves Service Accuracy** - accurate service of the participants and alerts provider and payer when visits were missed, late, or cut short.
- **Ensures Billing Accuracy** - Pre-submission validation and electronic transmission for adjudication that ensures claims Medicaid receives are clean
- **Provides Service Data Visibility** – Both real-time and retrospective analytics across all providers to track performance and improve quality – ***Provides Pre-Claim Data***

The Sandata Solution Benefits:

- **Reduce Fraud, Waste and Abuse –** 10-25% reduction in claims cost
- **Improvement of Quality –** ensure accurate service of the participants
- **Improve Program Efficiency –** Complete automation of process from scheduling to adjudication. Automated integration and billing prevents user errors that lead to audits.
- **Increase Visibility –** Utilization management, Score carding, benchmarking and real time analytics

Agenda

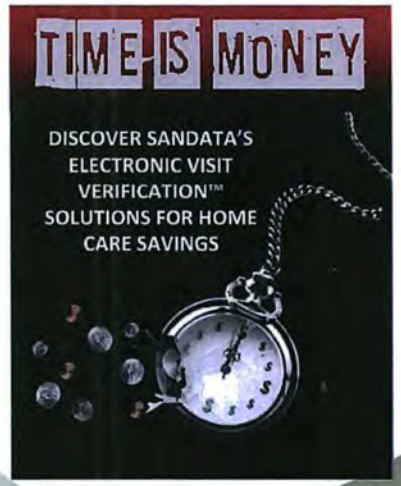
- Introductions
- What is EVV?
- Sandata Overview
- Solution and Technology Overview
- Questions and Answers
- Wrap Up

santrax PAYER MANAGEMENT

Santrax® Payer Management (SPM) reduces inaccuracies and potential abuse through our automated Electronic Visit Verification™ and claims validation processes. SPM reduces fraud in home care delivery by removing the elements most closely associated with improper recordkeeping including paper time sheets and manual billing.

By providing greater visibility into the delivery of home and community based services across a jurisdiction, SPM:

- *Reduces costs and the incidence of inappropriately billed services*
- *Has decreased claims costs by 10% to 50% in other programs*
- *Ensures tight control over services authorized and services paid*



VISIT VERIFICATION

OVERSIGHT

SAVINGS

Sandata Technologies, LLC
26 Harbor Park Dr.
Port Washington, NY 11050
Phone: 800.544.7263
Fax: 516.484.6084
Email: sprnteam@sandata.com

santrax® PAYER MANAGEMENT

Examples of Fraud and Abuse within Home Care

"Home health care aides accounted for more criminal convictions in FY 2014 than any other provider type investigated and prosecuted throughout the US."

— **Suzanne Murrin, Deputy Inspector General for Evaluations and Inspection, *Medicaid Fraud Control Units FY 2014 Annual Report***

Sandata

ELECTRONIC VISIT VERIFICATION

IMPROVED OVERSIGHT

SIGNIFICANT SAVINGS

District of Columbia

Owner of Three Home Health Care Agencies Indicted

The District of Columbia Medicaid Fraud Control Unit announced on December 19 that Florence Bikundi, also known as Florence Ngwe and Florence Igwacho, the owner of three home care agencies, was charged in a superseding indictment with six additional offenses related to a scheme to secure more than $75 million in District of Columbia Medicaid payments, even though she was barred from participating in any federal health care programs. The new charges include allegations that Bikundi and others conspired to bill the Medicaid program for services that were not provided.

"In 2011, Medicaid paid more than $12 billion for personal care services. In 2010, state Medicaid fraud units investigated more than 1,000 cases involving personal care services, more than any other type of Medicaid service."

- Office of Inspector General

AG Koster announces judgment against New Madrid County Medicaid provider

Apr 24, 2015, 13:02 PM

Jefferson City, Mo. – Attorney General Chris Koster announced today his office has obtained a civil judgment against Tina Hartlein, owner and operator of Caring Hands In Home Care, in Mathews, MO, for her company's submission of false claims to Missouri's Medicaid program. As part of the judgment, Hartlein has agreed to pay $115,298, which will be returned to Medicaid, along with $5,000 to cover investigative costs.

Koster's office conducted an investigation into Caring Hands after receiving complaints about several of the company's attendants. The investigation found that Caring Hands hired an attendant to provide in-home personal care services to her parents, which is prohibited by Missouri Medicaid regulations. The investigation also discovered that Caring Hands later replaced the attendant with her husband and that former Caring Hands employees instructed him to complete timesheets with inaccurate information.

http://www.namfcu.net/resources/medicaid-fraud-reports-newsletters/2014-publications/14NovDec.pdf

https://www.ago.mo.gov/home/ag-koster-announces-judgment-against-new-madrid-county-medicaid-provider

2 women charged with Medicaid fraud after investigations by Attorney General's Medicaid Fraud Control Section

4/20/2015

HARRISBURG – Attorney General Kathleen G. Kane today announced criminal charges have been filed against two women accused of committing Medicaid fraud.

The charges were the result of separate investigations by the Office of Attorney General's Medicaid Fraud Control Section. Those charged are:

- Kelly Ann Howley, 32, 45 Locust Lane, Levittown, Bucks County
- Nadia Shree Demota, 33, 4509 N. 12th St., Philadelphia

Howley charges

Howley, a therapeutic support staff worker for Horizons Behavioral Health, among other agencies, is accused of being paid $19,520 for services she never rendered. It is alleged that Howley billed two different agencies for services provided on the same dates and times to two different medical assistance recipients.

Demota charges

According to a criminal complaint, Demota was tasked with providing home health services for her grandmother. She submitted fraudulent time sheets indicating she provided services, when in fact her grandmother was hospitalized or in a rehabilitation center, the complaint alleges.

4/30/2015 – Louisiana

Four Arrested on Medicaid Fraud Charges

Medicaid billed for services while beneficiaries were on Caribbean cruise

Attorney General Buddy Caldwell announced that four individuals were arrested after an investigation conducted by agents with his Medicaid Fraud Control Unit revealed the state's Medicaid Program was billed for in-home personal care services while the Medicaid recipients purported to be receiving care were actually on a Caribbean cruise.

https://www.attorneygeneral.gov/Media_and_Resources/Press_Releases/Press_Release/?pid=1693

http://www.ag.state.la.us/Article.aspx?articleID=1000&catID=2

April 16, 2015 - Florida

Owner of Miami Home Health Company Sentenced to 113 Months in Prison for $32 Million Medicare Fraud Scheme

An owner of a Miami home health care company was sentenced today to 113 months in prison in connection with a $32 million Medicare fraud scheme.

Felix Gonzalez, 45, of Miami, pleaded guilty on Jan. 9, 2015, to one count of conspiracy to commit health care fraud, and was sentenced today by U.S. District Judge Kathleen M. Williams of the Southern District of Florida. In addition to the prison sentence, Gonzalez was ordered to pay $21,423,160 in restitution.

Gonzalez was an owner of AA Advanced Care Inc. (AA Advanced), a Miami home health care agency that purported to provide home health and therapy services to Medicare beneficiaries. As part of his guilty plea, Gonzalez admitted that he and his co-conspirators operated AA Advanced for the purpose of billing the Medicare program for, among other things, expensive physical therapy and home health care services that were not medically necessary or not provided at all.

"In 2012, the Government Accountability Office reported that 40% of all fraud convictions initiated by a group of Medicaid fraud-control units were for home health."

- Government Accountability Office

Friday, March 13, 2015 - Michigan

Owner of Detroit Home Health Care Companies Pleads Guilty to $12.6 Million Fraud Scheme

The owner of two home health care companies pleaded guilty to Medicare fraud and tax fraud charges in connection with his role in a scheme to fraudulently bill Medicare for $12.6 million in home health services that were not provided or were obtained through illegal kickbacks. Ten other individuals have been convicted at trial or pleaded guilty in this case.

http://www.justice.gov/opa/pr/owner-miami-home-health-company-sentenced-113-months-prison-32-million-medicare-fraud-scheme

http://www.justice.gov/opa/pr/owner-detroit-home-health-care-companies-pleads-guilty-126-million-fraud-scheme

March 29, 2015 – New Jersey

Former Passaic County Home Health Aide Sentenced to Three-Year State Prison Term for Falsely Billing Medicaid for Medical Services in No-Show Scam

TRENTON – Acting Attorney General John J. Hoffman and the Office of the Insurance Fraud Prosecutor (OIFP) announced that a former employee of a home health agency was sentenced to a three-year state prison term today for causing bills to be submitted to the Medicaid program for services that were never provided.

Thursday, March 12, 2015 - Illinois

Woman Admits Billing Home Services Program While In Jail

Stephen R. Wigginton, United States Attorney for the Southern District of Illinois, announced today that on March 12, 2015, Angela Jones, 51, of Madison, IL, pled guilty to a one-count indictment charging that she engaged in a scheme to commit health care fraud. At her sentencing Jones will face up to 10 years of imprisonment, a fine of up to $250,000 and up to 3 years of supervised release. Sentencing has been set for July 10, 2015, at 2:30 pm in United States District Court in East St. Louis, Illinois.

During her plea hearing, Jones admitted that she had submitted false and fraudulent bills in regard to the providing of personal assistant services in the Home Services Program, a Medicaid Waiver Program designed to allow individuals to stay in their homes instead entering a nursing home. Jones admitted that she was actually incarcerated while she was billing the Home Services Program.

http://nj.gov/oag/newsreleases15/pr20150429b.html

http://www.justice.gov/usao-sdil/pr/woman-admits-billing-home-services-program-while-jail

Electronic Visit Verification. Improved Program Management. Significant Program Savings.

Sandata's Electronic Visit Verification solutions have proven their effectiveness for payers in the following areas:

- Reduced claims costs
- Decreased HCBS utilization
- Increased on-time visits
- Decreased PMPM costs
- Decreased lag time between service delivery and payment

Connect with us:

SPMsales@sandata.com
twitter.com/Sandata_Tech
www.linkedin.com/company/sandata-technologies
www.facebook.com/pages/Sandata-Technologies/147789808570957
www.youtube.com/user/SandataTechnologes

Sandata Technologies, LLC
26 Harbor Park Drive
Port Washington, NY 11050

www.sandata.com
1.800.544.7413

Tuesday, 03 10, 2015 – Kentucky

Attorney General Conway Announces Guilty Plea in Medicaid Fraud Case

Attorney General Jack Conway and his Medicaid Fraud and Abuse Control Unit announce the guilty plea and sentencing of Hailey Smith in Hopkins District Court on a charge of defrauding the Kentucky Medicaid Program.

Smith, a resident of Madisonville, Kentucky, received a 12-month sentence, which will be diverted for a period of two years as long as she meets the terms of the plea agreement. Smith was also ordered to pay $8,290 in restitution to the Kentucky Department of Medicaid Services. As part of the guilty plea, Smith is prohibited from working in any Kentucky Consumer Directed Option (CDO) program.

Smith provided community living support, respite care, and attendant care services to several Medicaid recipients through the CDO program. By pleading guilty, Smith admits to submitting false time sheets between May of 2011 and April of 2012 for services she did not perform, resulting in a loss of $8,290 to the Medicaid program.

"The Florida Medicaid Telephonic Home Health Services Delivery Monitoring and Verification ("DMV') Program Annual Review Report (December, 2011) documents that "in first year of the DMV program, the largest home care agency in Dade County, Coral Homecare shut down due to the increased focus on fraud detection in the program area and the second largest agency, Sunshine Good Care, had its contract with AHCA terminated with two of their corporate officers arrested for suspicion of Medicaid fraud on similar but unrelated charges."

- Florida DMV 2011 Program Annual Report

http://kentucky.gov/Pages/Activity-Stream.aspx?

Electronic Visit Verification

Illinois Home Services Program 2014 Year End Review

Santrax Electronic Visit Verification™ (EVV™) optimizes compliance with the authorized care plan and reduces fraud, waste, and abuse by enabling Payers to monitor in-home care workers in real-time.

How the Department of Human Services' HSP EVV Program Works

Sandata's EVV system technology documents customer and IP IDs, location, arrival and departure times for visits

Step 1: Call Process
Individual Providers (IPs) and agency attendants call in upon arrival to the customer home to start work and call out once their work is completed using the customer's registered phone.

Step 2: Verification
Customers and DHS staff access IP's electronic timesheets for review, adjustment, and approval via Sandata's ADA Section 508 compliant Member Management web portal.

Step 3: Payment
Payroll file from EVV for approved visits is sent to IOC for issuing IP and attendant checks. IPs access *"You've Got Paid"* website for payment and tax history.

Step 4: Program Oversight
DHS uses EVV jurisdictional view, reporting capabilities, and data warehousing for auditing and oversight over entire HSP program.

Individual Provider (IP) Benefits

- Significantly reduces the need for manual paper timesheets
- Streamlines payment processes
- Improves IP and customer accountability

Illinois DHS Benefits

- Ensures tight control over authorized services and service delivery
- Reduces fraud, waste, and abuse
- Increases transparency into homecare provider networks

Sandata TECHNOLOGIES

DHS Program to Date Highlights*

*As of November 19, 2014

- Program launched January 1, 2014
- 51,000+ registered IPs
- 28,000+ customers
- 32,000 individuals trained on system
- IOC testing completed
- 24,000+ unique IPs using system / month
- Nearly 85% EVV utilization compliance
- 312,000+ calls per week on average
  - 42,000+ calls per week day
  - 26,000 +calls per weekend day
- Over $21 M in monthly payroll supported

What are Illinoisans Saying about EVV?

"Thanks to Sandata technology, we at R.G.U.S., Inc. were able to get rid of paperwork headaches, improve productivity that in return allowed us to improve client care and change quality of lives. We knew the change will be hard but with the professional help and expert guidance of Sandata implementation and customer support teams we had a peace of mind. Their [Sandata] product constantly evolves and we are looking forward getting additional features that will advance our small agency to the next level! By working with Sandata we not only found an excellent technical provider but also gain a valuable power partner! " - Lana Ananich, Manager, R.G.U.S. Inc. Home Care Agency

"We think it will be a way to give the system more integrity, it'll be the strongest system the state has ever had to maintain the accountability of the Home Services Program, and most importantly, it enables choice for the customer in the Home Services Program." - Tom Green, DHS Communications Director

"This state-of-the-art electronic timekeeping system will improve the accuracy and oversight of the program while improving the quality of care. This will be the most stringent timekeeping system in the program's history." - IDHS Secretary Michelle R.B. Saddler

"SEIU has told me that they have and will continue to support various fraud-prevention measures, including EVV and more and better training, as well as oversight and transparency." - David McSweeney (R-Lake Barrington)

"Sandata's Electronic Visit Verification technology has been extremely beneficial for our agency. Our processes are much more efficient, which allows us to focus on quality care for customers. It is an easy technology and gives us insight into our field staff activity that we did not have before." - Ron Ford, Chief Executive Officer, Help at Home, Inc.

Sandata Technologies, LLC
26 Harbor Park Drive
Port Washington, NY 11050

www.sandata.com
1.800.544.7413

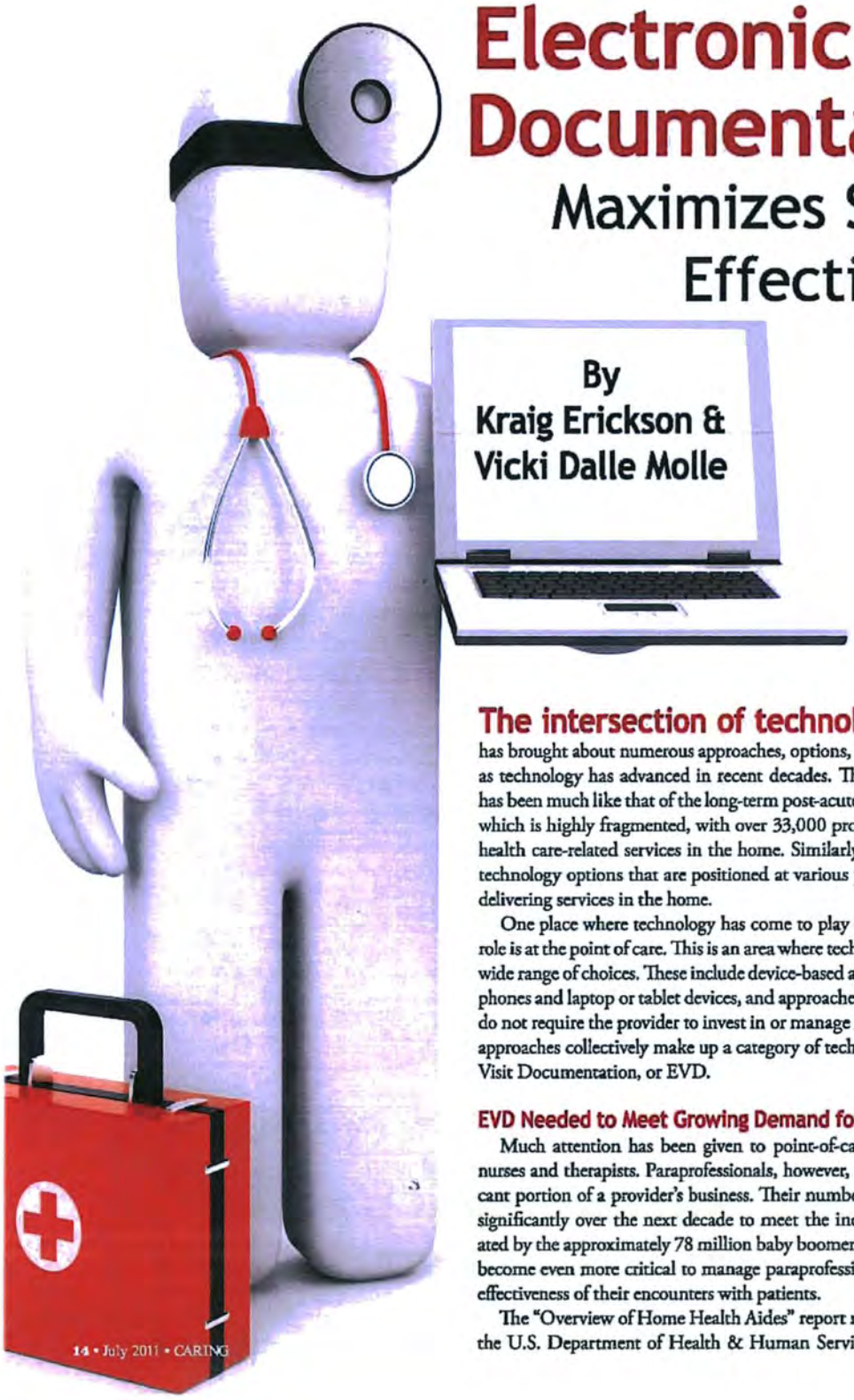
Connect with us:
SPMsales@sandata.com

twitter.com/Sandata_Tech

www.linkedin.com/company/sandata-technologies

Sandata TECHNOLOGIES

Electronic Visit Documentation Maximizes Service Effectiveness



By
Kraig Erickson &
Vicki Dalle Molle

The intersection of technology and care has brought about numerous approaches, options, vendors, and feature sets as technology has advanced in recent decades. The growth of technology has been much like that of the long-term post-acute care (LTPAC) industry, which is highly fragmented, with over 33,000 providers[1] offering personal health care-related services in the home. Similarly, there are a plethora of technology options that are positioned at various points in the business of delivering services in the home.

One place where technology has come to play a much more significant role is at the point of care. This is an area where technology offers providers a wide range of choices. These include device-based approaches, such as smart phones and laptop or tablet devices, and approaches, such as telephony, that do not require the provider to invest in or manage field devices. All of these approaches collectively make up a category of technology called Electronic Visit Documentation, or EVD.

EVD Needed to Meet Growing Demand for Information

Much attention has been given to point-of-care EVD approaches for nurses and therapists. Paraprofessionals, however, often represent a significant portion of a provider's business. Their numbers are projected to grow significantly over the next decade to meet the increasing demands generated by the approximately 78 million baby boomers. This means that it will become even more critical to manage paraprofessionals and maximize the effectiveness of their encounters with patients.

The "Overview of Home Health Aides" report released May 19, 2011 by the U.S. Department of Health & Human Services, Centers for Disease

Control and Prevention, states that "the number of home health and hospice aides is expected to increase 50% between 2008 and 2018. Direct care jobs are projected to be among the fastest-growing occupations with the greatest increases among home health and hospice aides." In fact, "the bulk of formal long-term care is provided by direct care workers, such as nursing assistants, home health aides, and personal aides, who provide basic care and essential help with daily activities, enabling people with functional and activity limitations to live independently in their homes."

These direct care activities could benefit greatly from EVD technology, as many payers and providers are beginning to realize. All too often, these patient encounters are documented manually, sometimes even with weekly visit logs, which does little to ensure that accurate, comprehensive information is collected at the point of occurrence. The practice of turning in weekly notes diminishes quality and creates a lapse between the time of the patient encounter and when the provider receives information on the visit, making it impractical to effectively manage these services. Even the FedEx guy collects electronic "proof of delivery" for a $4.00 book. Why shouldn't something as valuable as a patient encounter be electronically documented and verified?

While speaking to Senator Amy Klobuchar's (D-MN) legislative aides during the 2011 NAHC March on Washington, I was asked, "What is the industry doing to help reign in fraud and abuse?" I explained that many providers make use of technical and administrative safeguards and that public policy can help maximize the impact of available options. This article is spurred by that conversation. It shows how EVD can help facilitate a proactive approach to combating fraud and abuse instead of a reactive, retrospective approach to finding fraud by data mining, audits, and mandates.

EVD is Comprehensive and Integrated with EMR

While verification of a visit using EVV is important, it doesn't universally address the scope of the data set that is collected or the timely integration with the provider's EMR system. EVD, as stated, includes EVV-related date, time, and location, but also services, tasks, and other discipline specific information that makes up a complete record of the patient encounter. Because EVD solutions integrate tightly with a provider's EMR system, timely management of field staff can occur, enabling providers to effectively respond to scheduling, clinical, or service exceptions. EVD also yields precise productivity reporting, efficient payroll processing, and allows providers to generate accurate, timely claims.

EVD and EVV Standards

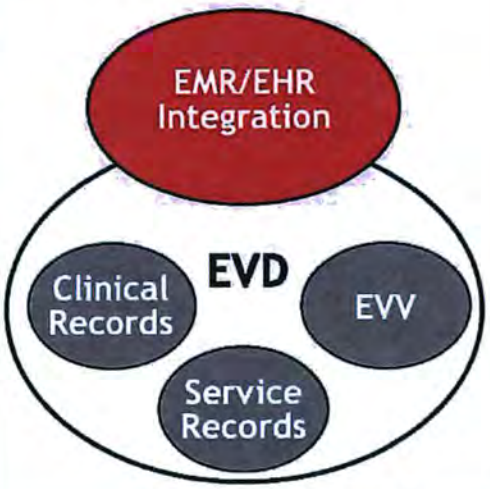
Drawing similarities again to the LTPAC provider market and its many options, the emergence of numerous EVD and EVV technology options and approaches can be overwhelming if commonalities and standards are not defined and understood. Just like a provider must meet CoPs in order to provide

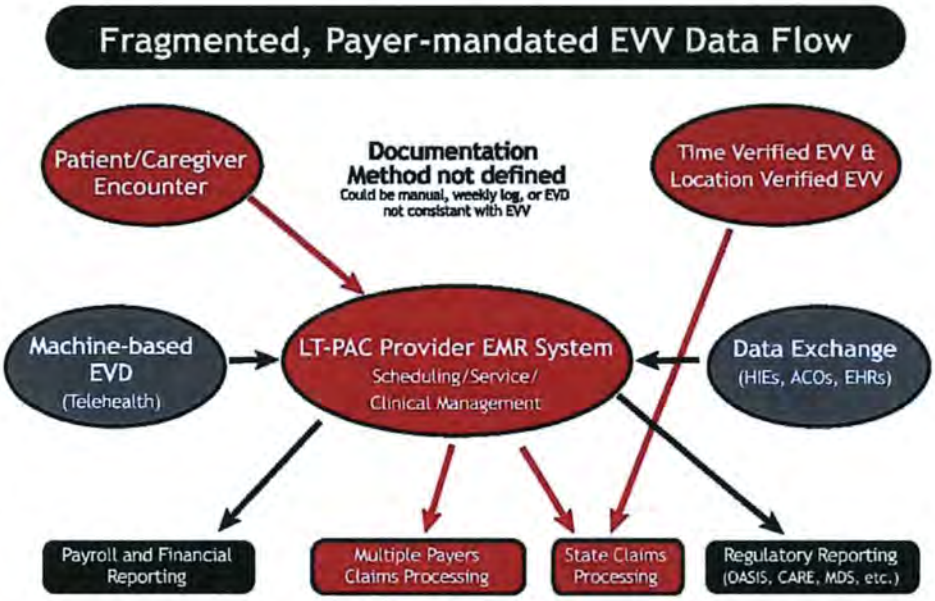
EVD and EVV Definitions

EVD, Electronic Visit Documentation, is a comprehensive, complete account of a patient encounter which is integrated tightly with a provider's EMR system. EVD should include everything on the patient encounter that is needed to support charting, billing, and payroll. EVD could represent human-based patient encounters and also machine-based patient encounters in the case of telehealth. This article will focus primarily on EVD for human-based patient encounters.

EVV, Electronic Visit Verification, is just one feature of a more comprehensive EVD solution that provides proof of visit. One of the most common methods of EVV, telephony, uses recognition of a recipient's phone number to capture the date, time, and location of service. Other types of EVV technology include cell phone GPS, tablet-based digital signature with time and date stamping, biometric recognition, and electronic random number generation matching devices.

For the purposes of this article, the term **patient** collectively represents consumers, clients, and recipients, and the term **clinician** includes field staff, caregivers, workers, aides, PCAs, and attendants. Providers represent businesses who manage both medical and non-medical services in the home.





certain services, wouldn't it also be helpful if standards could be established to ensure an EVD or EVV technology meets certain requirements?

There are emerging standards movements for EHRs (Electronic Health Records) that now include LTPAC providers, but they focus on aggregate standardized record sets and interoperability. Aside from OASIS, they provide minimal definition of "how" and "what" data gets collected during the patient encounter. The progression towards standardized EHRs further strengthens the need to collect patient encounter data electronically during the visit, at the point of care, via comprehensive EVD approaches that encompass all disciplines. As interconnected health care continues to evolve, this EVD data will pass through a provider's EMR system and on to other parts of the health care spectrum through their trusted HIE and ACO networks as well as being sent to payers for billing purposes.

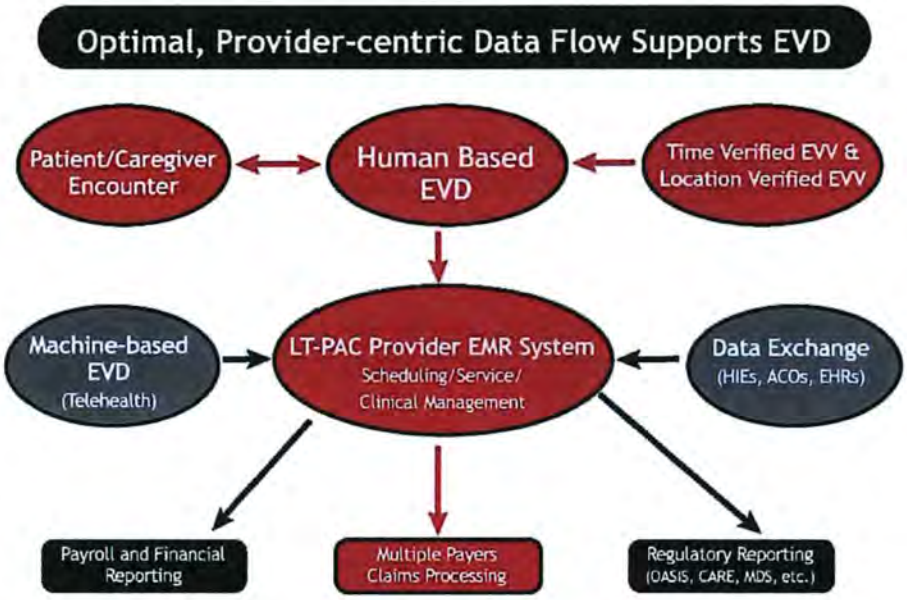
While no federal standards now define EVD or EVV, one group of industry vendors is working to provide a definition so providers and payers can be confident that features meet a minimum set of specifications. The EVV Workgroup for Home Care and Hospice (www.EVVworkgroup.org) has recently established draft standards for EVV. The language of the draft standards is designed to enable states and payers to ensure that a provider's chosen EVD or EVV solution meets basic criteria for proof of visit. The current verification standard published by the EVV Workgroup reads as follows:

At a minimum, an Electronic Visit Verification (EVV) system shall:

a. Record the exact date services are delivered;
b. Record the exact time the services begin and exact time the services end;
c. Verify the telephone number or location from which the services are registered;
d. Include a mechanism to verify whether their employees are present (e.g., at the beginning and end of a visit) at the location and time where services are to be provided for recipient;
e. Require a personal identification number unique to each caregiver and, if appropriate, a unique password established by said caregiver;
f. If required by a State or other jurisdiction, the system must have a proven biometric identification system for purposes of identifying the caregiver beyond the entry of a personal identification number and / or unique password;
g. Be capable of producing reports of services delivered, tasks performed, recipient identity, beginning and ending times of service and date of service in summary fashion that constitute adequate documentation of service;
h. The system must be HIPAA compliant;
i. The system must insure at least daily back-up of all data collected;
j. Due to the mission critical nature of such a documentation system, it must demonstrate a viable disaster recovery mechanism allowing for its use within 12 hours of any disruption to services, subject to exceptional circumstances such as war and other disasters of national scope.

EVV Movements and Payer Strategies

If you are providing services in Florida or Texas, you've likely heard of EVV. Pilot projects are currently underway in these states to examine payer-related benefits of EVV in an effort to curtail fraud and abuse and establish more control over some of their Medicaid programs. There appear to be two very different



strategies when it comes to how states are introducing EVV to provide proof of visit.

Taxpayer Funded, Single Vendor Strategy

Some states have gone down the path of purchasing and running their own EVV system and mandating its use, even though many providers already have EVV-capable systems in place.

The value proposition of providers is defined by the quality and scope of services they provide. To provide optimal value, it is important for providers to be in the direct path of data as it comes in from the patient encounter. With a state-run, state-mandated approach to EVV, providers are often left on the sideline and out of the data path if the EVV portion of the data set travels directly to the payer without first going through the provider's EMR system for QA, analysis, and processing. This is an obvious problem for providers serving multiple jurisdictions who already have a comprehensive EVD solution in place.

The red lines in Figure 1 below highlight how the data flow of state-run EVV sidesteps the provider. The patient encounter data travels into the provider's EMR system, either manually or electronically, while the EVV data travels directly to the payer.

While there is clearly some benefit for states to mandate use of EVV, the benefits are diluted when providers are forced to use state-run EVV systems in addition to their own more comprehensive EVD solution.

This approach introduces inefficiencies caused by redundant double entry, and creates "data silos," putting more administrative burdens on providers and decreasing their ability to effectively manage service delivery in a timely manner. It does not facilitate timely provider QA management, scheduling and services adherence, or billing and payroll compliance via a provider's EMR system, which likely manages services for multiple payers. This approach can only be effective for providers who service a single program or do not have an EMR system, limitations that do not support EVD and are not in line with national goals for EHRs.

Mandating use of a single, state-run system also limits the ability of the payer to take advantage of innovation and competitive drivers in the fast-paced world of mobile health care technology.

Standards Based, Free Market Strategy

An optimal, provider-centric EVD data flow is represented below in Figure 2. The red arrows follow the data path from the patient encounter > through the provider > to payer. The provider gets timely information to manage service quality and the payer gets the accountability they are seeking.

If providers are not in the path of the data flow, they lose control, as they would in the case of telehealth (identified in both figures as Machine-based EVD"). The result is to diminish manageability of field staff across all programs and their value proposition to the health care system.

Supporters of the EVV Workgroup believe that payers could realize maximum benefit by letting providers adopt whichever standards-based EVV type meets their needs. By promoting, encouraging, or even mandating use of a qualifying EVV system of the provider's choosing, public payers would not only save taxpayers the cost of paying for and maintaining their own EVV system, but also reap more benefit for themselves and other stakeholders by eliminating redundancies.

One state that has taken a supportive approach to standards-based EVV is Pennsylvania. The Pennsylvania Department of

Aging issued a bulletin on November 23, 2010 that "strongly encourages telephony." Acknowledging that providers also need administrative safeguards in place to complement this EVV type, the bulletin goes on to clarify that:

> *"Agencies must have a protocol in place for making edits to electronic time sheets that includes making contact with the participant and the worker.*
>
> *Telephony time & attendance electronic records are accepted by the Commonwealth as documentation of services rendered in support of claims for Medicaid reimbursement under OLTL Waivers. Substantiation or backup of telephony time & attendance records with paper timesheets is not required."*

Ohio is another state that has adopted a standards-based strategy to help provide time, location, and service delivery assurance through visit verification. The following is an excerpt from The Ohio Division of Medical Assistance Administrative Code, Chapter 510:3:

> *(2) A home care service provider, who provides home care services to a home care dependent adult, must have a system which effectively monitors the delivery of services by its employee(s). The system must include:*
>
> *(a) A mechanism to verify whether their employees are present (e.g., at the beginning and end of a visit) at the location and time where services are to be provided for home care dependent adults who have a mental impairment or life-threatening condition;*
>
> *(b) Verification of whether the provider's employees have provided the services at the proper location and time at the end of each working day for all other home care dependent adults.*

The State of Missouri had standards-based EVV language in place which was recently challenged. The state legislature was specifically asked to determine whether a single-vendor, state-mandated system should be piloted or if it should stay the course with a standards-based, free market approach. After becoming educated on the relative merits of each approach, the legislature opted for the standards-based, free market strategy, enabling innovation, competitiveness, and support for a provider's value.

Be sure to reference your payer's current policies since language is subject to change.

In today's budget crisis, it is important that public payers pursue strategies that maximize taxpayer dollars and choose the approach that yields the most benefit for all stakeholders, including the recipient, the provider, and the payer. Even though the value to providers of using EVV typically pays for the cost of these systems, payers could consider reimbursing more for

EVV visits than non-EVV visits, similar to how credit card companies charge merchants different rates based on the level of confidence in the transaction. Another approach would be to use an allotment of funds given back to providers who meet certain EVV-use percentages across their patient encounters for a particular program.

EVD in the Payer Provider Relationship

In summary, strategies and policies that encourage accountable, accurate service delivery information could be clarified by asking this question: Who needs the point-of-service data in real time, the provider or the payer?

Unless the payer is going to respond in real time to service alerts, vital sign exceptions, or scheduling variances, policy and strategy should support all patient encounter data traveling directly to the provider first, then to the payer. By establishing visit verification standards and enabling providers to choose EVV types and vendors that meet standards, both payers and providers can maximize the benefits of incorporating EVD into their practices and support national goals of EHRs. It is an important time for our industry's creative thought leaders to chime in to help guide and inform policy makers.

References

[1]This number is a combination of Medicare-certified home health agencies, Medicare-certified hospices, and an estimate of non-Medicare agencies providing care in the home. From a report prepared by The National Association for Home Care & Hospice, "Basic Statistics About Home Care – Updated 2010."

About the Author: *Kraig Erickson is a Vice President at Sansio and founding member of the EVV Workgroup for Home Care & Hospice. Established in 1997, Sansio helps Home Care & Hospice, Assisted Living, and Fire/EMS providers deliver and manage over 7 million patient encounters annually through its EVD and cloud-based decision support solutions. www.Sansio.com. EVV Workgroup for Home-Care & Hospice provides education, raises awareness, and assists with standards development on the use of EVV and full-featured EVD solutions so that payers and providers can maximize their effectiveness through free market, standards-based solution approaches. Connect with Kraig at: www.linkedin.com/in/kraigjerickson.*

Vicki Dalle Molle, MPA, is the Executive Director of Choice Home Care, a Medicare-certified home health agency, and the Southeastern Minnesota Center for Independent Living in Rochester, Minnesota. The agencies serve an 11-county area in southeastern Minnesota. Ms. Molle has led both organizations since 2002 and has worked in health care and human services for the past 20 years. She can be reached at vickidm@semcil.org.

MEDICAID & PUBLIC ASSISTANCE FRAUD

STRIKE FORCE

ANNUAL REPORT

October 1, 2011

Respectfully Submitted by

CHIEF FINANCIAL OFFICER JEFF ATWATER, CHAIRMAN

STRIKE FORCE MEMBERS

Chairman, Jeff Atwater, Chief Financial Officer, Florida Department of Financial Services

Vice Chair, Pam Bondi, Attorney General, Florida Office of Attorney General

Gerald Bailey, Commissioner and Executive Director of the Florida Department of Law Enforcement

Elizabeth Dudek, Secretary, Florida Agency for Health Care Administration

David Wilkins, Secretary, Florida Department of Children and Family Services

Harry Frank Farmer, Jr., M.D., Ph.D., FACP, State Surgeon General, Florida Department of Health

Katherine Fernandez-Rundle, State Attorney, Eleventh Judicial Circuit (Miami-Dade)

Sheriff David Gee, Hillsborough County Sheriff's Office

Sheriff Ric L. Bradshaw, Palm Beach County Sheriff's Office

Chadwick E. Wagner, Chief of Police, City of Hollywood Police Department

Juan Jesus Santana, Division Chief, Miami-Dade Police Department

ABOUT THE STRIKE FORCE

The Medicaid and Public Assistance Fraud Strike Force (hereafter referred to as "Strike Force") was established by the 2010 Florida Legislature under Chapter 624.351, Florida Statutes. It was established based upon a finding "that there is a need to develop and implement a statewide strategy to coordinate state and local agencies, law enforcement entities, and investigative units in order to increase the effectiveness of programs and initiatives dealing with the prevention, detection, and prosecution of Medicaid and public assistance fraud," Section 624.351(1), Florida Statutes.

Responsibilities of the Strike Force

The legislation directed that the Strike Force serve in an advisory capacity and provide recommendations and policy alternatives to help achieve the overall mission of the Strike Force: "to eliminate Medicaid and public assistance fraud and to recover state and federal funds," Section 624.351(2), Florida Statutes. To help the Strike Force achieve its purpose, in Section 624.351(6)(a) the Legislature authorized the Strike Force to advise on activities to include, but not be limited to:

1. Conducting a census of local, state, and federal efforts to address Medicaid and public assistance fraud in this state, including fraud detection, prevention, and prosecution, in order to discern overlapping missions, maximize existing resources, and strengthen current programs.

2. Developing a strategic plan for coordinating and targeting state and local resources for preventing and prosecuting Medicaid and public assistance fraud. The plan must identify methods to enhance multiagency efforts that contribute to achieving the state's goal of eliminating Medicaid and public assistance fraud.

3. Identifying methods to implement innovative technology and data sharing in order to detect and analyze Medicaid and public assistance fraud with speed and efficiency.

4. Establishing a program to provide grants to state and local agencies that develop and implement effective Medicaid and public assistance fraud prevention, detection, and investigation programs, which are evaluated by the strike force and ranked by their potential to contribute to achieving the state's goal of eliminating Medicaid and public assistance fraud. The grant program may also provide startup funding for new initiatives by local and state law enforcement or administrative agencies to combat Medicaid and public assistance fraud.

5. Developing and promoting crime prevention services and educational programs that serve the public, including, but not limited to, a well-publicized rewards program for the apprehension and conviction of criminals who perpetrate Medicaid and public assistance fraud.

6. Providing grants, contingent upon appropriation, for multiagency or state and local Medicaid and public assistance fraud efforts, which include, but are not limited to:
   a. Providing for a Medicaid and public assistance fraud prosecutor in the Office of the Statewide Prosecutor.
   b. Providing assistance to state attorneys for support services or equipment, or for the hiring of assistant state attorneys, as needed, to prosecute Medicaid and public assistance fraud cases.
   c. Providing assistance to judges for support services or for the hiring of senior judges, as needed, so that Medicaid and public assistance fraud cases can be heard expeditiously.

The legislation also authorized the Strike Force to receive periodic reports from state agencies, law enforcement officers, investigators, prosecutors, and coordinating teams regarding Medicaid and public assistance criminal and civil investigations. Such reports may include discussions regarding significant factors and trends relevant to a statewide Medicaid and public assistance fraud strategy.

Supports Established for the Strike Force

Within two months of the 2011 transition in gubernatorial and cabinet administrations, planning staff initiated a number of strategies to support Strike Force activities. Planners identified two full-time equivalent positions to staff the Strike Force and support its activities. These included an Executive Director and a second position to provide support in the areas of research, analysis, planning and funding strategies.

Prior to the first Strike Force meeting on February 25, 2011, staff also created a Web site (http://www.myfloridacfo.com/strikeForce/default.aspx) to provide a vehicle for allowing public access to information about the Strike Force and its activities. Also prior to the initial meeting, Strike Force staff had already undertaken a search of funding sources that could be used to defray the costs of staffing and strategies supported by the Strike Force.

Prior to the third meeting of the Strike Force, staff identified funds available for contracted services to retain the expertise of the ERS Group, a consulting firm providing economic analysis and consulting. At the time of this report, the scope of services for the economic study has been refined to address the fraud rate in the Supplemental Nutrition Assistance Program (hereafter referred to as "SNAP", formerly known as food stamps) administered by the Department of Children and Families (hereafter referred to as "DCF"). The contractor has identified a sample group that will be reviewed by the Division of Public Assistance Fraud in the Department of Financial Services (hereafter referred to as "DFS") to investigate the occurance of fraud within the sample group. Currently, the Contractor and the Strike Force have identified certain parameters for the identification of fraud that could be immediately discerned by link analyses in order to refine the number of cases from the sample group that the Division of Public Assistance Fraud (hereafter referred to as "DPAF") will need to review. Once this work is completed, the ERS Group should have sufficient data to establish a fraud rate for the SNAP program.

In addition, Advanced Systems Design (hereafter referred to as "ASD"), an information technology and government consulting firm was hired as a process mapping consultant. At the time of this report, ASD had completed a preliminary, high level visual representation of the prevention, detection, investigation and recoupment of funds processes across the agencies that are primarily responsible for combating fraud in the Medicaid and public assistance service systems. The Mapping Committee is currently reviewing the work product.

ABOUT THIS REPORT

In accordance with Section 624.351, Florida Statutes, "The strike force shall annually prepare and submit a report on its activities and recommendations, by October 1, to the President of the Senate, the Speaker of the House of Representatives, the Governor, and the chairs of the House of Representatives and Senate committees that have substantive jurisdiction over Medicaid and public assistance fraud."

This report is intended to meet this obligation without duplicating the requirements for the annual report on *The State's Efforts to Control Fraud and Abuse* prepared by the Agency for Health Care Administration (hereafter referred to as "AHCA") and the Medicaid Fraud Control Unit (hereafter referred to as "MFCU") within the Office of Attorney General (hereafter referred to as "OAG"). That report should be considered a reference source for more detailed information about the activities, processes, and operations of AHCA and MFCU.

This report, instead, focuses on what the Strike Force has done in its first six months, information that has been gathered and recommendations being proposed to support "a statewide strategy to coordinate state and local agencies, law enforcement entities, and investigative units in order to increase the effectiveness of programs and initiatives dealing with the prevention, detection, and prosecution of Medicaid and public assistance fraud," as required in Section 624.351(1), Florida Statutes.

Every effort has been made to ensure that data contained in this report are accurate as of the date this report was written. Because information used in generating data or making projections is routinely updated, minor inconsistencies between information in this report and that contained in subsequent reports will result.

COMMITTEES AND MEMBERS

Grants

The Strike Force established a Grants Committee in July 2011 with representation from each of the state agencies that hold seats on the Strike Force. The purposes of this Committee are:

1. To research and identify appropriate grant programs for the Strike Force and/or its partners to pursue.
2. To assist with pursuing funding opportunities for the Strike Force and/or the partner agencies.
3. To provide guidance on the development of a grant initiative for the Strike Force in which the Strike Force is the grantor.
4. To review applications and make recommendations to the Strike Force for grant awards under the Strike Force grant initiative.

The following members of the committee were designated by Strike Force members to represent their agencies:

Larry Daugherty, OAG
Cynthia Godbey, DFS
Jennifer Green, AHCA
Phil Street, DOH
Clayton Wilder, FDLE
Fred Young, DCF

Mapping

The Strike Force also established a Mapping Committee in July 2011 with representation from each of the state agencies that hold seats on the Strike Force. The purposes of this Committee are:

1. To advise the Strike Force in the development of a tool that can provide a succinct picture of the anti-fraud processes in the Medicaid and public assistance service systems.
2. To advise the Strike Force on priorities for mapping business processes on vulnerable points within the Medicaid and public assistance service systems.

Guidance from this group helped direct the work of ASD to develop a high level visual representation of the prevention, detection, investigation and recoupment of funds processes across the agencies that are primarily responsible for combating fraud in the Medicaid and public assistance service systems.

The following members of this committee were designated by Strike Force members to represent their agencies:

Lisa Allen, DFS
Randy Burkhalter, DFS
Matt Dempsey, DCF
Russ Fernandez, DFS
Maria Leon, DCF
David Lewis, OAG
Mike Magnuson, AHCA
Charlene Willoughby, DOH

Legislative and Policy

The Strike Force then established a Legislative and Policy Committee in August 2011 with representation from each of the state agencies that hold seats on the Strike Force. The purposes of this Committee are:

1. To develop a legislative platform for the 2012 Legislative Session that will support the implementation of Strike Force initiatives and strategies.
2. To review initiatives of other states that address Medicaid and public assistance fraud.
3. To make proposals to the Strike Force regarding innovative policy initiatives.

This committee reviewed and recommended adoption of the recommendations contained in this report.

The following members of this committee were designated by Strike Force members to represent their agencies:

Kimberly Berfield, DOH
Kim Case, OAG
Chris Chaney, AHCA
Matt Dempsey, DCF
Lynn Dodson, FDLE
Robin Westcott, DFS

Technology

The Strike Force also established a Technology Committee in August 2011 with representation from each of the state agencies that hold seats on the Strike Force. The purposes of this Committee are:

1. To interact with the Interagency Technology working group to guide policy regarding the implementation of technology solutions throughout the Medicaid and public assistance service systems.

2. Provide advice/guidance on specific technology options.

This committee met once as an orientation and members briefed the committee on an interagency working committee and current technology solutions being developed. They are prepared to advise the Strike Force, as needed, in implementing technology solutions to improve anti-fraud efforts within the Medicaid and public assistance service systems.

The following members of this committee were designated by Strike Force members to represent their agencies:

John Croft, DCF
Bob Dillenschneider, DOH
Tammy Joiner-Philcox, OAG
Terry Kester, DFS
Penny Kincannon, FDLE
Scott Ward, AHCA

STRIKE FORCE MEETINGS

The minutes from the first three meetings of the Strike Force can be found on the website at: http://www.myfloridacfo.com/strikeForce/default.aspx. Here is a summary of what has transpired at those meetings.

February 25, 2011

Strike Force members offered brief descriptions of the functions of their agency and the role they play in preventing, detecting, investigating and prosecuting Medicaid and public assistance fraud and recouping funds wrongfully obtained. In particular, Strike Force members representing local law enforcement and prosecutorial functions offered ways in which they have supported and are willing to do more to support such efforts. The Strike Force heard presentations from DCF on the eligibility determination process carried out through the Automated Community Connection to Economic Self Sufficiency (hereafter referred to as "ACCESS") and related statistics. AHCA gave an overview of their primary functions and related statistics. They also gave an overview of a pilot project being implemented in the Miami-Dade area in which home health care services were telephonically monitored and verified. The Department of Health (hereafter referred to as "DOH") provided an overview of their responsibilities related to licensure of professionals. DPAF and MFCU provided overviews of their functions and related statistics. The presentations included recommendations for improving system operations.

May 16, 2011

AHCA provided updates on recent legislation that will move the Florida Medicaid program to managed care statewide. DOH presented an overview of the 2009 Senate Bill 1986, which enhanced their efforts to sanction licensed practitioners and facilitated interagency communications. DCF reported on organizational changes being made in that department to improve anti-fraud efforts in recipient eligibility determination. MFCU reported on a federal Medicaid data mining waiver they are piloting, which allows their unit to review claims data to develop leads for prosecuting Medicaid fraud. The Medicaid Program Integrity unit in AHCA reported on a budget allocation they have received from the Legislature to support the move to a more advanced case tracking system that will incorporate analytic technology to help detect fraud. They also reported on an interagency working group that has been meeting for years to focus on planning improvements in prevention and detection techniques.

The Strike Force Director reported on Strike Force initiatives that are underway to develop a tool for measuring the extent of fraud within the system(s), an initial cross-agency mapping of prevention, detection, investigation, prosecution and recoupment of funds processes within the system(s) and an initial review of barriers to data sharing. The Director also called on the Strike Force members to identify representatives to serve on committees to support the efforts of the Strike Force.

September 14, 2011

The Strike Force heard presentations from local, state and federal agencies on multi-jurisdictional collaborations to combat public assistance fraud. Strike Force members gave reports on current activities in their agencies of interest to the Strike Force and the Strike Force committees reported on their activities.

THE REPORT TO THE LEGISLATURE

The Problem

In 2010, the Legislature found "that there is a need to develop and implement a statewide strategy to coordinate state and local agencies, law enforcement entities, and investigative units in order to increase the effectiveness of programs and initiatives dealing with the prevention, detection, and prosecution of Medicaid and public assistance fraud," Section 624.351(1), Florida Statutes. This finding has been validated by recent trends in utilization that reflect an increasing need for Medicaid and public assistance services. A major driving force behind these trends is the current economic downturn.

According to the National Bureau of Economic Research, the current recession began in December of 2007. Between December 2007 and December 2010, requests for Assistance submitted through ACCESS increased by 33%. Food stamp caseloads increased 118% and Temporary Assistance for Needy Families (hereafter referred to as "TANF") caseloads increased by 40%. Although not as dramatic, other public assistance programs in various state agencies receiving some General Revenue funding report increasing caseloads as well.

Along with increases in these caseloads, there has been an increase in referrals to DPAF, as the investigative unit dedicated to fraud detection in these public assistance programs and among Medicaid beneficiaries. Between December 2007 and December 2010, the number of referrals to DPAF has increased 35.6%.

During the same time frame, Medicaid increased its caseload by 36.86%. Using projected enrollment figures from AHCA, the average monthly caseload is projected to have increased by 48.5% from SFY 2007-2008 through SFY 2011-2012. By the end of the state fiscal year, enrollment is expected to reach 3.192 million. Florida Medicaid is, and has been the fourth largest Medicaid program in the country based upon number of recipients.

Florida's Medicaid program is the fifth largest in terms of Medicaid expenditures with an estimated spending of over $21.2 billion for SFY 2011-2012; state funds make up about 45% of that budget. In general, services provided to the elderly and the disabled cost more per person/per month than services provided to children or healthy adults. Approximately 30.7% of the Florida Medicaid population is elderly or disabled. This same population accounts for approximately 59.6% of the Medicaid expenditures.

While there continues to be growth in the Medicaid program and AHCA has implemented efforts to manage costs, AHCA recognizes the continuing need to be persistent about deterrence and detection of fraud and abuse. Health care fraud is a serious and costly problem that affects all Floridians. Although there are varying estimates of the amount of program loss due to fraud and abuse, no one knows for certain how much fraud exists in the Medicaid program. While there are national estimates that range from a low of one percent to a high of 20 percent, these estimates are just that – estimates. To be most accurate these figures would actually have to be calculated for each distinct provider type and not the program as a whole. By the time such calculation could be completed on a particular provider type, dynamics within the system and the naturally occurring environment in which it operates would likely result in any findings being dated.

This actually points to another vulnerability of the system in that the scope of services available is very broad. Florida's current Medicaid enrollment is divided among four broad service delivery systems, which are categorized by the general payment/reimbursement methods used in each. However, within those broad areas, services are broken down into 25 service types, each with different methods used to determine the rates for reimbursement.

A 2010 white paper, *Combating Health Care Fraud*, published by SAS Institute, Inc. states:

> Amid these dynamics, fraudsters have become more resourceful than ever. Recruitment and transport of patients for bogus procedures, trading narcotics in exchange for member IDs, identity theft, doctor and pharmacy shopping – all result in claims that appear legitimate when viewed in isolation. Timely

> payment requirements, automated claims processing and lack of widespread, prepayment fraud detection capabilities have helped make health care fraud a low-risk, high return criminal activity - second only to tax evasion in economic crime. Today's fraudsters also have a good understanding of fraud detection systems, frequently recruit insiders into their schemes, and actively test and exploit thresholds and detection rules to avoid exposure.

Herein lies a significant challenge to fighting Medicaid fraud: it is the practice of some to test the system, detect new detection tools or enforcement strategies and move their activities to more vulnerable targets within the program. This is exacerbated by the fact that, with the recession, it is becoming easier for sophisticated criminal enterprises to recruit less sophisticated cohorts to assist them, who, also become victims in the process.

Ongoing Efforts to Combat Medicaid and Public Assistance Fraud

Currently, AHCA has a multitude of processes in place to prevent and detect fraud and recoup overpayments. These are covered in great detail in the Agency's annual report, *The State's Efforts to Control Fraud and Abuse*, and will not be reiterated here. However, the results of their efforts are important to note. In 2010-2011, overpayments identified by the Bureau of Medicaid Program Integrity (MPI) totaled approximately $39.2 million. In addition, MPI identified approximately $13.3 million in contractual assessments, fines/sanctions, and costs. Identified amounts due AHCA for SFY 2010-2011 totaled $52.5 million. At the time of publication, the Agency has collected $48.2 million. Through the employment of Third Party Liability (hereafter referred to as "TPL") contractors using computer assisted analyses of paid claims, an additional $30 million was recovered for the State of Florida.

MFCU is the referral point for AHCA when cases are determined to entail fraud, an intentional deception or misrepresentation made by a person with the expectation that the deception results in unauthorized benefit to herself or himself or another person. In SFY 2010-2011, MFCU reported receiving 99 fraud referrals from AHCA. They also report recoveries totaling $110,276,959 for the year.

As a result of the efforts by DPAF in the Department of Financial Services during SFY 2010-2011, $15,428,238 in public assistance dollars was withheld. Cases involving an additional $1,524,053 were referred back to the Department of Children and Families for Administrative Hearings and almost 99% of those cases resulted in public assistance disqualification. Cases with an additional $5,244,118 in potential loss due to fraud were referred to State Attorney Offices for prosecution and 86.91% of those cases were accepted for prosecution.

New and Innovative Local, State and Federal Initiatives

In the six months that the Strike Force has been organized and staffed, an effort has been made to identify innovative strategies for combating fraud. This is an initial census of those that have been identified.

Telephonic Delivery Monitoring and Verification. As a result of anti-fraud and abuse provisions included in 2009 Senate Bill 1986, AHCA contracted with a vendor, Sandata Technologies, LLC, to implement the Telephonic Home Health Service Delivery Monitoring and Verification (hereafter referred to as "DMV") Program. Sandata utilizes the Santrax Payor Management (hereafter referred to as "SPM") system to address aberrant billing practices, potential fraud and the quality of recipient care in home health care. The contract was signed April 8, 2010 and the DMV project was successfully launched on July 1, 2010.

The goal of the project is to ensure that home health nurses and aides actually go to the homes of the recipients that have been prior authorized to receive home health visits to provide the services outlined in the recipients' plans of care and ensure that home health service providers receive reimbursement for services actually provided.

Medicaid reimbursable home health visits provided by registered nurses (RNs), licensed practical nurses (LPNs) and home health aides are scheduled, verified and tracked through Sandata's SPM system.

After one full year of piloting this strategy, AHCA reports a decrease of 50% in claims paid for home health visits in SFY 2010-2011 when compared to the prior year. This program also resulted in a reduction in home health care visits by 51% during the same time period.

Link Analysis. Link Analysis is a technique used to evaluate relationships (connections) between nodes, as they are called in network theory. Relationships may be identified among various types of nodes or objects, including organizations, people and transactions. Link analysis has been used for investigation of criminal activity (fraud detection, counterterrorism, and intelligence). Link analysis is used for 3 primary purposes: 1) To find matches in data for known patterns of interest; 2) To find anomalies where known patterns are violated; and 3) To discover new patterns of interest (social network analysis, data mining). Two of the agencies represented on the Strike Force have been conducting pilot projects using link analysis.

AHCA. AHCA is currently performing link analyses on the individuals and groups found in the following databases:

- All 130,000 providers in the Medicaid Management Information System (hereafter referred to as "MMIS") database
- All owners in the MMIS database
- All provider groups in the MMIS database
- All prescribing doctors in the Medicaid pharmacy system
- All providers in the managed care networks
- All providers in the Health Quality Assurance (hereafter referred to as "HQA") licensure files

Match and link technologies are being used to gather information from the following sources that may be related to the entities identified above:

- Federal List of Excluded Individuals and Entities
- Other states' exclusion lists
- Department of Health adverse actions & previous terminations
- Other criminal databases
- Florida Corporate records
- Medicaid prescribing database
- MMIS ownership records
- National Provider Identifier records (National Provider and Plan Enumeration System)
- Tax records
- Property records
- Familial and social records

Potential relationships with excluded/criminal entities are identified on the providers using different parts of their names, abbreviations and/or without providing social security numbers. These technologies are intended to uncover providers providing false identity information to evade exclusion matching and people hiding as disclosed owners and officers of companies; people hiding as non-disclosed owners, directors, or officers; people using their immediate relatives to reopen new companies or continue existing companies often at the same business address; people using their partners to continue doing business or open related businesses; people using multiple electronic funds transfer accounts; and prescribing/referring services (Part D, Labs, and Durable Medical Equipment) in states which either do not require them to be enrolled for these referrals or do not check valid referral national provider identifiers (NPI) on claims.

From July 2011 through September 2011 there have been 120 providers identified and actions taken which involved one or more of the following:

- Termination from the program
- Denial of prescriptions written by the provider
- Placement on pre-payment review
- Referrals to Medicaid Managed Care Organizations (hereafter referred to as "MCO")
- Referrals to field staff
- Potential sanctions and fines

DCF. DCF has recently worked with LexisNexis in a pilot project using technology to perform link analyses between information available in distinct databases. This pilot project demonstrated the capacity of such link analyses to aid in the verification of applicant identities. Incorporating this technology into the current ACCESS system can prevent identity fraud at the entry point for eligibility determination.

MFCU Data Mining. One obstacle MFCU faced concerned using already accessible data to generate leads for investigations. MFCU operates on a budget that includes Federal matching grant funds. A federal grant restriction for MFCU was it could not conduct routine reviews of Medicaid claims data to look for patterns in billing that would identify fraud. The rationale for the restriction was that AHCA receives federal funds to do this data mining and the federal government didn't want to pay two agencies to do the same thing, since it had historically been a costly process.

However, since the initial enactment of the restriction, processes have become more automated and there have been huge advances in computer hardware, software and the ability to manage data. In addition, MFCUs have developed the capability to undertake such tasks. However, the restriction remained in place.

The Florida MFCU, in collaboration with AHCA, asked the Centers for Medicare and Medicaid Services (hereafter referred to as "CMS") for a waiver of the grant restriction. The objective is to supplement AHCA's data mining activities. CMS granted the waiver request as a three year pilot project. For the first year, three Medicaid Fraud Analysts will devote up to 15% of their time to the project. During the last two years they will devote up to 25%.

As of October 1, 2010, MFCU began data mining. All leads are still under investigation, and no investigations have been resolved yet. Florida is the only state that has been granted such a waiver. In fact, although they have not yet been adopted, the U.S. Department of Health and Human Services recently proposed amendments to the Federal Code to allow more flexibility for MFCUs to do data mining.

MFCU's Complex Civil Enforcement Bureau. The Complex Civil Enforcement Bureau (hereafter referred to as "CCEB") is a section within MFCU. CCEB investigates and litigates cases that allege violations of the Florida False Claims Act when the false claims were submitted to the Florida Medicaid Program. The majority of the cases are *qui tam* actions filed in federal court containing allegations that the Florida False Claims Act has been violated. CCEB evaluates *qui tam* complaints and prioritizes them according to their underlying merit and value to the State of Florida. In addition, CCEB has expanded Florida MFCU's role among the multi-state working groups litigating Medicaid fraud issues.

Problem Solving through Process Mapping. As used here, process mapping is another term for business process mapping. Business process mapping refers to activities involved in defining exactly what a business entity does, who is responsible, to what standard a process should be completed and how the success of a business process can be determined. Once this is done, there can be no uncertainty as to the requirements of every internal business process. The first step in gaining control over an organization's performance is to know and understand the basic processes.

Emergency Suspension Orders. As an outgrowth of the new provisions of Senate Bill 1986, DOH undertook an initiative to map the processes that are involved in issuing an Emergency Suspension Order (hereafter referred to as "ESO"). This mapping began on May 5, 2011, and an initial map was completed by May 31, 2011. DOH used the activity of mapping to define current processes and identify where they could be improved. After the initial mapping to define improved processes, DOH identified and incorporated additional improvements. As a result of this initiative, DOH has been able to reduce the time required to issue an ESO from 121 days to 19 for Category 1 suspensions and down to 21 days for Category 2 suspensions.

High Level Cross Agency Mapping. The Strike Force has also undertaken a project to develop a very high level representation of the prevention, detection, investigation and recoupment of funds processes across the agencies that are primarily responsible for combating fraud in the Medicaid and public assistance service systems. The Strike Force has worked with AHCA to utilize the prevention, detection, recoupment process maps developed as a result of Senate Bill 1986 (2009 Legislative Session). AHCA's process maps, while focused on provider fraud, are ones that can be replicated for recipient and public assistance business practices. Although this high level cross-agency visual is not yet complete, the high level mapping has already revealed minimal fraud prevention processes in the eligibility determination processes. Mapping the ACCESS processes will, as was the case for DOH, help identify where processes can be improved to prevent fraud.

Multi-Jurisdictional Partnering. The following descriptions represent examples of how multi-jurisdictional partnerships have been of value in combating fraud.

Federal/Local Collaborations. The Palm Beach County Sheriff's Office (hereafter referred to as "PBSO") began investigating public assistance fraud several years ago. In 2009 a joint investigative team was established in collaboration with the State Attorney's Office for the Fifteenth Judicial Circuit, and the U.S. Department of Housing & Urban Development Office of Inspector General to investigate criminal activity relating to federal or state funded public assistance. Recently the Sheriff has formally created a PBSO Public Assistance Fraud Unit.

The investigative group has expanded to include the Inspectors General for the U.S. Departments of Veteran's Affairs, Agriculture, and the Social Security Administration as well as many housing authorities in public assistance providers. Through the collaboration with these agencies, numerous public assistance fraud investigations are conducted including housing assistance, food stamp/Electronic Benefit Transfer (hereafter referred to as "EBT") fraud, and other federal and state welfare programs.

These investigations have also led to several arrests and convictions for public corruption and official misconduct. In addition, as a result of these targeted investigations, other organized criminal operations are being uncovered.

In the past year, over 100 public assistance recipients have been arrested for fraud with more than $2,000,000 ordered in restitution.

Federal/State/Local Collaborations. Ten years ago, the U.S. Department of Agriculture (hereafter referred to as "USDA") designated DPAF as the State Law Enforcement Bureau (hereafter referred to as "SLEB") for EBT cards. In that role, they serve as the liaison between local and state agencies and USDA in carrying out targeted investigations and prosecution of EBT fraud. DPAF supports the investigations by creating and funding EBT cards that can be used in undercover buys by investigative units. DPAF works with the local law enforcement agencies to ensure that targeted retail establishments are cleared for investigative units to enter under cover and gather the necessary evidence to create a case of fraud against the retail operator. DPAF then collaborates with any involved law enforcement and prosecutorial agencies in the pursuit of criminal prosecutions. DPAF also follows up with USDA to provide the information necessary to disqualify the retail locations and with investigations of recipient fraud that may have been integral to the retailer fraud.

Needs Assessment

As part of its mission, the Strike Force has gathered information through meetings of the Strike Force and its committees in an effort to identify needs or additional improvements that can be made in the Florida Medicaid and public assistance delivery systems. The member agencies were asked to identify what they considered to be weaknesses in the system at the very first Strike Force

meeting. However, such an inventory would not be complete without a full recognition of concomitant strengths that can be built upon. The following needs have been identified as areas to address in order "to develop and implement a statewide strategy to coordinate state and local agencies, law enforcement entities, and investigative units in order to increase the effectiveness of programs and initiatives dealing with the prevention, detection, and prosecution of Medicaid and public assistance fraud," Section 624.351(1), Florida Statutes.

Increase Emphasis on Prevention. Reports from and interviews with law enforcement agencies, investigative units and prosecutorial entities have made it clear that efforts to enhance enforcement and prosecution once fraud has occurred is not the most cost-effective approach to minimizing fraudulent activity. It is not possible to have the greatest impact after a crime has already occurred if insufficient efforts have been made to prevent the criminal activity at the front end of the system. The Strike Force has identified a number of ways to improve the system's prevention processes.

Changes to Statutes. Currently, AHCA has a multitude of processes in place to prevent inappropriate payments to providers. There are approximately 18 processes and programs in place that address background screening and initial eligibility determination of providers, education of providers, promulgation of policies and rules, audits and edits of claims and institution of oversight and controls. All are intended, in some way, to prevent fraud or abuse before a payment is ever made. In addition, these processes are connected to other detection and recoupment processes to provide feedback that can be used to continuously improve prevention efforts. However, additional statutory authority is needed to broaden their power to restrict potentially fraudulent providers from entering the system. In particular, licensure exemptions that currently exist for health care clinics need to be statutorily minimized.

DOH also identified a need for statutory changes to assist them in doing more comprehensive background checks to prevent fraudulent providers from being licensed in the State of Florida. Chapter 456, Florida Statutes, identifies the health care providers for which DOH is authorized to conduct background screenings. This authority needs to be expanded to allow for screenings of all health care professionals licensed by DOH.

Improvements in Eligibility Determination. Upon his appointment, DCF Secretary David Wilkins began a thorough review of his agency's efforts to prevent, detect and recover from public assistance fraud and abuse within the temporary cash assistance, SNAP and Medicaid programs. DCF's ACCESS program conducts eligibility determinations not only for the programs which DCF administers, but also for Medicaid. In examining this function, it was determined that critical components in the eligibility process, such as information technology and organizational design, were primarily intended to meet the goal of the federal SNAP program which is to increase participation. The ACCESS Program has enjoyed tremendous success in this regard, most recently by being awarded more than $11 million in federal bonuses for reporting the lowest "payment error rate" in the nation for the Federal Food Stamp Program. However, its error rate for conducting Medicaid eligibility remains among the highest in the country: 9.2%. This is well above the national average of 6.7%, according to the latest CMS Payment Error Rate Measurement (PERM) analysis.

Access Process Mapping. While it is important to ensure that all the Federal programs that DCF administers comply with applicable Federal rules and guidelines relating to payment timeliness and accuracy, it has also become clear that fraud prevention must also begin to occur during the same eligibility determination process and continue throughout the time that benefits are being distributed and received. ACCESS, as the entry portal to the Florida Medicaid Program and other public assistance programs, is the first line

of defense against fraud. Therefore, the Mapping Committee determined that mapping the ACCESS processes should be the first priority for the Strike Force's mapping initiative. This will require a legislative appropriation.

Identity Verification. Reflecting society's "virtual environment", over 90% of all applications for public assistance are received virtually through the technology program designed for that purpose; ACCESS On-line. While this method is very useful in expediting payment of benefits, it also means that verification of eligibility must also occur on-line. Fortunately, technology and innovation have evolved to develop meaningful tools to rapidly verify applicants' identities as well as information which impacts eligibility. The current ACCESS On-line system does not have the capability of using any type of link analysis to verify identity. DCF needs funding and/or technology resources that will enable the system to accurately verify applicant identity.

Make Better Use of Available Data. A major strength in the Medicaid and public assistance service systems is the prolific availability of data on recipient applicants and Medicaid claims. In AHCA's data connectivity plan, there were 14 databases identified and the inventory continues to grow as more agencies join this endeavor. Unfortunately, there are a number of weaknesses that compromise the ability to make the best use of this data. This is particularly critical in efforts to detect criminal behavior patterns.

Currently, the technology is not in place that connects all the databases that contain health care fraud and related data. Section 409.913(38)(b), Florida Statutes, requires AHCA to develop a strategic plan to connect these databases. In addition, a recent bi-annual audit from the Office of Program Policy Analysis and Government Accountability (OPPAGA) recommended that AHCA expand its detection tools to include neural networking and other advanced techniques for detecting emerging fraud and abuse patterns.

Implement AHCA's Data Connectivity Plan. AHCA completed *The Strategic Plan for Data Connectivity – Health Care Fraud Databases* in December 2010. AHCA designed the plan to be a dynamic document that can be adjusted to meet the needs of an ever changing Medicaid service system. AHCA is currently enhancing the strategic plan to connect the databases, bridge gaps between silos and make the best use of this data to combat fraud and abuse in the Medicaid program.

The plan provides for replacing an aging case tracking system and incorporating advanced detection methodologies. These are essentially detection devices that are able to learn from existing automated audit processes. As it goes through the normal audit processes and identifies inappropriate claims, they are flagged so the system begins to learn what an inappropriate claim looks like. Over time, it is able to work in the background, automatically reviewing all the data that is available.

The 2011 Florida Legislature approved a Legislative Budget Request (hereafter referred to as "LBR") in the amount of $800,000 that will enable AHCA to replace the current case tracking system and incorporate advanced detection capabilities. It will be necessary for the Legislature to continue to fund AHCA's implementation of *The Strategic Plan for Data Connectivity – Health Care Fraud Databases.*

Incorporate Advanced Analytics in Upgrades to Information Systems. In addition to the ability to connect databases, the pilot projects that have been done on link analyses have demonstrated the value of identifying connections between information maintained in various diverse databases on providers and recipients in detecting fraudulent activity. It is important to these efforts that every consideration is given to providing the resources to incorporate such analytics or predictive modeling software into any upgrades to databases that help to prevent, detect, investigate and prosecute fraud as well as to recoup wrongful payments. In the immediate

future, this would include the incorporation of such technology into upgrades to the FLORIDA System and the EBT system. In order for DCF to proceed with these plans, they will need a legislative appropriation to conduct a feasibility study to plan for these enhancements.

Gather the Standard National Identifier for Practitioners to Enable Link Analyses. One standard data element on providers that is needed to link provider information across databases is the National Provider Identifier. Currently, DOH and AHCA do not collect this information because statutory authority is required to enable them to do so.

Increase Leveraging of Resources. A recurring theme in reports to the Strike Force is the lack of resources available to support existing processes intended to prevent, detect, investigate and prosecute fraud. From the need for additional staff, to more competitive salaries, to better training, no agency is funded at the level they would prefer. As indicated in the previous section, some of these needs can be met in part through better, more advanced technology. This will require an investment in resources, as well. However, there are other ways in which resources can be leveraged to increase the effectiveness of our efforts.

AHCA dedicates a significant amount of resources to the prevention of fraud and abuse. Prevention activities include prepayment reviews, site visits, terminations, and sanctions. The most recent data available (SFY 2009-2010) from AHCA on return on investment demonstrate that funding to support detection and investigation has been well directed. AHCA's Bureau of Medicaid Program Integrity (hereafter referred to as "MPI") documented that for every dollar spent to avoid costs, $3.3 is saved. In addition, for every dollar spent on recovery efforts, the MPI has been able to recoup $6.4 dollars. Similarly, DPAF has documented (SFY2010-2011) that for every dollar spent to fund their operations (both State and Federal shares), they provide a return of $6.05 in benefits saved/denied, prosecuted, or collected through their partner agencies (DCF, Agency for Workforce Innovation-Office of Early Learning, DOH, and the Social Security Administration). Similarly, during SFY 2010-2011, for every dollar of General Revenue expended, MFCU recovered $32.44.

Establish Funding Sources. Given these Return on Investment (ROI) figures, it is justifiable to direct more resources to combating fraud and abuse in order to increase returns to General Revenue or prevent unnecessary expenditures. While there are generally not surplus General Revenue funds available to do this, the Strike Force believes it important to continue to explore additional funding sources to support its administrative and operational costs and the anti-fraud projects it approves as a body. Recommendations that have been raised to the Strike Force that would require additional budget allocations from the legislature would be among the first considered for funding by the Strike Force.

Maximize External Resources through Partnerships. Another opportunity that exists to help leverage resources is the opportunity to partner with local and federal agencies to enhance detection, investigation and enforcement efforts. There are already numerous multi-jurisdictional task forces in place that enable cooperative initiatives. Supporting and growing these collaborative relationships can result in aggressive investigations into fraudulent practices from various levels. An added benefit to being more aggressive with these cases through partnerships is that illegally gained assets could be seized, preventing the perpetrators from passing along the infrastructure needed to continue the criminal activity. The Strike Force can be integral in maximizing this opportunity by advocating for and supporting these initiatives in any way possible, including coordinating the provision of training for local law enforcement, other partner agencies and lay citizens. Having funds available through whatever funding sources the Strike Force secures would provide the resources to support these initiatives.

RECOMMENDATIONS

Based upon this review of needs and in consideration of the innovative initiatives currently underway, the Strike Force compiled the following recommendations to the Legislature.

1. Minimize the licensure exemptions that currently exist for clinics through AHCA.

2. Give DOH the statutory authority to conduct state and national criminal history record checks on all professions they regulate. Create statutory/rule provisions for timely reporting of arrests of practitioners to DOH via retention of fingerprints by FDLE. (See Appendix A "Criminal History Record Checks" for explanation of the criminal history record check process and the retention of fingerprints).
   i. In conjunction with the Interagency Workgroup on Background Screening, examine methods to maximize the sharing of criminal history information to reduce additional costs for licensees and duplicative processes by state licensing agencies.

3. Give DOH and AHCA the authority to collect the National Provider Identifier from providers.

4. Establish a funding source for the Strike Force to use to enhance anti-fraud efforts.

5. Provide contractual services to map ACCESS, as the entry to public assistance programs, in order to identify technological and organizational processes that can be reengineered to improve prevention and detection processes and support the feasibility study for replacement of the FLORIDA System.

6. Fund the incorporation of identification verification and fraud prevention processes into the ACCESS On-Line capabilities in the immediate future.

7. Support a feasibility study for ultimately replacing the FLORIDA System with an updated system that incorporates identification verification and fraud prevention technology.

8. Continue to fund the implementation of AHCA's Data Connectivity Plan.

In addition, there are recommendations that have been presented that the Strike Force can take the lead on implementing:

1. Expand participation on Strike Force working committees to include other public assistance agencies (e.g., Department of Education, Agency for Persons with Disabilities).

2. Coordinate training sessions around the state to empower local government and law enforcement to partner on initiatives to fight Medicaid and public assistance fraud and train citizens in identifying and reporting suspicious activity in order to support local initiatives.

Other recommendations have been presented to the Strike Force, but have not been fully evaluated to determine how to proceed. These will be followed up on in the upcoming year:

1. Find a way to get more timely information from employers in order to verify employment status on benefit applicants and/or recipients.

2. Secure cooperation from the federal government on a Treasury Offset Program to allow recoupment of overpayments through an offset of income tax returns.

3. Provide statutory authority to garnish state employee wages for recoupment of overpayments.

4. Incorporate the use of biometrics into current system processes to help ensure that services are, in fact, provided to eligible applicants.

Other Opportunities

The Strike Force has just begun to explore the opportunities available to fight fraud in the State of

Florida. In the coming year, the Strike Force will investigate the potential of other strategies to enhance efforts to prevent, detect, investigate and prosecute fraud and recoup overpayments. The Technology Committee will continue to review other technological advances. The Grants Committee will review the impact of a Background Screening Grant that AHCA has received. The Mapping Committee will follow the progress in mapping the ACCESS processes and provide direction to this initiative. The Strike Force, as a whole, will follow AHCA's progress in the move to statewide managed care and offer assistance and support wherever possible.

ACTION PLAN

Based upon the information that has been presented to the Strike Force it has become evident that there can never be enough resources in terms of traditional law enforcement activities to combat the fraud that is occurring each year throughout the Medicaid and Public Assistance programs. Prevention and detection of fraud are complicated by the fact that the many and varied public assistance programs are spread throughout state government and the funding sources for these programs are separated among various federal government agencies, each with its own criteria and rules relating to administration and oversight. Medicaid is especially complicated in that the qualification process for recipients is housed within DCF while the providers for Medicaid are licensed by DOH and regulated, as Medicaid providers, by AHCA. Investigations for suspected criminal activity are then referred to two separate agencies as well, with AHCA referring suspected provider fraud to MFCU and DCF and AHCA referring suspected recipient fraud to DPAF.

The resulting Action Plan for the Strike Force will place the greatest emphasis on prevention, particularly as it can be applied within the Medicaid program. However, the Strike Force recognizes the need to ensure that investigative and law enforcement agencies have tools and resources that can help maximize the effectiveness of their efforts. This led to a two-pronged approach for the Strike Force Action Plan for SFY 2011-2012 and laying the groundwork for action planning in subsequent years.

Initiative #1: Enhanced Prevention & Detection

This initiative is focused on establishing the necessary tools and then working to increase emphasis on prevention.

Phase I: Statutory Changes and Budget Authority

This first phase will focus on putting tools in place through legislative action that will enhance the ability of the key agencies to prevent likely fraudulent providers from working within the Medicaid program.
Goal: Secure the Tools and Resources to Improve Prevention Efforts

Statutory Changes are needed which will:

1. Minimize the licensure exemptions that currently exist for clinics through AHCA.
2. Give DOH the statutory authority to conduct state and national criminal history record checks on all professions they regulate.
3. Give DOH and AHCA the statutory authority to collect the National Provider Identifier from providers.
4. Establish a funding source for the Strike Force to use to enhance anti-fraud efforts.

Budget Authority is needed which will:

1. Provide contractual services to map ACCESS, as the entry to public assistance programs, in order to identify technological and organizational processes that can be reengineered to improve prevention and detection processes and support the feasibility study for replacement of the FLORIDA System.
2. Fund the incorporation of identification verification and fraud prevention processes into the ACCESS On-Line capabilities in the immediate future.
3. Support a feasibility study for ultimately replacing the FLORIDA System with an updated system that incorporates identification verification and fraud prevention technology.
4. Continue to fund the implementation of AHCA's Data Connectivity Plan.
5. Provide funding to support the Strike Force and its initiatives.

Phase II. Mapping and Establishing Performance Measures

Once the tools have been put in place in Phase I, Strike Force members will work to implement these tools to devise strategic, inter-agency approaches to improving prevention and detection activities.

Goal: Identify processes that can be improved and activities and resources that can be reallocated to prevention in the Medicaid service delivery system.

Objective 1. Map ACCESS to identify processes that can be improved and activities and resources that can be redirected to prevention.

Activities

1. The Strike Force will retain the services of a mapping consultant to map ACCESS and establish performance measures that accurately reflect the ability to prevent and detect fraud in the applicant eligibility determination stage.
2. Identify processes that can be improved and activities and resources that can be reallocated to prevention.
3. Reengineer technological and organizational processes to improve prevention and detection of fraud during eligibility determination and after to ensure recipient eligibility.
4. Monitor performance measures and take corrective action, as needed.
5. Refine the ACCESS map, as needed.

Objective 2. Continue iterations toward cross agency mapping of vulnerable process areas that have not previously been mapped.

Activities

1. The Mapping Committee will review the initial high level representation of the prevention, detection, investigation and recoupment of funds processes across the agencies that are primarily responsible for combating fraud in the Medicaid and public assistance service systems.
2. The Mapping Committee will work with Strike Force staff to refine this overview.
3. The Mapping Committee will recommend to the Strike Force a priority order for mapping other process areas that appear to be most vulnerable to fraud that should be mapped.
4. Subsequent mapping will be undertaken at the direction of the Strike Force following the steps identified for mapping ACCESS.

Objective 3. Identify activities and resources that can be redirected to prevention through technological and organizational process improvements.

Activities

1. A new subcommittee made up of Strike Force members that represent state agencies will be convened.
2. This committee will review the work of the mapping consultant and subsequent mapping initiatives and develop proposals and recommendations for reallocating technological and organizational resources to prevention.
3. When technological solutions are proposed to enhance prevention efforts, recommendations should include the incorporation of predictive modeling capabilities that will allow databases to also be mined to detect fraud, waste and abuse.
4. This committee will develop performance measures that will be used to effectively measure the cost savings for the program based upon the move to a prevention-focused model.
5. This committee will work with the agencies to redirect their resources to prevention.

PHASE III. IMPLEMENTATION AND EVALUATION

Goal: Determine the effectiveness of reallocating resources to place even greater emphasis on prevention.

Objective 1. Implement the redirection of resources as recommended by the new subcommittee of the task force.

Activities

1. Individual agencies will be responsible for effecting the redirection within their agencies.

Objective 2. Evaluate the effectiveness of reallocating resources to place even greater emphasis on prevention.

Activities

1. Strike Force staff will design evaluation methodologies specific to each of the identified reallocations and the performance measures established for use in the evaluation.
2. Strike Force staff will work with member agencies to gather the data necessary to complete the evaluation.
3. The data will be compiled and analyzed and an evaluation written for each reallocation made.

Initiative #2: Geo-Centered Partnership Model.

(18-24 month implementation process)

This initiative will entail the development, refinement and deployment of a "geo-centered" model for targeting fraud, similar to the Palm Beach County Sheriff's Office example described in this report. Concentrating resources in geographic areas with higher rates of crime is not a new concept in law enforcement; historically, targeted investigations in specific high crime areas result in significant arrests and prosecutions. The "geo-centered" model for combating Medicaid recipient fraud and public assistance fraud would identify areas throughout the state where high rates of either recipient or provider fraud have been identified. The key to success with this model will be building collaborations throughout the state between state, local and federal partners.

Phase I: Identify Geographic Targets

This first phase will involve identifying geographic areas with high incidences of detected fraud in the public assistance programs, using data available from DPAF.

Objective 1. Identify geographic and public assistance programs with the potential for the greatest returns from a targeted enforcement initiative.

Activities

1. DPAF will identify the incidence of recipient fraud identified in individual public assistance programs.
2. Starting with the highest incidence rate, DPAF will identify the top three geographic areas in the state in which the fraud is occurring.

Phase II: Build Collaborations

This phase will involve building the relationships necessary to implement the geo-centered enforcement activities effectively. Agencies that should be considered in forming partnerships should be specific to the type of public assistance program and the geographic area being targeted. Agencies that should be considered in building these partnerships include local law enforcement agencies, other local agencies that may be able to support the initiative (e.g., Chambers of Commerce), federal agencies involved in the targeted public assistance program (e.g., HUD, USDA, U.S. Attorney), and other interested stakeholders.

Objective 1. Establish the collaborations needed to address the targets identified in Phase I.

Activities

1. DPAF will identify the stakeholder agencies in the targeted public assistance program and local agencies that should be involved.
2. DPAF and Strike Force staff will meet with the key stakeholders and orient them to the type of collaboration envisioned using examples of successful collaborations from around the state.
3. DPAF and Strike Force staff will provide training for the partners using federal and state resources and initiating support for integrated databases between investigatory and law enforcement agencies.

Phase III. Carry Out Sweeps of the Targeted Program and Geographic Area

Objective 1. Develop the interagency strategy for carrying out the sweep.

Activities

1. A lead agency should be identified for carrying out the sweep based upon jurisdictional parameters for each agency.
2. The lead agency will develop the strategy in consultation with the other agencies depending upon the resources required and/or available from each agency.

Objective 2. Carry out the sweep.

Activities

1. The lead agency will schedule the sweep activities in coordination with the schedule of the other agencies.
2. The lead agency will direct the sweep.

Phase IV. Replication

This phase will be used to determine the extent to which this model can be replicated in targeting other public assistance programs, as well as Medicaid providers. This phase will take the successes and lessons learned from Phase I through III and expand the targeted sweeps to other types of public assistance benefits as well as to other areas of the state.

Objective 1. Identify geographic areas and public assistance programs with the potential for the greatest returns from a targeted enforcement initiative.

Activities

1. DPAF and AHCA will identify the incidence of recipient fraud identified in individual public assistance programs and provider fraud in the Medicaid service delivery system.
2. Starting with the highest incidence rate, DPAF and AHCA will identify the top three geographic areas in the state in which the fraud is occurring.

Objective 2. Establish the collaborations needed to address the targets identified in Objective 1.

Activities

1. DPAF and AHCA will identify the stakeholder agencies in the targeted public assistance or Medicaid program and local agencies that should be involved.
2. DPAF, AHCA and Strike Force staff will meet with the key stakeholders and orient them to the type of collaboration envisioned using examples of successful collaborations from around the state.
3. DPAF, AHCA and Strike Force staff will provide training for the partners using federal and state resources and initiating support for integrated databases between investigatory and law enforcement agencies.

Objective 3. Develop the interagency strategy for carrying out the sweep.

Activities

1. A lead agency should be identified for carrying out the sweep based upon jurisdictional parameters for each agency.
2. The lead agency will develop the strategy in consultation with the other agencies depending upon the resources required and/or available from each agency.

Objective 4. Carry out the sweep.

Activities

1. The lead agency will schedule the sweep activities in coordination with the schedule of the other agencies.
2. The lead agency will direct the sweep.

Subsequent to the replication of this strategy, a review of the results from instances of implementation will be carried out by the Strike Force to determine the extent to which it is facilitating accomplishment of the Strike Force mission. Plans for further expansion and replication will be determined based upon direction from the Strike Force.

Appendix A

Criminal History Record Checks Florida Department of Law Enforcement (January 2011)

Criminal History Record Check: The term "background check" is often used interchangeably with "criminal history check" or "criminal history record check." Some companies use the phrase "background check" to include driver's record, credit history, or interviews with neighbors and employers. From the Florida Department of Law Enforcement (FDLE) perspective, a background check as required by Florida Statutes for licensing, employment or regulation is a criminal history record check to determine if a person has been arrested and/or convicted of a crime. A criminal history record check is a search of the following databases:

- The Florida Computerized Criminal History (CCH) Central Repository for Florida arrests (STATE CHECK).
- The Florida Computerized Criminal History Central Repository for Florida arrests AND the national criminal history database at the FBI for federal arrests and arrests from other states (STATE AND NATIONAL CHECK).
- The Florida Crime Information Center for warrants and domestic violence injunctions (HOT FILES CHECK) Note: These are performed for both state and national checks.

A national criminal history record check is based on the submission of fingerprints. State criminal history record checks are based on a name (and other descriptors) or fingerprints.

How can a criminal history record be obtained?

The information is provided through a variety of means:

- Public record requests for criminal history information are provided over the Internet, through a modem system or through the mail.
- Applicant requests (licensing or employment, or a volunteer employee under the National Child Protection Act) are submitted with fingerprints through either an inked card or a livescan device.

What is the current fee for a criminal history check?

The fee for a Florida criminal history check is $24.00 as provided in Section 943.053(3)(b), F.S. The law also establishes specific rates for certain entities as follows:

- $18 for requests under the National Child Protection Act;
- $15 for requests through the Department of Agriculture and Consumer Services for checks such as concealed weapon license holders; and
- $8 for vendors of the Department of Children & Families, Department of Juvenile Justice and the Department of Elder Affairs; and Guardian Ad Litem and
- Public Defender Offices employees, conducting a check as part of their official duties, are not assessed a fee.

The fee for a FBI national criminal record check is:

- $19.25 if received electronically
- $30.25 if received by paper card
- $15.25 for volunteers submitted under the National Child Protection Act

What is a "retained" fingerprint?

An agency may request to have fingerprints retained at FDLE. When the subject of retained fingerprints is identified with fingerprints of an incoming Florida arrest, FDLE notifies the licensing or employing agency of the arrest (referred to as arrest hit notifications). The arrest hit notification will include the name of the arresting agency.

Currently only state arrests are searched against the applicant retained fingerprints file. The FBI is currently enhancing its systems to allow for retained prints and arrest hit notifications from other states; the FBI anticipates implementation in 2014.

What determines if a fingerprint will be "retained" by FDLE?

FDLE retains the fingerprints of applicants pursuant to Florida Statutes or upon request of the agency or entity head and notifies the licensing or employing agency or qualified entity if the retained subject is arrested in Florida. This system is partially automated and partially manual and includes fingerprint comparison to ensure that the arrest notification is sent only when there is assurance that it is the correct subject.

Those currently designated for fingerprint retention are:

- Criminal justice employees; sworn personnel must be submitted for retention and non-sworn at the option of the employing agency.
- School district instructional and non-instructional employees and contractors.
- Private school employees.
- Department of Juvenile Justice employees and contractors.
- Racino employees.
- Mortgage brokers and loan originators.
- Elder Affairs vendors.
- Professional guardians (when submitted electronically).

What period of time are the fingerprints retained for?

Fingerprints are retained until the individual is no longer in the capacity for which the agency submitted their prints. The agency must request deletion of the prints.

Is there a fee associated with the retention of fingerprints?

Agencies/Entities that request FDLE to retain fingerprints are charged a $6.00 annual fee per year following the initial year of submission and retention.

CHIEF FINANCIAL OFFICER

JEFF ATWATER

FLORIDA DEPARTMENT OF FINANCIAL SERVICES

IN GOD WE TRUST

MEDICAID & PUBLIC ASSISTANCE FRAUD

STRIKE FORCE

FLORIDA MEDICAID

A Division of the Agency for Health Care Administration

Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program

EVALUATION REPORT

Submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives

February 1, 2011

AHCA

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

Table of Contents

List of Tables and Graphs

Acronyms and Abbreviations

Agency-The Florida Agency for Health Care Administration

ALTD-Alternative Location Tracking Device

CMS-Centers for Medicare and Medicaid Services

FMMIS-Florida Medicaid Management Information System

HCAF-Home Care Association of Florida

HIPAA-Health Insurance Portability and Accountability Act

HP-HP Enterprise Services

ITN-Invitation to Negotiate

IVRA-Interactive Voice Response Authentication

MPI-Medicaid Program Integrity

QIO-Quality Improvement Organization

SFY-State Fiscal Year

SPM-Santrax Payor Management System

EXECUTIVE SUMMARY

Background

In 2009, the Florida Legislature directed the Agency for Health Care Administration (Agency) through Senate Bill 1986 to develop and implement a home health agency monitoring pilot project in Miami-Dade. The language was incorporated into section 31 of Chapter 2009-223, Laws of Florida (See Appendix A). The bill authorized the Agency to competitively procure a contract with a vendor to verify the utilization and delivery of home health services and provide an electronic billing interface for home health services. In accordance with Section 31 of Chapter 2009-223, Laws of Florida, the Agency evaluated the Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program for the purpose of submitting a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Through a competitive procurement process, the Agency contracted with Sandata, LLC to operate a program in Miami-Dade County to verify the utilization and delivery of home health visits reimbursed through the Medicaid program. The program requires providers to submit claims for home health visits electronically through the vendor's system. Home health visits are verified by telephone using a technology called "voice biometrics." Sandata's Santrax Payor Management (SPM) System maintains databases for each home health agency in the program pilot area. The databases contain information on home health agency staff, recipients, service authorizations, visit schedules, visit verification and billing activity. Each home health agency logs in to the SPM System to access its database.

This program provides the Agency with more tools to detect the appropriateness of service provision and to hold home health agencies accountable for providing authorized services. In addition, the data obtained through the SPM system will enable the Agency to better track quality of service to ensure that our most vulnerable population gets the services needed. Many of the data elements that are now available through the SPM system had not been available to the Agency prior to implementing this project and will help drive future policy decisions.

Sandata receives data feeds from the Florida Medicaid Management Information System (FMMIS) that contain prior authorization information for home health visits granted to home health agencies in Miami-Dade County. When the nurse or home health aide arrives and leaves the recipient's residence, he or she calls a toll-free number assigned to the home health agency, enters a unique staff identification number, and completes the speaker verification process. The voice of the nurse or home health aide is matched to a pre-recorded voice print to verify that the assigned staff is providing a home health visit to a specific recipient. This accomplishes the voice biometrics component of the program.

Once a home health visit has occurred and the verification process is complete, Sandata's SPM System generates the claims file. Each provider is responsible for reviewing the claims in its SPM System database and giving approval for Sandata to

electronically transmit the claims to the Florida Medicaid fiscal agent. Providers may have claims submitted through the SPM System daily or as often as desired. FMMIS will deny claims for home health visits in Miami-Dade County if the claims are not submitted through Sandata's SPM System.

The program began July 1, 2010 and the results in this evaluation are reflective of paid claims for the first quarter of SFY 2010-2011. It should be noted the Medicaid providers have 12 months from the date of service to file claims for reimbursement. This complicates expenditure analysis since some providers have yet to bill Medicaid for services rendered since the program began due to unresolved visit exceptions (see description in the following paragraph). Lastly, there have been multiple efforts by the Agency to combat fraud and abuse in the program pilot area, so it is difficult to establish a single causal relationship between the decrease in expenditures for home health visits in Miami-Dade County and the implementation of the Telephonic Home Health Services Delivery Monitoring and Verification Program. The concurrent implementation of a second pilot project in Miami-Dade County, Comprehensive Care Management, which includes face-to-face assessments conducted by nurses in recipients' residences to validate medical necessity for home health visits, makes it more difficult to determine a one-to-one impact.

Findings

The Agency has already experienced successes since the program began operating on July 1, 2010. Medicaid expenditures for home health visits have decreased in Miami-Dade County and statewide since 2009 due to the Agency's onsite reviews of home health agencies in Miami-Dade County conducted during State Fiscal Year 2009-2010 and strict enforcement of the prior authorization requirements for home health visits. Medicaid expenditures in Miami-Dade County for home health visits have decreased by over 35% since SFY 2006-2007, representing over $23 million in savings to the State of Florida, and continue to decrease since implementation of this pilot project. While the Agency ensures all medically necessary services are available, the number of Medicaid recipients receiving home health visits has also decreased, and there are fewer home health agencies in Miami-Dade County providing home health services.

After six months of program operations, an increasing percentage of visits are being automatically verified in the SPM system and an increasing number of home health providers are successfully submitting claims through the SPM System. However, visit exception rates remain high. Exceptions are generated when the required elements to verify a home health visit in the SPM system do not align. Specific data elements needed to verify a visit are: 1) recipient information; 2) service authorization; 3) staff-speaker verification; and 4) schedule. The three issues that generate the largest number of exceptions at this time are:

- Visits not being scheduled in the SPM System
- Incorrect recipient phone numbers in the FMMIS
- The length of the visit was more or less than the scheduled times in the SPM system.

Next Steps

Based upon the initial outcomes of this evaluation, the Agency has identified several process steps to enhance operation and ensure value:

- Establish acceptable rates or ranges for visit exceptions in the SPM System;
- Impose sanctions for providers who fail to competently participate in the program (e.g., failure to schedule visits and not following protocols for using the SPM System);
- Use data obtained from this program for future policy development, (e.g., service quality, reimbursement methods, etc.);
- Establish a reliable and effective process to update recipient telephone number data, particularly for dually-eligible recipients of Medicare and Medicaid;
- Establish a direct data feed of home health visit authorization data from the Agency's contracted quality improvement organization to Sandata, LLC. This data feed would supplement the authorization files Sandata receives from FMMIS, and provide detailed visit frequency to strengthen visit limitations in the SPM System and simplify the visit scheduling process for service providers;
- Evaluate any changes in expenditures, number of enrolled providers, and recipients receiving services in surrounding counties to determine whether this pilot has impacted utilization rates in those counties; and
- Continue to review and evaluate claims data and data received from the SPM System to determine whether expanding the pilot into other areas of the state would be beneficial and provide cost savings.

Many of these recommendations are already being implemented by the Agency, which will continue to strengthen the program and build on its successes.

This initial evaluation of the Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program indicates that the incorporation of a web-based system that includes recipient, provider, service authorization, and scheduling information, combined with the use of voice biometrics, not only supplements physical documentation of delivery and utilization of home health visits, but also provides the Agency with tools to effectively monitor the provision of home health visits to Medicaid recipients. More importantly, the program has great potential for reducing fraud and abuse in Florida Medicaid by reducing the submission of claims for services that were not provided. As the program moves toward completion of its first year of operation, and the Agency implements activities to increase provider compliance and strengthen the program, it is anticipated that the Agency will have access to more detailed data to assist with policy development, and experience continued reduction of Medicaid expenditures for home health visits in Miami-Dade County.

BACKGROUND

In 2009, the Florida Legislature directed the Agency for Health Care Administration (AHCA or the "Agency") through Senate Bill 1986 to develop and implement a home health agency monitoring pilot project in Miami-Dade. The language was incorporated into section 31 of Chapter 2009-223, Laws of Florida. (See Appendix A). The bill authorized the Agency to competitively procure a contract with a vendor to verify the utilization and delivery of home health services and provide an electronic billing interface for home health services. The contract required the creation of a program to submit claims electronically for the delivery of home health services. Additionally, telephonic verification of visits for the delivery of home health services was required, using a technology called "voice biometrics."

Home health services are delivered as a home health visit, which is a face-to-face contact between a direct care service provider, such as a registered nurse, licensed practical nurse, or qualified home health aide, and the recipient at the recipient's place of residence. A home health visit is not limited to a specific length of time, but is defined as the length of time needed to provide the medically necessary nursing or home health aide service(s). Recipients are limited to four (4) intermittent visits per day with any combination of nursing and/or home health aide visits. Home health visits must be provided through a Medicaid enrolled licensed home health service provider. (Please refer to Appendix B for detailed descriptions of home health services.) All services must be authorized by the Agency's contracted quality improvement organization (QIO) before being provided.

The Agency maintains the Florida Medicaid Management Information System (FMMIS) that contains recipient and provider information, and claims data. The Agency's contracted QIO interfaces with the Agency's Medicaid fiscal agent, HP Enterprise Services, to generate a prior authorization number for home health visits. The FMMIS contains information about each service provider that allows the system to generate a service authorization with service provider and recipient specific information. Once providers receive these service authorizations, they are allowed to begin delivery of the services. Services are to be provided in accordance with the schedule and units specified in the service authorization.

DESCRIPTION OF THE PROGRAM

The primary purposes of the Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program are to 1) track the time spent in the home by a person providing home health visits; 2) verify that those visits occurred as reported by the home health service provider and as authorized by the Agency's QIO; and, 3) electronically submit claims to the Agency's fiscal agent. The system interfaces with the FMMIS to electronically submit claims based on verified service delivery and produces exception reports for services not delivered as authorized.

The goal of the Telephonic Home Health Services DMV Program is to ensure that the Agency pays providers only for approved services rendered by appropriate home health agency personnel while in the recipient's home. By employing verification of services prior to payment of claims, the Agency will be able to ensure that Medicaid recipients receive home health care services as authorized. The expectation is that fraud and abuse will be reduced significantly by these visit verification efforts.

With the expansion and growing need for in-home care and services to Medicaid recipients, it becomes increasingly important to have assurances that care is being delivered properly and that publicly-funded resources are being managed and spent appropriately. Through the Telephonic Home Health Services DMV Program, the Agency sought to contract with a vendor to operate a program that would achieve the following:

- Reduce inappropriately billed home health services;
- Generate cost savings to the Agency and to the home health service providers due to improved efficiencies and reduced paperwork;
- Improve quality assurance through a unified view of home health care activities across multiple agencies;
- Assist home health service providers in identifying and responding to unmet recipient needs (missed visits, late visits);
- Capture visit and scheduling information in order to identify deficiencies;
- Create a single composite view of home based care delivery for improved data collection and evaluation;
- Present data to assist policymakers in developing strategies to address gaps in the delivery of home health services;
- Enhance the effectiveness of home health provider administrative processes, (e.g., invoice and billing, scheduling, and documentation of service delivery);
- Automatically capture and electronically submit claims with accurate dates and times of service; and
- Permit direct care providers to easily report information about the supports and services they have provided in a central location.

Through competitive procurement (AHCA ITN 1004), the Agency entered into a contract with Sandata, LLC for the development, implementation and on-going management and operation of a home health service verification monitoring pilot project in Miami-Dade County, Florida, that uses an interactive voice response authentication (IVRA) system to improve the delivery of home health services. See Appendix C and D for a summary of the procurement and implementation activities. Sandata also provides an automated system that tracks times of service delivery and provides information for electronic billing. This system, combined with IVRA technology, is an integral part of increasing accountability for home health service delivery and providing a tool for quality assurance.

Sandata, LLC provided services required for development, implementation and on-going operation of the Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program:

- System with the capacity to automatically capture and accurately invoice in-home service visits with recipients. The SPM system integrated real-time system data with service authorization database files and a web interface to provide time and attendance tracking, a calendar/scheduler and invoicing functions directly pertaining to the provision of those specifically designated services paid through Medicaid.

- System through IVRA that permitted direct care providers to report information about the supports and services they had provided;

- A formal service delivery verification process that alerted home health service providers when a service delivery failure occurred for any recipient targeted for increased monitoring because health and/or safety was jeopardized by a missed service visit;

- IVRA host system(s) that are available 99.9% of scheduled uptime, twenty-four (24) hours a day, seven (7) days per week;

- Training to home health services providers and state office staff on the use of the IVRA system;

- U.S. based toll-free telephone line for participating home health service providers to record services provision data twenty-four (24) hours per day, seven (7) days per week, (excluding Agency agreed upon downtime for routine system maintenance); and

- A U.S. based toll-free telephone number connected to a Florida-based help desk staffed by English and Spanish-speaking staff that provide technical assistance to users experiencing problems using the system.

PROGRAM IMPLEMENTATION

Outreach and Education:

The Agency, in collaboration with Sandata, used a myriad of communication vehicles for provider outreach in preparation for the July 1, 2010, implementation date. With fewer than three months between contract execution and the beginning of the program, intense and quick outreach was a necessity. Sandata launched the program website (www.sandatafl.com) on April 27, 2010 (See Appendix E).

The majority of outreach and education activities were directed to home health agencies (providers) and recipients of Medicaid home health visits. However, the Agency also included outreach to its staff through publications and presentations, and to the home health industry association, Home Care Association of Florida, to provide information about the program and request its assistance in sharing information about the program with its membership of home health agencies. In addition, Sandata recruited a provider pilot group that met at the Medicaid Area 11 Field Office in Miami on May 6, 2010 to give input on training and other communication materials.

Training Activities:

Great emphasis was placed on training the home health agencies. Sandata partnered with HP Enterprise Services (HP) as a subcontractor to oversee all training and outreach activities, which provided additional support for the project. The formal training was a two day, in-person training. During the first day of training, information was presented with a lecture style delivery method that included PowerPoint presentations. The second day of training provided participants with hands-on practice using Sandata's Web-based system. Additional educational and outreach opportunities included several topic-specific Webinar sessions that focused on critical elements in the adoption of the system by home health service providers.

Registration:
Since training of providers was considered crucial to successful pilot implementation, registration was required for all in-person sessions and the Webinar sessions provided during the week of June 21, 2010. Registration was accomplished through the program's website. An extensive outreach effort was undertaken to get home health providers to register for training. Those efforts included an initial invitation letter sent to the home health agencies in the pilot area, a second reminder invitation letter for providers that had not registered for training prior to June 16th, as well as independent efforts by the Agency and Sandata (via phone calls and e-mails) to encourage a 100% registration rate for the 2-day in-person training sessions. To assist with outreach efforts, HP provided daily registration reports that were used to compare training registrations against the Master Provider List. Providers that made errors in the registration process were also contacted via phone to confirm their registration.

Registration and Attendance Statistics:

- 283 of 345 (Medicaid enrolled at time of program implementation) home health agencies in Miami-Dade registered for 2-day in-person training sessions; 261 (92%) agencies attended. An additional 19 home health agencies attended the 2-day in-person training sessions without prior registration.
- 645 individuals registered for 2-day in-person training sessions; 577 (89%) attended.
- 546 Webinar registrations were received for 10 webinars conducted during the week of June 21, 2010; 355 (65%) attended.
- 175 Webinar registrations for Director of Nursing sessions; 119 (68%) attended.

Systems Development and Testing:

Several systems changes within FMMIS were required to permit Sandata to receive information necessary to populate its Web-based Santrax Payor Management (SPM) System with the data necessary for home health visit scheduling, maintenance, visit verification and electronic submission of claims to the Medicaid fiscal agent. Furthermore, system edits were required in FMMIS to deny claims for reimbursement of home health visits provided by home health agencies in Miami-Dade that were not submitted through Sandata. These system edits were vigorously tested to confirm that claims for home health visits provided by home health agencies in the pilot area would be denied payment if not submitted through Sandata.

Implementation Challenges:

- ***Systems impacts to the Florida Medicaid Management Information System (FMMIS).*** The DMV Program requires data feeds of files including prior authorizations, recipient and provider information to be transmitted from FMMIS to Sandata. Additionally, system edits had to be created in FMMIS to deny claims if the claims were not submitted through the Santrax Payor Management System. The Agency management team provided executive support to meet the technical requirements of the program.

- ***Inaccurate recipient telephone numbers in FMMIS.*** For approximately one-third of the recipients receiving home health visits from home health agencies in the program pilot area, the telephone number in FMMIS was incorrect. The FMMIS receives this information via data feeds from the Department of Children and Families' FLORIDA system and the Social Security Administration. Recipients are not required to have telephones to receive Medicaid services; thus telephone numbers are not a critical eligibility criterion and recipients often do not update the information as it changes. Providers were asked to encourage their patients to inform Medicaid of their current phone number.

- ***Provider compliance.*** Providers were advised in April 2010 via written notification letters and the program website www.sandatafl.com that the DMV program was starting on July 1, 2010. However, a significant number of

providers did not provide information regarding their home health agency and staff that was necessary to establish the provider databases in Sandata's Web-based system. To address this challenge, the Agency conducted aggressive follow-up using written correspondence and follow-up calls to non-compliant providers. Additionally, Sandata conducted training sessions, Webinars and provided one-on-one assistance to home health agencies who did not previously participate in training, and extended customer service hours to facilitate troubleshooting and quick responses to questions from providers.

The Agency and Sandata worked together to ensure that the implementation activities were completed in time to meet the July 1, 2010 program implementation date. Sandata's onsite contract manager in Miami provided additional assistance by serving as a liaison between Sandata and the home health providers. Upon completion of implementation activities, seventy-five percent (75) of providers had attended in-person training sessions and Sandata had established a database within its SPM System for each home health agency in Miami-Dade County.

MAJOR PROGRAM COMPONENTS

The Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program consists of several major components. They include: Santrax Payor Management (SPM) System, Speaker Verification, Electronic Submission of Claims, Customer Service, Training, Reporting and Data Downloads. Detailed descriptions and explanations of how each component contributes to the program are provided below.

Santrax Payor Management (SPM) System

The SPM System is a Web-based system which receives data feeds from FMMIS with daily information of approved prior authorizations for home health visits, as well as provider and recipient data.

- Each home health agency has a database within the SPM System that contains its staff, recipients, authorizations, and visit schedules.

- Office staff at each home health agency log onto the SPM System to schedule authorized home health visits for Medicaid recipients.

- Each home health agency has assigned toll-free numbers (English and Spanish) for staff to use for speaker verification.

- To bill for a home health visit, four elements must align:
    1. Recipient
    2. Service Authorization
    3. Staff-Speaker Verification
    4. Schedule

- If all elements do not align, an "exception" results for the visit; exceptions must be resolved by the provider's director of nursing (DON) before billing can occur. The most frequent exceptions are:
    - Unscheduled Event (Visit not scheduled or mismatch to scheduled visit)
    - Unknown Client (Incorrect recipient phone number)
    - Actual visit time more or less than scheduled

- Sandata electronically transmits claims for verified visits to the Medicaid fiscal agent after the provider has created and submitted invoices in the SPM System.

SPM System Process Overview

Sandata receives a daily electronic feed that contains authorizations for home health visits from FMMIS which is then loaded onto the SPM System. On a weekly basis, Sandata receives an electronic data file containing recipient information (e.g. name, Medicaid ID, address, phone number, etc.) from FMMIS. Provider information is transmitted as changes in their data (e.g., address, telephone number, and owner) are processed. The provider's database within the SPM System is then updated to reflect new information.

The maximum units of service that have been authorized are displayed and tracked against the units of service that have been used. The SPM System does not permit providers to schedule visits that have not been authorized, nor may providers assign staff members that are not available (i.e., have been scheduled to provide other visits at the same time) or properly credentialed (e.g., a home health aide may not be assigned to perform a skilled nursing visit) to provide a home health visit.

Speaker Verification (Using Interactive Voice Response Authentication)

When the home health agency's staff arrives at a recipient's home to provide a home health visit, the staff uses the recipient's phone to call the home health agency's specific toll-free number. Interactive voice response authentication (IVRA) technology is used to verify that the voice of the staff calling in at the beginning of the visit and calling out at the end of the visit matches the staff's previously recorded voiceprint. The use of IVRA technology fulfills the requirement that voice biometrics be part of the program.

If a recipient does not have a telephone, or refuses to allow the staff to use his or her phone, Sandata has an alternative location tracking device (ALTD) that is used to track the date and time of visits. The nurse or home health aide presses the button on the device at the beginning and end of the visit and records the six-digit codes that appear on the screen. The codes correspond to the date and time of the visit. When the visit has been completed, and the nurse or home health aide has access to a phone, he or she will call the home health agency's toll-free number, and complete the speaker verification process. When prompted, the nurse or home health aide will enter the codes from the ALTD (see Appendix F). This maintains the voice biometrics component of the program.

Electronic Submission of Claims (Billing)

When an authorized home health visit has been provided as scheduled to the recipient, the visit is deemed to be validated, and is ready to bill. The Santrax Payor Management (SPM) System generates the claims file and electronically submits the claims to the Medicaid fiscal agent. Claims can be submitted as often as the provider desires. The systems edits made to the FMMIS cause denial of claims for reimbursement of home health visits provided by providers in the pilot area if they are not submitted through the SPM System. Providers may check the FMMIS Web Portal to confirm payment just as they would for any other Medicaid claim.

Customer Service

Customer service is an important component of the DMV Program. Sandata's customer service center is located in Tallahassee and is staffed by four full-time customer service representatives, two of whom are bilingual in English and Spanish. Customer support is available to home health providers from 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding State observed holidays. Since implementation, the customer service center has met all contractually required service levels (i.e., 90% of calls are answered within 30 seconds and less than 10% of calls are abandoned or rolled to voicemail).

The most frequent reasons for provider calls to customer service are:

- Visit maintenance;
- Speaker verification;
- Billing export;
- Scheduling; and
- Invoicing.

In addition to answering incoming calls from providers, customer service representatives also make outgoing calls to providers to assist the Agency in outreach efforts. These outgoing calls have been made to providers to make them aware of outstanding exceptions, billing activity (or non-activity), and to offer training.

Ongoing Training and Outreach

After the initial training provided during the program's implementation period, home health providers were given opportunities to receive training on specific topics. These one-on-one Webinar training sessions are typically an hour in length, and deliver training targeted specifically to a particular home health agency's needs. From August through November, seventy-six sessions were scheduled, and of these forty sessions were completed. The remaining sessions were rescheduled or cancelled by the providers.

In addition to these individual training sessions, providers receive updates and notifications via e-mail and through the Santrax Payor Management (SPM) System.

Reporting and Data Downloads

On a monthly basis, Sandata provides reports that detail various program activities such as provider participation, service authorization numbers, billing and invoice activity, visit schedules, visit verification rates, and information on visit exceptions. In addition to these contractually required reports that Sandata submits to the Agency, each home health agency in the program has the capability to create reports from its individual provider database within the SPM System. While home health providers may only access their own database in the SPM System, the Agency for Health Care Administration staff can sign onto the SPM system and view information on all providers. This allows the Agency to view real time data and download reports that can be saved in various formats for analysis.

EVALUATION METHODOLOGY

In order to evaluate the effectiveness of the program, the Agency evaluated Medicaid home health visit data to assess the impact of the pilot to reduce fraud and abuse. This was accomplished by assessing trends in Medicaid expenditures for home health visits; the number of Medicaid enrolled home health agencies providing home health visits; the number of recipients receiving home health visits; and the average number of visits per recipient.

Data Sources

The data source for this report is the Florida Medicaid Management Information System (FMMIS) and the extracting tool used was the Florida Medicaid Data Warehouse/ Decision Support System (DSS), which is a relational database that allows Medicaid data analysis based on paid claims data. The reported data is for the home health visit procedure codes T1030, T1031, T1021 and the associated modifiers.

Table 1: Home Health Visit Procedure Codes

CODE	MODIFIER 1	MODIFIER 2	DESCRIPTION OF SERVICE	MAXIMUM FEE
T1030			Registered Nurse (RN) Visit	$31.04/per visit
T1030	GY		Registered Nurse (RN) Visit to Dually-Eligible Recipient	$31.04/per visit
T1031			Licensed Practical Nurse (LPN) Visit	$26.19/per visit
T1031	GY		Licensed Practical Nurse (LPN) Visit to Dually- Eligible Recipient	$26.19/per visit
T1021	TD		Home Health Aide (HHA) Visit—associated with skilled nursing services	$17.46/per visit
T1021	TD	GY	Home Health Aide (HHA) Visit—associated with skilled nursing services to Dually-Eligible Recipient	$17.46/per visit
T1021			Home Health Aide (HHA) Visit—unassociated with skilled nursing services	$17.46/per visit
T1021	GY		Home Health Aide (HHA) Visit—unassociated with skilled nursing services to a Dually-Eligible Recipient	$17.46/per visit

Data relative to Telephonic Home Health Services DMV Program activity was supplied by Sandata, LLC, based on information in its Santrax Payor Management (SPM) System.

Data Analysis

DSS paid claims data was analyzed for each quarter of State Fiscal Year (SFY) 2006-2007, 2007-2008, 2008-2009, 2009-2010 and the first quarter of SFY 2010-2011 (July 1, 2010-October 1, 2010). The State Fiscal Year is from July 1st of each year through June 30th of the next year.

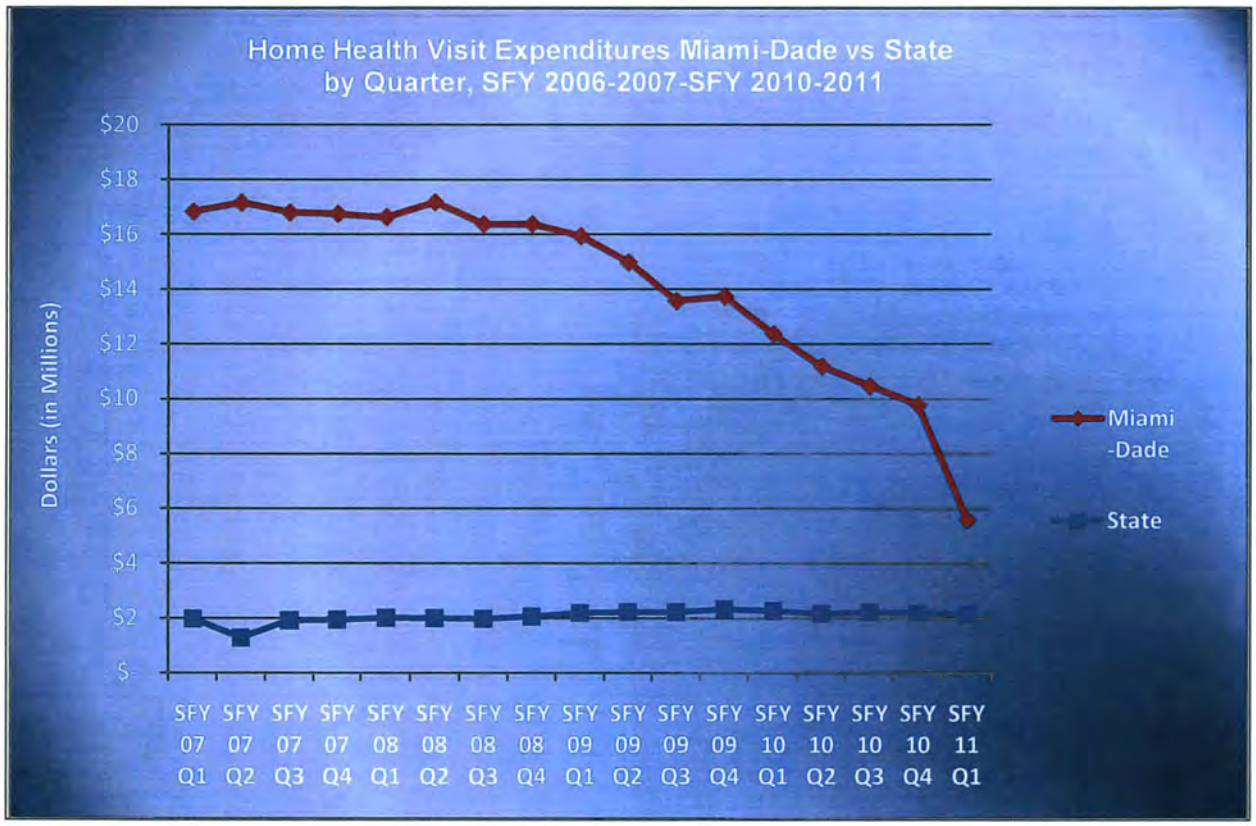
The primary data fields selected for examination and comparison include:

- Home health agency (Medicaid enrolled provider) census
- Expenditures for home health visits, based upon date of service
- Unduplicated count of recipients receiving home health visits
- Average units of service (one visit = one unit of service) per recipient

RESULTS

The issue of fraud and abuse within the home health system of care has been a key issue – both at the federal and state level. Addressing overutilization and aberrant billing practices in the home health program, particularly in Miami-Dade, has been an important focus within the Agency. The Division of Medicaid has engaged in a number of activities that aid in the prevention and detection of Medicaid fraud, abuse and overpayments. As Figure 1 illustrates, Medicaid quarterly expenditures in Miami-Dade County for home health visits (codes T1030, T1031, and T1021) have decreased by over 35% since SFY 2006-2007 through the first quarter of SFY 2010-2011, representing over $23 million in savings to the State of Florida.

Figure 1: Miami-Dade home health visit expenditures are dropping steadily

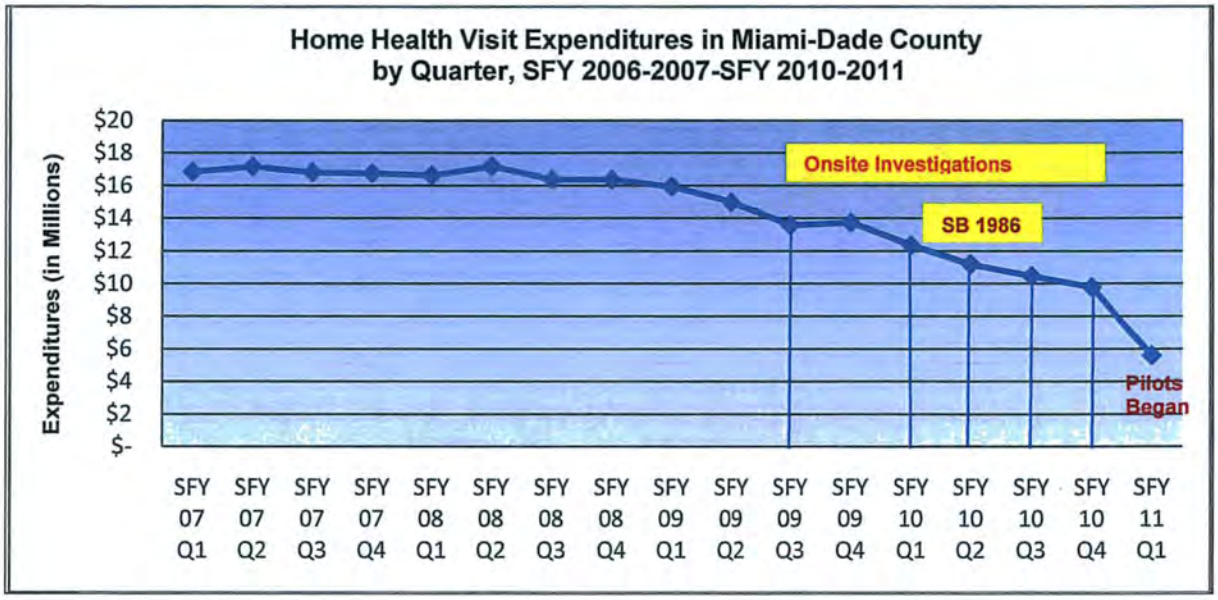


Note: For the purposes of this report, and to simplify illustration, in Figures 1 and 2, the SFY labels correspond to SFY's as listed below:

SFY 07 = SFY 2006-2007
SFY 08 = SFY 2007-2008
SFY 09 = SFY 2008-2009
SFY 10 = SFY 2009-2010
SFY 11 = SFY 2010-2011

The quarterly data consistently shows a decrease in expenditures for home health visits in Miami-Dade County (See Figure 2 below).

Figure 2: Agency anti-fraud efforts reduce Miami-Dade home health expenditures



These outcomes are due to multiple efforts by the Florida Legislature, the Agency for Health Care Administration and the Medicaid Fraud Control Unit (MFCU) and therefore cannot be attributed to only one initiative. For example:

- **January 2008:** Home health aide services in the Miami-Dade County area were analyzed by the Agency's Medicaid Program Integrity and Medicaid Services Bureaus, the Office of the Attorney General's Medicaid Fraud Control Unit and the Centers for Medicare and Medicaid Services (CMS). This review resulted in over 30 internal and external investigative referrals.

- **July 1, 2009, Senate Bill No. 1986 became law:** Miami-Dade County was designated as a health care fraud area of concern and the Agency for Health Care Administration was instructed to implement pilot projects to monitor home health services and home health care management.

    - Moratorium on licensure of new home health agencies in Miami-Dade County, effective July 1, 2009-June 30, 2010;
    - Enhanced prior authorization of home health services
        - All home health services must be prior authorized before initiating care.
        - The plan of care and physician's order must be submitted with the prior authorization request.
        - Proof of a physician visit must be submitted at the time of the request to initiate services, and biannually thereafter.

- **July 1, 2009-June 30, 2010:** Agency for Health Care Administration's Office of Inspector General, Bureau of Medicaid Program Integrity (MPI) and staff from Medicaid visited all 379 home health agencies in Miami-Dade County. The review also included physicians that write prescriptions for home health aide visits. This effort resulted in:

    - $282,098 in paid claims recouped
    - Sixteen home health agencies terminated (not at the address of record and contract)
    - Fifty-two sanctions; Fifty physicians cited for violations totaling $26,500 in fines
    - Fifty-eight referrals to Department of Health for review of possible practice violations
    - Six home health agencies placed on prepayment review where Agency Medicaid Program Integrity staff review all claims for appropriateness prior to authorizing payment
    - One referral for medical privacy violations
    - Five provider education letters to remind providers of Medicaid policy and allow providers the opportunity to correct minor non-compliance issues
    - Five referrals to the Centers for Medicare & Medicaid Services; one resulting in a home health agency suspension from Medicare

- **July 1, 2010, Implementation of two pilot programs in Miami-Dade:** The Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program and the Comprehensive Care Management Program (See Appendix G).

Since implementing the pilot projects in Miami-Dade, two large home health providers (each serving over 250 Medicaid recipients in the county, with annual reimbursement exceeding $1 million) were terminated from participation in the Medicaid program and one provider was suspended from the program.

Figures 3 and 4 highlight the decrease in the numbers of recipients using home health visit services and the decrease in the number of home health agencies providing home health visits in Miami-Dade County. Please note that data for SFY 2010-2011 is not yet complete. For comparative purposes, 3,613 Medicaid recipients in Miami-Dade County received home health visits during the first quarter of SFY 2010-2011.

Figure 3: The number of recipients receiving home health visits in Miami-Dade continues to decrease as the number of recipients increases

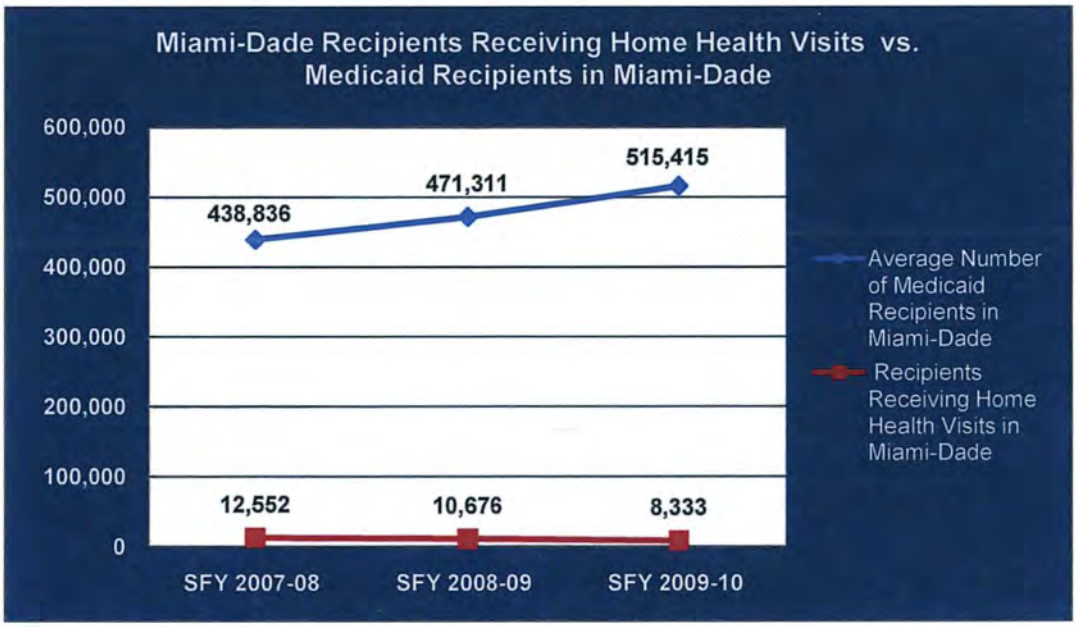
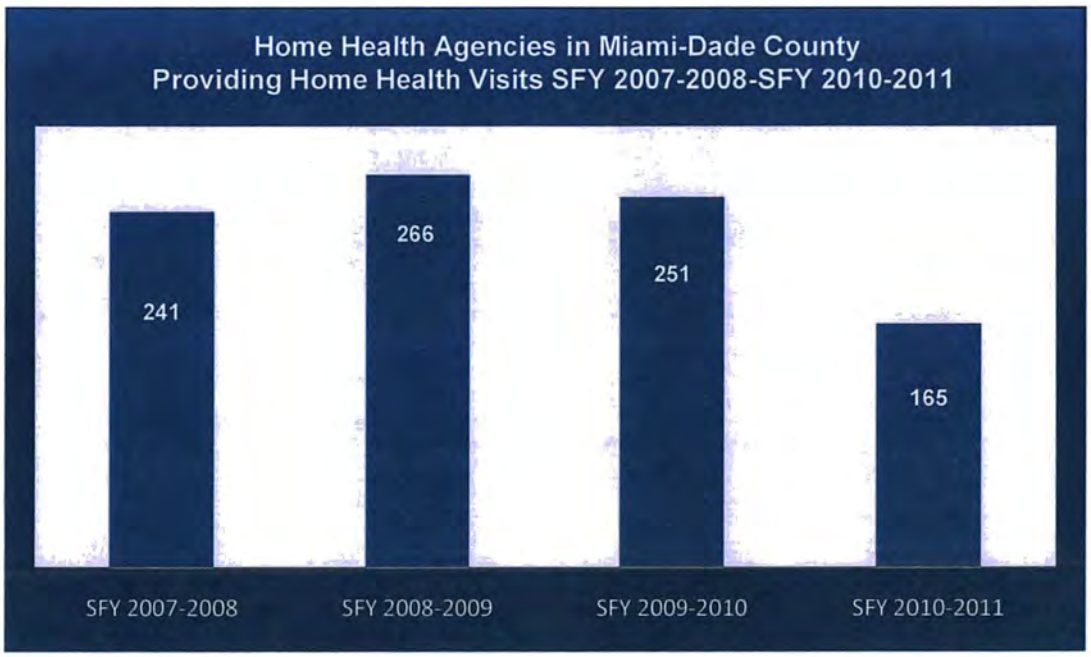


Figure 4: The number of home health agencies in Miami-Dade County providing home health visits to Florida Medicaid recipients continues to decrease



Program Activity in Sandata's Santrax Payor Management (SPM) System:

Sandata's SPM System contains information related to home health visit activity for the Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program. Tables 2 and 3 reflect SPM System activity and billing activity that has taken place from program implementation on July 1, 2010 through December 31, 2010.

The total number of providers with active databases in the SPM system has decreased since program implementation due to provider terminations and fewer providers that provide Medicaid home health services. As the number of providers decreased, the number of visits scheduled also decreased.

Table 2: Monthly SPM System Activity Summary

Month	Providers*	Total Visits Verified	Total Calls	Visit Schedules Created
July 2010	345	113,533	290,967	161,861
August 2010	345	101,555	261,804	176,533
September 2010	330	93,387	243,640	148,710
October 2010	332	86,159	240,172	146,023
November 2010	333	69,430	219,496	137,375
December 2010	333	72,916	220,754	131,480

** 226 of these providers currently have authorizations to provide home health visits.*

During this same timeframe, the number and percentage of home health agencies with authorizations to provide home health visits that successfully used the SPM System to bill (submit claims) for services increased. This is an indication that providers are becoming more familiar with the system.

Table 3: Provider Use of the SPM System Is Growing

Month	Agencies with Authorizations	Agencies that Submitted Invoices	% Agencies with Authorizations that Invoiced during the Month	Total Number of Claims Submitted	Total Number of Services on Claims	Total Amount Submitted (excluding co-pay)
July 2010	214	86	40.0%	5,889	51,851	$912,766
August 2010	218	142	65.1%	10,333	101,673	$1,768,293
September 2010	217	148	68.2%	16,104	82,078	$2,209,834
October 2010	219	156	71.2%	15,604	79,027	$2,098,531
November 2010	224	154	68.8%	11,886	68,752	$1,784,605
December 2010	226	150	66.4%	11,188	82,841	$2,107,448

Exceptions Analysis

The SPM system requires a match from the recipient that has an authorization for home health visits with the staff scheduled to do the visit and the speaker verification conducted at the beginning and the end of each visit. The system verifies that the scheduled visit corresponds to a recipient that has an authorization to receive home health services; that the authorized visit is occurring at the scheduled time by the assigned staff member that has the credentials (i.e., RN, LPN, or home health aide) to perform the services; and that speaker verification took place.

When the proper procedures are not followed within the SPM System, an exception is generated for the specific home health visit. In order to resolve a visit exception and make the visit eligible for billing, the home health agency must manually correct the visit information prior to submission of the claim for payment through the SPM System. Only designated staff within the home health agency who have been authorized to make manual corrections may resolve exceptions. The primary reasons for exceptions are described below:

- *Unscheduled Events (Visits.)* Providers are to schedule home health visits prior to the delivery of services. If a visit occurs without prior scheduling, when the staff call-in and call-out from the recipient's home, there is no schedule to match up with the speaker verification. This results in an "Unscheduled Event" exception.

- *Unknown Client.* The recipient telephone number in the Florida Medicaid Management Information System (FMMIS) differs from the phone number from which the call-in and call-out were made. When the call in and call out does not match to the recipient telephone number as indicated within the SPM System, an "Unknown Client" exception results. The Agency has been seeking correct telephone numbers through letters to recipients (in English and Spanish) requesting that they supply their correct telephone number, along with a copy of the first page of their phone bill for verification. 1,300 letters were mailed at the end of August and 263 responses were received. The Agency entered the 263 correct phone numbers in the SPM System. However, the FMMIS continues to reflect the information it receives via data feeds from the Department of Children and Families' FLORIDA system and the Social Security Administration.

- *Actual Hours More or Less than Scheduled.* The visit time does not match the scheduled time. For example, a visit is scheduled to take place from 9:00 a.m. to 10:30 a.m., however, the actual visit was provided from 10:30 a.m. to 11:30 a.m.

Home Health Agencies Visit Activity and Exceptions

As expected during the first months of implementation, a high percentage of visits were manually verified (exceptions resolved) by the home health agencies. This could be explained by various factors, among them: providers' lack of experience with the

Santrax Payor Management (SPM) System (some providers postponed training until right before program implementation); providers failing to set up speaker verification for all members of their staff; providers failing to provide Sandata with the necessary information to set up their individual databases within the SPM System; and delaying visit scheduling in the SPM System. Compounding these factors was the large number of incorrect recipient phone numbers, causing exceptions due to the mismatch between the number from which service providers called and the recipient phone number in FMMIS.

Tables 4 and 5 reflect monthly exception trends and a summary of visit verification activity and exception rates.

Table 4: Monthly Exception Trends

	August	September	October	November	December	Average
Unscheduled Event (Visit)	32.4%	38.8%	42.7%	39.4%	42.0%	39.0%
Unknown Client (Recipient)	22.9%	26.5%	27.7%	27.1%	28.5%	26.5%
Total Visit Time More or Less than Scheduled	25.7%	16.2%	10.8%	9.3%	9.6%	14.3%
Other Exceptions	19.0%	18.5%	18.9%	24.2%	19.9%	20.1%

Visit Exception Causes

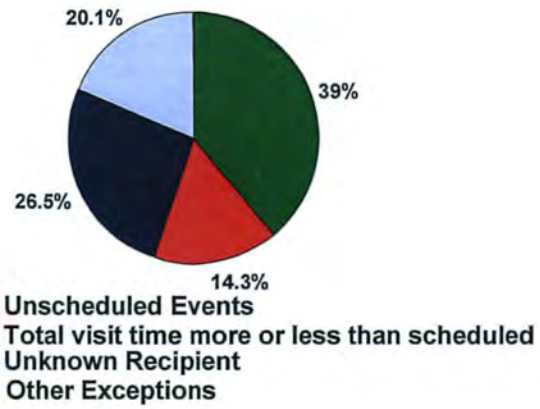


Table 5: Visit Verification Summary and Total Exception Rate

Month	Total Visits Verified	% Auto Verified	% Manually Verified	% of Visits with Exceptions
July	113,533	28.6%	71.3%	73.0%
August	101,555	31.5%	68.5%	76.3%
September	93,387	47.0%	53.0%	70.2%
October	86,159	54.2%	45.8%	71.2%
November	69,430	52.7%	47.3%	84.5%
December	72,916	47.0%	53.0%	78.1%

In an effort to decrease the number of visits with exceptions, Sandata and the Agency have taken the following actions:

- Provided ongoing provider outreach and education;
- Targeted outreach to correct recipient phone numbers; and
- Changed SPM System to allow more flexibility in total visit time. This decreased the "Total visit time more or less than scheduled" exception rate from 26% in August to 16% in September.

Upcoming exception reduction measures:

- Second letter to recipients for whom phone number mismatches have occurred requesting that they provide the Agency with their current telephone numbers;
- Expanded use of alternative location tracking devices (ALTDs) for recipients that either do not have a home telephone or will not permit home health agency staff to use their telephone.

The Agency will continue to implement activities to encourage provider compliance. These activities include, but are not limited to: mailing providers a "scorecard" that includes each provider's visit exception rates; giving providers opportunities to obtain additional training to reduce their exception rates; and placing providers on corrective action plans. Additionally, the Agency is exploring the feasibility of legal options, which may include: sanctions, limitations on provider override capabilities in the SPM System, prepayment review of claims documentation and Medicaid Program Integrity provider reviews.

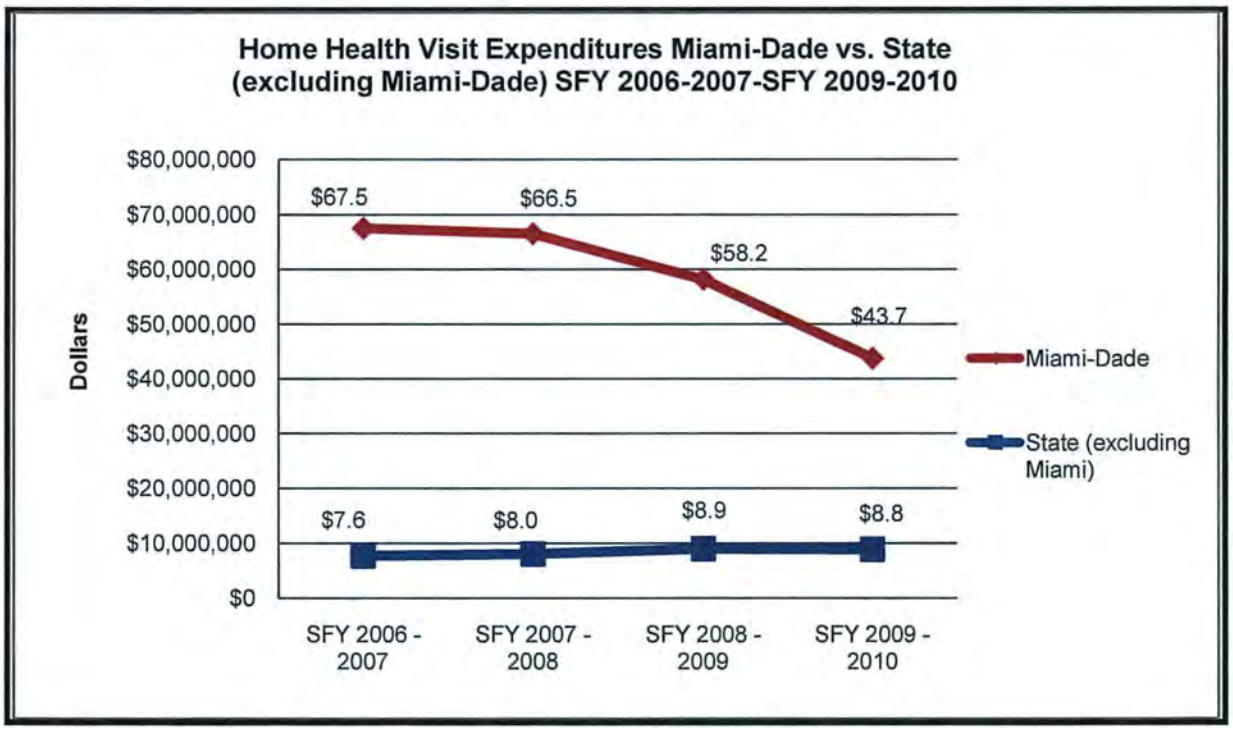
SUMMARY OF FINDINGS

An increasing percentage of providers are successfully billing through the Santrax Payor Management (SPM) System. Home health visits are increasingly being automatically verified through the SPM System. In addition, the Agency is able to access data that it did not have prior to this program, such as:

- Missed or late visits
- Length of time for each visit
- Information on the specific person providing the visit

Exception rates in the SPM System remain high, despite the program being operational for over six months and the on-going training opportunities for home health providers. The Agency continues to work with Sandata to monitor progress of the pilot and to identify strategies to reduce the number of exceptions. Overall, home health visit expenditures in Miami-Dade continue to decrease as a result of the targeted efforts to address fraud and abuse as depicted in Figure 5.

Figure 5: Home health visit expenditures in Miami-Dade continue to decrease



EVALUATION LIMITATIONS

There are several limitations inherent within this evaluation of the Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program:

- ***Short period of program operations:*** The program began July 1, 2010. The results in this evaluation are reflective of paid claims for the first quarter of SFY 2010-2011 (July, August, and September 2010).
- ***Timeframe for claim submission:*** Medicaid providers have twelve months after the date of service to file a clean claim for payment of services. Home health providers who rendered services since the implementation date (July 1, 2010) of the program may still submit claims for payment within the twelve months after the date of services, thus making expenditure analysis difficult. As a result, the reduction in expenditures will change until the claims lag period has closed.
- ***Confounding Factors.*** A single causal relationship between the decrease of expenditures for home health visits in Miami-Dade and the implementation of the "*Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program*" cannot be established at this time, since the project has been operational for only a short period of time and there have been multiple efforts by the Agency to combat fraud and abuse in Miami-Dade County. The concurrent implementation of a second pilot project, "*Comprehensive Care Management,*" which includes face-to-face assessments conducted by nurses in recipients' residences to validate medical necessity for home health visits, also makes it difficult to determine a one-to-one impact.

NEXT STEPS

Based upon the initial outcomes of this evaluation, the Agency has identified several process steps to enhance operation and ensure value:

- Establish acceptable rates or ranges for visit exceptions in the SPM System;
- Impose sanctions for providers who fail to competently participate in the program (e.g., failure to schedule visits and not following protocols for using the SPM System);
- Use data obtained from this program for future policy development, (e.g., service quality, reimbursement methods, etc.);
- Establish a reliable and effective process to update recipient telephone number data, particularly for dually-eligible recipients of Medicare and Medicaid;
- Establish a direct data feed of home health visit authorization data from the Agency's contracted quality improvement organization to Sandata, LLC. This data feed would supplement the authorization files Sandata receives from FMMIS, and provide detailed visit frequency to strengthen visit limitations in the SPM System and simplify the visit scheduling process for service providers;
- Evaluate any changes in expenditures, number of enrolled providers, and recipients receiving services in surrounding counties to determine whether this pilot has impacted utilization rates in those counties; and
- Continue to review and evaluate claims data and data received from the SPM System to determine whether expanding the pilot into other areas of the state would be beneficial and provide cost savings.

Many of these recommendations are already being implemented by the Agency, which will continue to strengthen the program and build on its successes.

This initial evaluation of the Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program indicates that the incorporation of a web-based system that includes recipient, provider, service authorization, and scheduling information, combined with the use of voice biometrics, not only supplements physical documentation of delivery and utilization of home health visits, but also provides the Agency with tools to effectively monitor the provision of home health visits to Medicaid recipients. More importantly, the program has great potential for reducing fraud and abuse in Florida Medicaid by reducing the submission of claims for services that were not provided. As the program moves toward completion of its first year of operation, and the Agency implements activities to increase provider compliance and strengthen the program, it is anticipated that the Agency will have access to more detailed data to assist with policy development, and experience continued reduction of Medicaid expenditures for home health visits in Miami-Dade County.

APPENDIX A: LEGISLATIVE AUTHORITY

CHAPTER 2009-223 LAWS OF FLORIDA

Section 31. Pilot project to monitor home health services.—The Agency for Health Care Administration shall develop and implement a home health agency monitoring pilot project in Miami-Dade County by January 1, 2010.

The agency shall contract with a vendor to verify the utilization and delivery of home health services and provide an electronic billing interface for home health services. The contract must require the creation of a program to submit claims electronically for the delivery of home health services. The program must verify telephonically visits for the delivery of home health services using voice biometrics. The agency may seek amendments to the Medicaid state plan and waivers of federal laws, as necessary, to implement the pilot project. Notwithstanding s. 287.057(5)(f), Florida Statutes, the agency must award the contract through the competitive solicitation process. The agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives evaluating the pilot project by February 1, 2011.

APPENDIX B: MEDICAID HOME HEALTH SERVICES

(Excerpts from Florida Medicaid Home Health Services Coverage and Limitations Handbook, online at: http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_08_080701_Home_Health_ver1.2.pdf)

Purpose of the Home Health Program
The purpose of the home health program is to provide medically-necessary care to an eligible Medicaid recipient whose medical condition, illness or injury requires the care to be delivered in the recipient's place of residence.

Home Health Services Definition
Home health services are medically necessary services, which can be effectively and efficiently provided in the place of residence of a recipient. Services include home health visits (nurse and home health aide), private duty nursing and personal care services for children, therapy services, medical supplies, and durable medical equipment.

Home Health Visit Definition
A home health visit is a face-to-face contact between a registered nurse, licensed practical nurse, or home health aide and a recipient at his place of residence.

A home health visit is not limited to a specific length of time, but is defined as an entry into the recipient's place of residence, for the length of time needed, to provide the medically-necessary nursing or home health aide service(s). Medicaid reimbursement for a home health visit does not include travel time to or from the recipient's place of residence. Such expenses are administrative and not reimbursable by Medicaid.

Place of Residence Definition
Place of residence is the location where a Medicaid recipient lives and may include:
Recipient's private home;
Assisted Living Facility (ALF);
Developmental services group home;
Foster or medical foster care home; or
Any home where unrelated individuals reside together in a group.

Who Can Receive In-Home Services
Medicaid reimburses home health services for Medicaid recipients who are under the care of an attending physician.

The recipient must meet the following requirements:
Require services that, due to a medical condition, illness or injury, must be delivered at the place of residence rather than an office, clinic or other outpatient facility because:

- Leaving home is medically contraindicated and would increase the medical risk for exacerbation or deterioration of the condition; or
- The recipient is unable to leave home without the assistance of another person;

Require services that are medically necessary and reasonable for the treatment of the documented illness, injury or condition;
Require services that can be safely, effectively and efficiently provided in the home; and
Live in a residence other than a hospital, nursing facility or intermediate care facility for the developmentally disabled (ICF/DD). (See exceptions for ICF/DDs in 42 CFR 483, Subpart I.)

Medicaid does not reimburse home health services solely due to age, environment, convenience or lack of transportation.

Home Health Visit Limitations
Home health visits are limited to a maximum of four intermittent visits per day.
The visits may be any combination of licensed nurse and home health aide visits.
Each recipient who is receiving services on a fee-for-service basis is limited to a maximum of 60 visits in a lifetime without precertification. Recipients requiring more than 60 visits may receive additional visits through a precertification request to the Medicaid peer review agency for the services.

Skilled Nursing Services
The following are examples of services that require the direct care skills of a licensed nurse:

Administration of intravenous medication;
Administration of intramuscular injections, hypodermoclysis, and subcutaneous injections only when not able to be self administered appropriately;
Insertion, replacement and sterile irrigation of catheters;
Colostomy and ileostomy care; excluding care performed by recipients;
Treatment of decubitus ulcers when:
- deep or wide without necrotic center;
- deep or wide with layers of necrotic tissue; or
- infected and draining;
Treatment of widespread infected or draining skin disorders;
Administration of prescribed heat treatment that requires observation by licensed nursing personnel to adequately evaluate the individual's progress;
Restorative nursing procedures, including related teaching and adaptive aspects of nursing, which are a part of active treatment and require the presence of licensed nurses at the time of performance;
Nasopharyngeal, tracheotomy aspiration, ventilator care;
Levin tube and gastrostomy feedings, excluding feedings performed by the recipient, family or caregiver; and complex wound care requiring packing, irrigation, and application of an agent prescribed by the physician.

Home Health Aide Services
Home health aide services help maintain a recipient's health or facilitate treatment of the recipient's illness or injury.

The following are examples of home health aide services reimbursed by Medicaid*:

Assisting with the change of a colostomy bag;
Assisting with transfer or ambulation;
Reinforcing a dressing;
Assisting the individual with prescribed range of motion exercises that have been taught by the RN;
Assisting with an ice cap or collar;
Conducting urine test for sugar, acetone or albumin;
Measuring and preparing special diets;
Providing oral hygiene;
Bathing and skin care; and
Assisting with self-administered medication.
.

*Home health aides must not perform any services that require the direct care skills of a licensed nurse.

APPENDIX C: PROCUREMENT ACTIVITIES

The activities undertaken by the Agency to competitively procure a vendor to operate the Telephonic Home Health Services DMV Program are highlighted below:

Procurement Activities: June 1, 2009 - April 8, 2010

Date	Activity
June 2009	Research on Telephony and Telephony Programs in other states
July 2009	Agency determination of project parameters and components; procurement type selection-invitation to negotiate (ITN); First draft of Scope of Services and Procurement Documents
August 2009	Internal Agency meetings to determine Systems Requirements for the project; First round of revisions to the scope of services and procurement documents
September 2009	Revised scope and procurement documents are routed for approval and forwarded to the Medicaid Services Procurement Coordinator for review
October 2009	Revised and approved scope and procurement documents sent to the Agency's Procurement Office for preparation of the official ITN Solicitation; Additional revisions made by the Program Office
November 2009	Routing, review and approval of the final draft of the Solicitation Package
December 7, 2009	Posting of AHCA ITN 1004 on the Vendor Bid System (VBS)
December 17, 2009	Deadline for receipt of written inquiries
January 5, 2010	Agency responses to written inquiries were posted on the VBS
January 11, 2010	Vendor Conference
January 19, 2010	Public opening of response to ITN 1004; Appointment of Evaluation Team
January 25-29, 2010	Evaluation of response
February 1, 2010	Appointment of Negotiation Team
February 4th & 9th, 2010	Negotiations with prospective Vendor
February 16, 2010	Posting of Notice of Intent to Award on the Vendor Bid System
March 12, 2010	Final draft contract sent to Vendor
March 30, 2010	Agency contract review and approval completed
April 1, 2010	Contract sent for vendor signature
April 7, 2010	Agency received signed contract from vendor
April 8, 2010	Contract execution

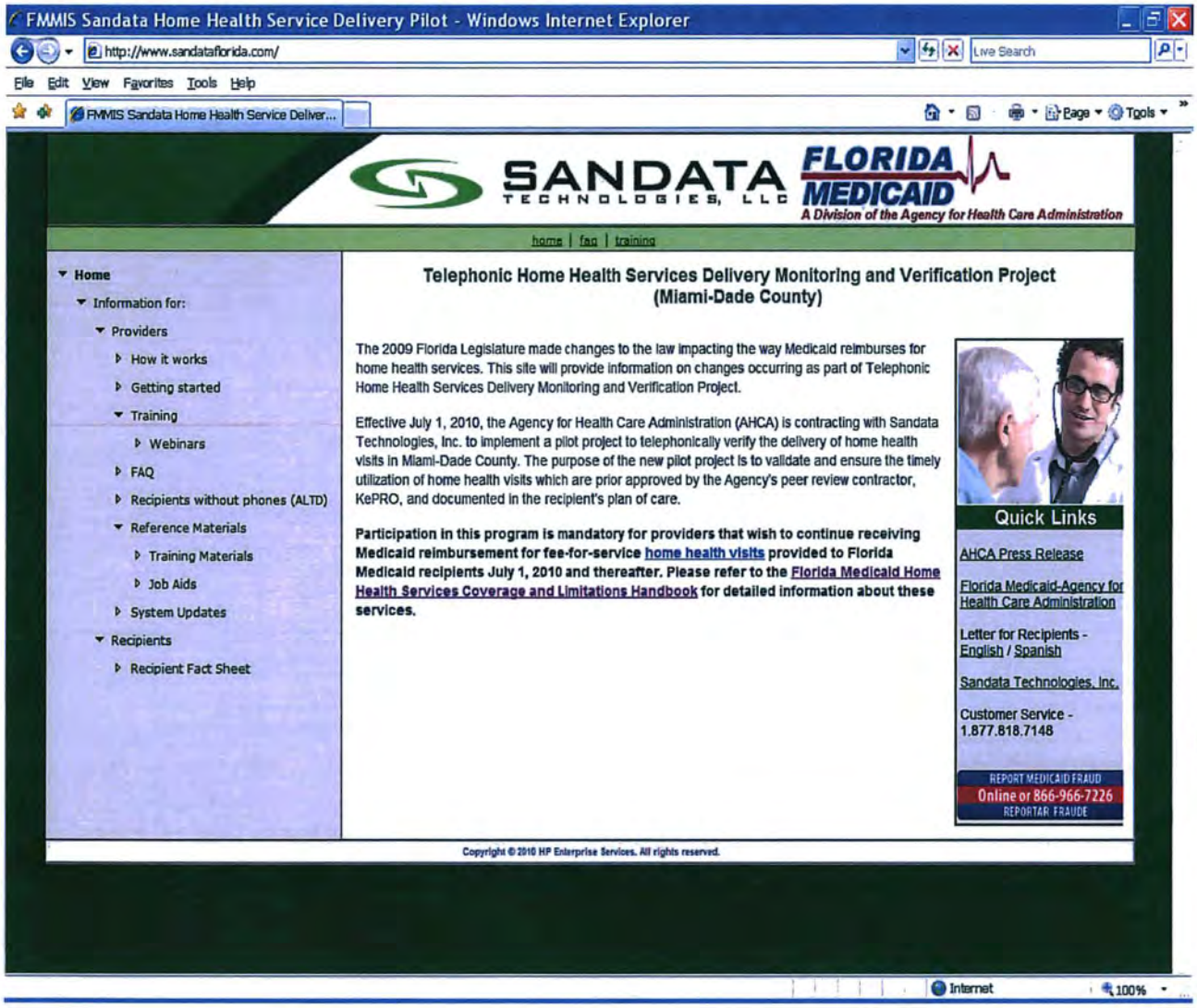
APPENDIX D: PROGRAM IMPLEMENTATION ACTIVITIES

After the execution of the contract, the Agency and Sandata embarked upon an aggressive implementation schedule designed to ensure that the program became operational on July 1, 2010. Major milestones in program implementation are outlined below.

Program Implementation Major Milestones: April 1- June 30, 2010

Timeframe	Implementation Activities
April 2010	Submission of programming request for required FMMIS changes
	Pre-Implementation Kick-Off meetings with vendor
	Press Release to Publicize the Program to Providers
	Provider Notice Mail Out
	Website Launch
	Recipient Notice Mail Out
	Finalization of Outreach and Implementation Plans
May 2010	Home Health Agency Pilot Group-Initial Meeting
	Information Session in Miami-Dade County
	Systems Design and Development
May and June 2010	Home health agencies registration with Sandata; recording of direct care workers' voices for speaker verification
June 2010	Sandata Systems Testing
	Readiness Review conducted by the Agency
	Home health agency Training Sessions
July 1, 2010	"Go-Live" Date-Home health agencies use Sandata's web-based system and IVRA

APPENDIX E: PROGRAM WEBSITE HOMEPAGE



APPENDIX F: ALTERNATIVE LOCATION TRACKING DEVICE (ALTD)

The alternative location tracking device (pictured at left) developed by Sandata Technologies, Inc. is a battery operated device with dimensions approximately 1 ½" x 2 ¼" x ¾" that can be affixed to a surface with screws or double-sided adhesive tape. The device is installed in the residences of recipients of home health visits who do not have a landline telephone. Each device is registered to a specific recipient and activated upon installation in the recipient's place of residence.

Rather than calling-in and calling-out from a recipient's home phone at the beginning and end of each home health visit, the nurse or home health aide simply presses the button on the device and records the six-digit codes that appear on the screen. The codes correspond to the date and time of the visit. When the visit has been completed, and the nurse or home health aide has access to a phone, he or she will call Sandata's toll-free number established for the home health agency, and follow the speaker verification process. When prompted, the nurse or home health aide will enter the codes from the ALTD. This maintains the voice biometrics component of the program.

As of December 31, 2010, sixty-five alternative location tracking devices had been distributed.

APPENDIX G: COMPREHENSIVE CARE MANAGEMENT PILOT

Section 32 of Chapter 2009-223, Laws of Florida directed the Agency for Health Care Administration to implement a pilot project for home health care management.

> Section 32. Pilot project for home health care management.—*The Agency for Health Care Administration shall implement a comprehensive care management pilot project for home health services by January 1, 2010, which includes face-to-face assessments by a nurse licensed pursuant to chapter 464, Florida Statutes, consultation with physicians ordering services to substantiate the medical necessity for services, and on-site or desk reviews of recipients' medical records in Miami-Dade County. The agency may enter into a contract with a qualified organization to implement the pilot project. The agency may seek amendments to the Medicaid state plan and waivers of federal laws, as necessary, to implement the pilot project.*

The Agency amended its existing contract with KePRO (Keystone Peer Review Organization) to include implementation of the comprehensive care management (CCM) pilot project for home health services. The CCM pilot project includes face-to-face assessments of Medicaid recipients that receive home health visits by a nurse licensed pursuant to chapter 464, Florida Statutes; consultation with physicians ordering services to substantiate the medical necessity for services; and on-site or desk reviews of recipients' medical records in Miami-Dade County.

KePRO has the responsibility of identifying potential problem areas through data analysis and monitoring of selected cases, verifying through medical record review the existence of problems or violations of provider obligations, and reporting findings to the Medicaid provider and the Agency.

From July 1, 2010 through November 30, 2010, KePRO completed 1,836 face-to-face assessments, four provider audits, and made 134 referrals to Medicaid Program Integrity, with recommendations for further investigation, recoupment of claims paid, and/or reduction or termination of services.

ACKNOWLEDGEMENTS

The Florida Agency for Health Care Administration acknowledges the following persons for supplying information for this report:

Teri Arnoldy, Medical/Health Care Program Analyst
Fraud Prevention and Compliance Unit
Bureau of Medicaid Program Analysis

Horace Dozier, Field Office Manager
Office of the Inspector General
Bureau of Medicaid Program Integrity
Intake and Field Assessment Unit

Steven Hardy, Medical/Health Care Program Analyst
Office of the Inspector General
Bureau of Medicaid Program Integrity

Gordon McCleary, Program Administrator
Office of the Inspector General
Bureau of Medicaid Program Integrity, Data Detection Unit

Yolanda Sacipa, MPH, Program Consultant
Fraud Prevention and Compliance Unit
Bureau of Medicaid Services

HP Enterprise Services:
Beth Henry, Program Manager (Customer Service)

Sandata, LLC Project Team:
Rossana Follender, Director, Program Management
Jorge Garcia, Contract Manager
Brian Lawson, SPM Product Manager
Patrick Warren, Reporting and Analytics Project Manager

The Alaska Personal Care Assistance (PCA) Program is a Medicaid program which allows a qualifying person (consumer) with a functional disability to receive in-home hands on care to maintain their health and safety. There are two models of PCA services in Alaska. In the Agency Model the agency is responsible for the oversight of the services, training, and management of the Personal Care Assistant. In the Consumer Directed model the consumer is responsible to recruit, hire, train, and manage a Personal Care Assistant of their choice with the agencies oversight and assistance. Both models have strong regulatory oversight.

Who is eligible for the PCA program?

- Individuals eligible for Alaska Medicaid that require physical hands on assistance with their Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) as determined by assessment.

What are ADLs and IADLs?

- These are the activities that an individual needs to do on a regular basis to maintain health, safety and welfare.
- Bathing, dressing, eating, preparing meals, medication reminders, and attending medical appointments are just a few examples of these activities.

How is eligibility determined?

- An application is submitted to the Alaska Division of Senior and Disability Services (SDS). This application includes demographic information and a Verification of Diagnosis from an approved medical professional.
- SDS assigns and schedules state assessment personnel (usually an RN) to come to an individual's home and conduct an extensive functional assessment.
- This assessment is reviewed by SDS staff for regulatory compliance.

What are the benefits to the individual receiving PCA Services?

- Individuals with functional disabilities who utilize PCA Services overwhelmingly report that these services have reduced or prevented falls, infections, and poor nutrition.
- Services very often delay or prevent hospitalization and admission into more restrictive care environments such as Assisted Living Homes and Nursing Homes.
- Individuals being discharged from hospitals and Nursing Homes have better success remaining in their homes and communities when supported by PCA Services.

What are the benefits to the State of Alaska's Medicaid budget?

- At the time of the report titled "Potential Impact on Expenditures from Terminating the Personal Care Program" developed for the 2004 Legislature, there were 730 Nursing Homes Beds in the State of Alaska. The estimates in that report were that, absent Home and Community Based PCA Services, by 2018 our growing senior population would require an additional 1,118 beds. And that the demand for Assisted Living Home beds would increase to 5,100 beds. Yet, despite the evidence that the aging population projections were on target, according to the "Health Care Alaska" report in 2014 Alaska was supporting just 674 Nursing Home Beds and 3,644 Assisted Living Home beds.
- Delay and prevention of more costly and restrictive services.

Electronic Visit Verification systems for Personal Care Program Accountability

Medicaid budgets are severely strained and program integrity is on the front-burner for public officials. Alaska, along with many other states, is currently working on Medicaid Reform efforts to ensure that the State Medicaid Program addresses the right services, in the right place, for the right price.

Home and Community Based Personal Care Assistant Services ("PCA") is a vital service that provides hands-on assistance to seniors and individuals who experience disabilities throughout the state of Alaska. PCA and related services keep the consumers of care from moving into more expensive facility-based care.

Program integrity of Personal Care Services has been on the forefront of the agenda for the Alaska PCA Providers Association for over 10 years. The Alaska PCA Providers are now supporting that the provider agencies and the State cooperate in adopting technology used by several other state Medicaid programs to address cost and integrity in their PCA programs; namely use of Electronic Visit Verification (EVV) systems.

When PCA care in the home is documented manually, it is easier for a fraudulent employee (or consumer) to report to the Provider Employer care that was never delivered. It's easier for a fraudulent employee to get the consumer to sign a timesheet that is not truthful, as the consumer is likely to be frail or ill. It's also easier for PCA employees to make mistakes on the timesheets they submit for billing. To thwart deliberate fraud and to improve accountability, PCA Provider agencies (or a state) can choose among many available Electronic Visit Verification systems (EVV), systems that are extremely difficult to fool.

EVV systems electronically verify the time and location of the PCA worker claiming to have provided home care services. EVV systems can be as simple as "telephony" in which a direct service worker calls in from the consumer's verified land-line phone, to as complex as GPS verification of the location of the worker's cellular phone being used for worker and client sign-in. EVV systems all aim to facilitate electronic documentation needed to record those services and capture a consumer's verification.

Several states have mandated the use of EVV systems for documentation of delivery of Home and Community based PCA type services. There are two ways in which these mandates have been addressed by states:

1. **State Medicaid Program mandated single vendor EVV system:** The state Medicaid program contracts with a single EVV vendor and mandates that all Provider Agencies use that vendor. Many in the industry believe that this approach is wasteful and may greatly increase cost and risk to the state Medicaid program.
2. **Standards-Based EVV Mandate:** The state Medicaid program develops technical and functional standards and timelines by which Providers must meet those standards. This approach allows provider agencies to choose the EVV system which best meets their needs. Many times, provider agencies use integrated software programs that perform client/employee scheduling, service tracking, billing, and EVV. Having the state set the

standards, provides assurances that any system selected will feature strong technical controls that guarantee visit verification, thereby minimizing fraud, abuse, and errors. More importantly, it relieves the state from having to incur the upfront costs and risks associated with selecting a single source EVV system and forcing all providers to use it, including providers that already have an EVV system in place.

Benefits for state Medicaid programs: Medicaid personal care services are becoming increasingly more important as the need for them continues to grow. However, there is also growing concern that there may be unacceptable levels of improper payments in this area. Proponents of EVV systems state that these systems will help address these concerns by requiring providers to adopt an EVV system to verify the date, time and site of the visit as well as the individual worker providing the services. Many states already mandate EVV systems and they have seen a decrease in improper payments and significant cost-savings for the states. Supporters believe that this makes these home-care programs more sustainable, accountable, and transparent.

Drawbacks for state Medicaid programs, especially if state chooses a state-mandated and controlled central EVV system: State Medicaid personal care services are often very tightly regulated and controlled by the state Medicaid programs. There are some cautions from the U.S. Department of Labor that state-controlled EVV systems may put the state at a high risk of being deemed a third-party employer.[1] (Some states have been told they are now accountable for any overtime or travel time between clients when a PCA service worker works for more than one PCA provider employer agency.)

There is also concern that the state may have difficulty recruiting or retaining PCA provider agencies in geographic areas that are harder to serve, which could happen in rural Alaska. State-controlled EVV systems will also likely create unnecessary duplication of work, unless the state creates an EVV system so sophisticated that every PCA Provider Agency employer can have real-time access to the worker-input data on the EVV system; for monitoring of their PCA workers and for access to bundles of data that the Provider Agency can use for payroll and billing.

Benefits for Provider Agencies /Consumers: Provider Agencies report that EVV systems assist them in protecting against allegations of fraud and abuse and inappropriately billed services. Consumers are less likely to be fooled by a PCA worker who tries to pad the timesheet. Provider-chosen EVV systems often are already integrated, or can be integrated into back-office scheduling, billing and payroll software, which can significantly improve provider agencies' ability to manage service delivery. Integrated EVV solutions could save staff time and errors from manual entry of time cards, enhance compliance and assist in State audits, and improve service delivery to consumers. Many EVV systems include alerts to advise agencies if workers fail to report timely to duty for high-risk consumers.

Drawbacks for Provider Agencies/Consumer: EVV systems can be costly and complicated to integrate into an agency's current business practices. Staff and direct service workers may have a significant learning curve to overcome to meet compliance in use of the EVV. Agencies would need to develop significant policies and procedures to address compliance and exceptions. Required EVV use may be problematic in areas with limited phone services or other technological limitations.

2016 Proposal by the Alaska PCA Providers' Association Supporting State-mandated use of EVV Systems in Personal Care Services.

The Alaska PCA Providers Association supports the State development of standards for and mandates to use EVV systems for the provision of Medicaid PCA Services in Alaska. We believe that it is best that the State not adopt one state-managed EVV system, but instead move quickly to develop a standards-based EVV mandate with free market solutions, a phased-in approach to implementation, and ample opportunities for Provider Agency input into the development of those standards and their implications for operations.

We would caution that, while EVV systems have potential for cost-savings, there is a cost to PCA Provider agencies in both start-up and continuous implementation of an EVV system. Our support for an EVV mandate is based on trust that the State will adequately address those costs, as other states have in their implementation plans (one state pays six cents extra per unit of service when the claim came from an EVV-using provider agency).

We also expect that special consideration be given to the small agencies/rural providers that may not have the resources to develop or purchase an EVV system to meet a mandate. Some options for the very small or rural provider agencies may include delayed implementation, higher enhanced reimbursement, limited exceptions and/or other options made available to those agencies. The Association has discussed an EVV mandate with Senior and Disabilities Services, and found the division to be receptive. At this time, the PCA Providers Association is seeking Legislative support and direction to DH&SS to move toward an EVV system in Medicaid PCA service delivery (and perhaps to other appropriate services).

For questions, please call or email one or more of the following:

Allison Lee, ResCare Alaska, Chair, Alaska PCA Providers Association
allisonlee@rescare.com 907-978-2556

Connie Sipe, Center for Community, Co-Chair, Alaska PCA Providers Association
csipe@cfc.org 907-966-4232

Kevin Jardell, lobbyist employed by Alaska PCA Providers Association

Footnote (1): Regarding state governments becoming third-party joint employers of Personal Care workers:

U.S. Dept. of Labor Guidance: (year 2015)
The existence of an EVV system is one of many factors that may be relevant to whether a particular entity is an employer of a home care worker. As with all relevant factors, this fact alone is not determinative, but must be considered as part of the complete economic realities analysis, as to which there is no precise formula. (Please see our guidance regarding joint employment by public entities in consumer-directed programs, available at http://www.dol.gov/whd/homecare/joint_employment.htm, for more information about this test and joint employment generally.)

As with any other factor, whether an EVV system is a strong, moderate, or weak indicator of joint employer status depends upon the circumstances. If a state or other public entity runs an EVV system, is the recipient of the information collected, uses that information to track and pay for the work time of home care providers, and the consumer does not verify or approve provider time sheets, that would be a strong indicator of employer status of the state or public entity. If a state or other public entity runs an EVV system but uses the information collected solely as a quality control mechanism (e.g., to ensure that a consumer is receiving the amount of care accounted for in the consumer's plan of care, or to ensure that a consumer is not left unattended inappropriately), and the consumer still retains the ultimate responsibility for verifying or approving provider timesheets, that would be a moderate indicator of employer status of the state or public entity. If an EVV system is run by a fiscal intermediary or other private agency and a state or public entity **does not have access to the information collected**, or there is no EVV system in place at all, that would be a weak indicator of employer status of the state or public entity. Whether any fiscal intermediary or other private agency is a joint employer for purposes of the Fair Labor Standards Act (possibly along with the state or public entity as well as with a consumer) requires a separate analysis of the economic realities test as to that potential employer; for any entity, the facts regarding an EVV system would be one, non-determinative factor to consider when conducting the analysis. T

State continues crackdown on Medicaid fraud

By Kate McPherson 11:22 PM July 28, 2014
3

Medicaid fraud costs the state of Alaska $45 million a year, and that's just a conservative estimate according to Andrew Peterson, assistant attorney general and director of Alaska's Medicaid Control Fraud Unit. The FBI says up to 10 percent of claims made to Medicaid are fraudulent.

Peterson is currently prosecuting the case of Anchorage physician Dr. Shubhranjan Ghosh, who's accused of fraudulently billing Medicaid for hundreds of thousands of dollars.

Ghosh is a high-profile case, but there are many cases involving smaller amounts of money that state investigators are turning their attention to. Many of those cases involve a personal care assistant (PCA), who is hired to provide health care and other help in the homes of the elderly and vulnerable adults.

"Medicaid operates essentially in this arena on a system of trust," Peterson said.

PCAs fill out time sheets and submit them to a PCA agency, which then sends it to Medicaid. Operating on trust means there's plenty of room for people to be dishonest on their times sheets about hours worked and services provided, especially if the client is a family member.

"The difficulty there in proving that fraud is this service [that] happens in the home, one family member to another, and it's difficult to encourage individuals to report on their own family members or indicate they aren't receiving a service that they should," Peterson said.

In October 2012, the state allocated more money and personnel toward investigating Medicaid fraud. Since then, the Medicaid Control Fraud Unit has overseen 56 convictions. Peterson says it's a joint effort with multiple agencies and law enforcement involved in gathering the evidence needed for a successful prosecution.

Peterson can't confirm if fraud is increasing, but he can confirm that the cost of health care is going up – specifically in the home health care arena.

"Just a few years back it was about $60 million a year in cost to the state of Alaska; it's currently $160 million a year," he said.

The Department of Health and Social Services (DHSS) has announced it's going to pilot an electronic visit verification and monitoring system. The system will verify the in-home visit of a PCA.

"The PCA that goes into a home has to make a phone call in to say that they are there and providing a service and that's how it would work into the time sheet," said Lynne Keilman-Cruz, chief of quality with the DHSS' Senior Disability Services.

Keilman-Cruz says even though there are still ways to cheat the system, the electronic visit verification system will discourage fraud. She's seen it work in other states, she said.

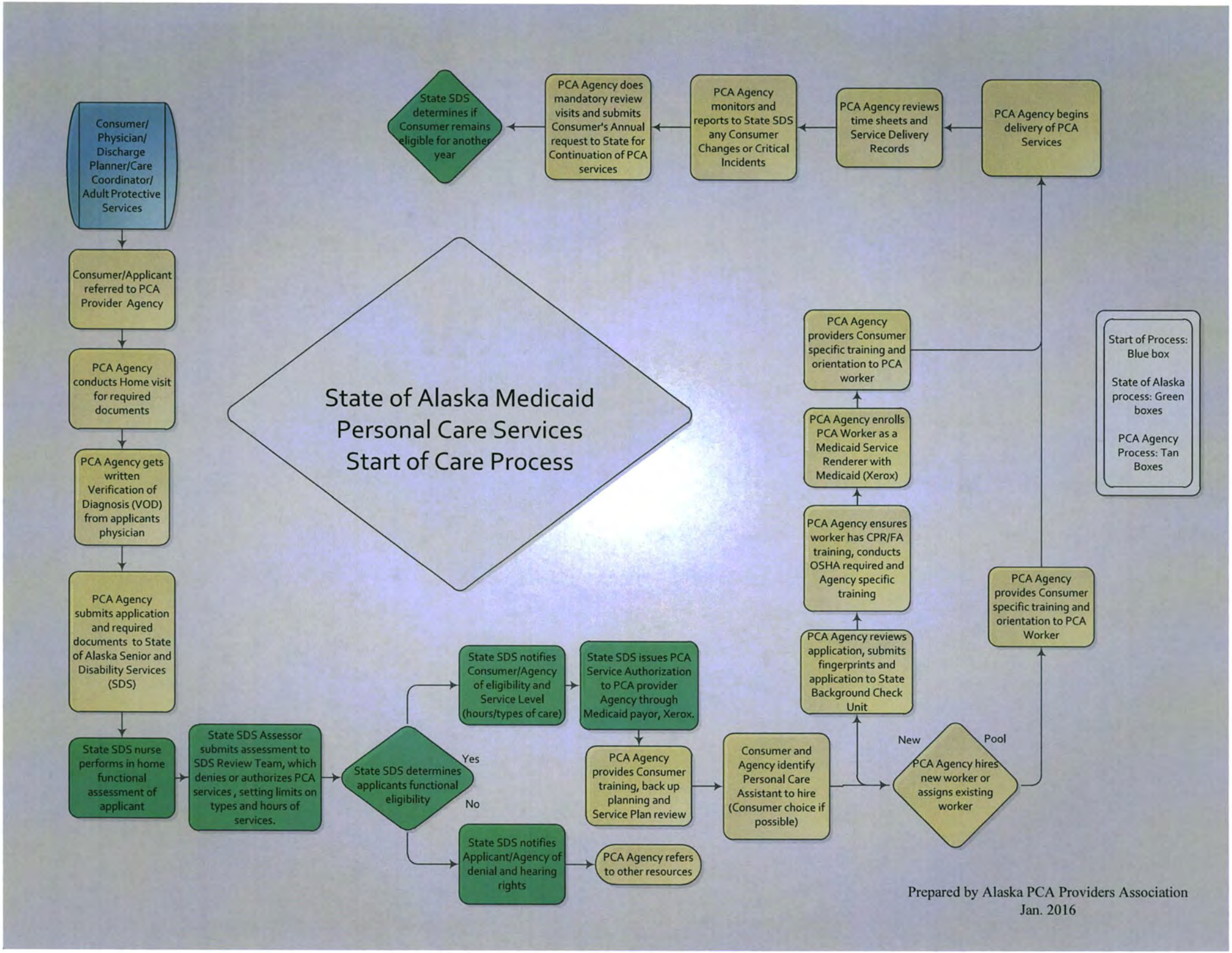
The DHSS also has the power to suspend Medicaid payments while investigations are ongoing. Just in the last two months, Mat-Su Activity and Respite Center, along with Anchorage-based agency A Loving Care PCA, were suspended from billing Medicaid while allegations of fraud are investigated. People who rely on them have been notified and given a list of other providers.

http://www.ktva.com/state-continues-crackdown-on-medicaid-fraud-988/

When a PCA or agency is charged, it's up to the DHSS to make sure vulnerable clients aren't left without care.

"We work together to triage to make sure the people with higher needs get into services in a timely manner," Keilman-Cruz said.

There is currently a moratorium on new PCA agencies in Alaska to allow investigations to be completed and regulations to be reviewed.



Prepared by Alaska PCA Providers Association
Jan. 2016

Wage and Hour Division (WHD)

(Revised June 2014) (PDF)

Fact Sheet #79E: Joint Employment in Domestic Service Employment Under the Fair Labor Standards Act (FLSA)

Introduction

Domestic service employment means services of a household nature performed by a worker in or about a private home (permanent or temporary). The term includes services performed by workers such as babysitters, cooks, waiters, maids, housekeepers, nannies, janitors, caretakers, handymen, gardeners, and family chauffeurs, as well as those services provided by home care workers. Home care workers may include companions, personal care aides, home health aides, nurses, and other workers who provide assistance to individuals in their homes. These examples are illustrative and not exhaustive.

Domestic service employees are generally covered under the Fair Labor Standards Act ("FLSA") and therefore must be paid at least the federal minimum wage for all hours worked, and overtime pay at not less than one and one-half times the regular rate of pay for all hours worked over 40 in a workweek. Section 13(a)(15) of the FLSA provides a narrow exemption from the minimum wage and overtime pay requirements for domestic service employees who are casual babysitters and domestic service workers employed to perform companionship services for people with disabilities and older adults ("companionship services exemption"). Section 13(b)(21) of the FLSA provides an exemption from the overtime pay requirement, but not the minimum wage requirement, for those employees who reside in the private home where they work ("live-in domestic service employee exemption").

In the Final Rule, Application of the Fair Labor Standards Act to Domestic Service, 78 FR 60454 (Oct. 1, 2013),[1] the Department modified the "third party employment" regulation, 29 C.F.R. 552.109, to prohibit third party employers of domestic service employees—i.e., employers other than the individuals receiving services or their families or households—from claiming

the companionship services exemption from minimum wage and overtime or the live-in domestic service employee exemption from overtime. 78 FR 60480-85.

Private agencies, non-profit organizations, or public entities may be third party joint employers of domestic service employees, and in particular home care workers, under the FLSA. Although the Final Rule did not change any of the Department's guidance about joint employment, the regulatory changes prohibiting third party employers from claiming the companionship services and live-in domestic service employee exemptions will require every potential employer to evaluate whether it may be a joint employer under the FLSA.

This fact sheet summarizes general longstanding joint employment principles established by case law, discusses how joint employment may arise in the home care context, and provides nine hypotheticals analyzing how these existing principles would apply in common home care scenarios, including both private-pay examples as well as Medicaid-funded consumer-directed programs.

Joint Employment – General Principles

A single individual may be simultaneously considered an employee of more than one employer under the FLSA. In such cases, the employee's work for the joint employers is considered as one employment for purposes of the Act, and the joint employers are individually and jointly responsible for FLSA compliance, including paying not less than the minimum wage for all hours worked during the workweek and, if applicable, overtime compensation for all hours worked over 40 in the workweek. 29 C.F.R. 791.2(a). A determination of whether joint employment exists must be based upon all the facts of the particular case. For instance, two employers may both supervise the same employee or one may hire and set the pay rates while another has authority to supervise or fire the worker; both scenarios may represent a joint employment relationship.

As a general example, workers sent by a cleaning company to a client-hotel to clean hotel rooms may be jointly employed by both the cleaning company and the hotel. Similarly, a private agency, non-profit organization, or public entity that hires a home care worker to provide services in an individual's home may be a joint employer with the individual (or family or household member of the individual).

Determining Joint Employment

Joint employment is determined by applying the "economic realities" test, which examines a number of factors to determine whether a worker is economically dependent on a purported employer, thus creating an employment relationship. Factors to consider may include whether a possible employer has the power to direct, control, or supervise the worker(s) or the work performed; whether a possible employer has the power to hire or fire, modify the employment conditions or determine the pay rates or the methods of wage payment for the worker(s); the degree of permanency and duration of the relationship; where the work is performed and whether the tasks performed require special skills; whether

the work performed is an integral part of the overall business operation; whether a possible employer undertakes responsibilities in relation to the worker(s) which are commonly performed by employers; whose equipment is used; and who performs payroll and similar functions. Other factors also may be considered and no one factor is controlling. The ultimate question is one of economic dependence.

Joint Employment and Home Care Workers

In the home care context, there are a variety of employment situations in which joint employment may exist. Many home care providers are jointly employed by two or more entities; these entities may include a consumer,[2] a private home care agency, a non-profit organization, or a public entity (which include instrumentalities of state, county, or municipal governments or special-purpose entities created by a state, county, or municipal government). For example, a private home care agency and consumer may jointly employ a provider.

In other situations, a public entity and a consumer may jointly employ a provider through a Medicaid-funded consumer-directed program. In these programs, consumers (or their representatives, if applicable) have decision-making authority over some services and take direct responsibility for managing their services, assisted by a system of available supports. Other third parties may also be joint employers in consumer-directed programs. For example, a public entity, non-profit home care agency, and consumer could all potentially jointly employ a provider through a consumer-directed program.

The Department has published Administrator's Interpretation No. 2014-2 (AI) to help determine when public entities are employers of home care workers who provide services through consumer-directed programs. The AI describes in detail many common aspects of consumer-directed programs, such as which entity retains the right to hire and fire, which entity controls the wage, schedule and other conditions of employment, and which entity performs payroll and other administrative functions. The AI provides guidance as to whether these various aspects are "strong," "moderate," or "weak" indicators of employer status.

In any potential joint employment situation, the same economic realities analysis applies. All of the facts and circumstances relevant to whether a worker is economically dependent on a possible employer must be assessed in order to make a determination about employment status.

Obligations of Joint Employers Under the FLSA

Generally, where a joint employment relationship exists, each employer is responsible for complying with the FLSA (including payment of at least the federal minimum wage for all hours worked and overtime pay at not less than one and one-half times the regular rate of pay for hours worked over 40 in a workweek).

Under the Final Rule, in joint employment situations, the individual, family, or household employing the worker will be able to claim the companionship services or live-in domestic service employee exemption if the prerequisites

for claiming those exemptions are met. (For information about the companionship services exemption, see Fact Sheet # 79A: Companionship Services Under the Fair Labor Standards Act (FLSA). For information about the live-in domestic service employee exemption, see Fact Sheet #79B: Live-In Domestic Service Workers Under the Fair Labor Standards Act (FLSA).) This means that an individual consumer, family, or household who may properly claim the companionship services or live-in domestic service employee exemptions will not be liable for minimum wage or overtime pay obligations related to those exemptions.

Under the Final Rule, third party employers of home care workers (that is, any employer who is not the consumer or a member of the consumer's family or household, such as a private or non-profit home care agency or a public entity administering home care programs) are not permitted to claim either the exemption for companionship services or the exemption for live-in domestic service employees. Third party employers may not claim these exemptions even when they jointly employ a worker with an individual, family, or household who may claim either exemption. Thus, any third party employer of a domestic service worker is obligated to pay not less than the minimum wage for all hours worked and overtime compensation for all hours worked over 40 in a workweek, and any third party employer of a live-in domestic service worker is required to pay overtime pay for all hours worked over 40 in the workweek.

In addition, all third party employers of domestic service workers will be required to pay for time spent traveling between consumers, as well as overtime generated by working for multiple consumers. An employee's normal commute between home and the worksite is not considered "hours worked" and therefore does not have to be paid. However, the time an employee spends traveling from job site to job site during the workday for an employer (when, for instance, a home care worker assists multiple clients) must be counted and paid as hours worked. Additionally, an employee who works for multiple consumers of a single joint employer (typically, a public entity or a private home care agency) must be paid at the overtime rate for any hours worked over 40 in a single workweek, aggregating the time worked across consumers for a joint employer. For example, if a worker spends 30 hours per week providing home care services to one consumer and 20 hours per week providing home care services to a second consumer, then any joint employer – whether a private agency, a public entity, or both – is responsible for ensuring that the worker receives overtime pay for the 10 hours over 40 worked each week.

Joint Employment Examples in the Home Care Context

Below are several examples of common home care models and how joint employment principles would apply to each. Although this guidance focuses on the most common factors that may create an employment relationship in the home care context, all of the relevant facts and circumstances must be considered to make a determination about employment status, and courts may consider other factors when evaluating the economic dependence of a worker on a possible employer.

In these examples, the term "consumer" may also include an individual's family member, household member, or representative.

Example One – Private-Pay Registry with Consumer as Sole Employer

A private home care agency advertises as a "registry" that provides potential home care workers. The registry conducts a background screening and verifies credentials of potential workers, and assists consumers by locating home care workers who may be able to meet a client's needs. The registry informs a home care worker of the opportunity to work for a potential client. If interested in the opportunity, the worker is responsible for contacting the client for more information. The worker is not obligated to pursue this or any other opportunity presented and is not prohibited from registering with other referral services or from working directly with clients independent of this private registry. The registry does not provide its workers any equipment, does not supervise or monitor any work they perform, and has no power to terminate a worker's employment with a client. The registry processes the worker's payroll checks according to information provided by clients, but does not set the pay rate.

In this scenario, the home care worker is likely not an employee of the registry, and the consumer is the sole employer. There is no permanency in the relationship between the registry and provider. The registry does not provide any equipment or facilities, exercises no control over daily activities, and has no power to hire or fire. The worker is able to accept as many or as few clients as he or she wishes. The client sets the rate of pay and negotiates directly with the worker about which services will be provided. This conclusion, however, does not mean that every "registry" will not be an employer; any change in the specific facts may change the outcome. For example, a home care registry that maintains a log of assignments showing the shifts worked, establishes the rate which will be charged, and exercises control over the home care workers' duties and the work schedules would be an employer.

Example Two – Private Agency and Consumer as Joint Employers

A private home care agency offers a variety of services to older adults who require assistance in order to live at home. The agency recruits and hires providers, and ensures they are properly trained to assist with activities of daily living or instrumental activities of daily living, or to provide companionship services such as watching over a consumer while he or she sleeps. Consumers contract with the agency to receive services and are billed at a set hourly rate. The agency determines each worker's rate of pay based on factors such as the services performed and the worker's qualifications and tenure at the agency. The agency performs typical payroll functions and provides the workers with some other job-related benefits.

The consumer decides what services he or she requires, how the worker will perform the services, the number of work hours he or she requires, and the schedule for the workers. Together, the agency and consumer agree on how many workers will be assigned to provide assistance. Although the agency retains the ultimate decision of whether to terminate the worker's employment with the agency, a consumer who is not satisfied with the performance of a particular worker may request a different worker at any time.

In this scenario, the agency and the consumer are joint employers. The agency, among other factors, sets the rate of pay, hires and trains the worker, and has the ability to terminate employment, while the consumer sets the schedule and solely controls and supervises the actual work performed.

Example Three – Consumer-Directed Program with Public Entity and Consumer as Joint Employers

In this consumer-directed program, the public entity collectively bargains with a union representing home care providers. The public entity exercises control by providing required training, offering paid time off, furnishing equipment, creating a procedure for redress of grievances, setting a wage rate, and offering a benefits package. The public entity also retains some control over hiring and firing by completing performance evaluations and reserving the right to terminate a worker for poor performance. A fiscal intermediary processes payroll and tax withholding.

The Department believes that in such programs, the public entity administering the program is a joint employer of the provider along with the consumer. The fiscal intermediary, performing purely ministerial functions, would not be an employer.

Other public programs in which the home care providers are not parties to a collective bargaining agreement but in which the public entity nonetheless demonstrates similar levels of control over the providers' working conditions will also be considered joint employers. For example, some programs are structured such that a case manager is involved in determining the worker's schedule or directing the method of work, or the public entity sets a wage rate for providers. In programs such as these, with similar levels of control as described above, the public entity will be considered a joint employer with the consumer.

Example Four – Consumer-Directed Program, with Consumer as Sole Employer

In this consumer-directed program, the public entity sets forth basic hiring requirements (such as a criminal background check or CPR/First Aid certification) and retains the limited right to remove a provider from the program if it is determined, after an investigation, that there has been fraud or abuse. The public entity also sets a wage rate range for services that is approved by the Centers for Medicare and Medicaid Services. The wage rate range for home care workers is from $10 per hour to $24 per hour. A consumer can hire anyone who meets minimal qualifications and the consumer retains the ability to fire for any reason. A budget is developed annually by the consumer with the help of a case manager. It is the responsibility of the consumer to keep up with financial statements to determine whether monthly spending should be adjusted. The consumer sets the worker's schedule, determines the tasks to be performed, and supervises how the work is performed. The consumer reviews and approves the worker's payroll, and the provider's tax withholdings are deducted from the individual consumer's budget (not any general state fund). The consumer has a choice between three fiscal intermediaries that perform payroll and other administrative functions. The public entity does

not provide any paid time off, equipment, mandatory training, or contributions to health insurance premiums.

In this scenario, the consumer is likely the sole employer of the worker. Any slight change in the specific facts of this example may change the analysis.

Example Five – Consumer-Directed Program, with Consumer and Public Entity as Joint Employers

In this consumer-directed program, the consumer posts the job announcement and selects applicants to interview. The consumer conducts interviews and chooses a provider, but the case manager must approve the hiring decision. The consumer provides all day-to-day supervision and controls the schedule as well as the manner in which work is performed. The consumer and public entity case manager conduct regular performance evaluations, and the case manager or consumer may decide to fire the provider for poor performance. The program also has required, ongoing, comprehensive, state-sponsored training requirements. The public entity sets a reimbursement rate for home care services, from which the consumer may not deviate. Payroll and withholdings are processed through a fiscal intermediary of the consumer's choice.

In this scenario, the public entity and the consumer are likely joint employers of the provider. The fiscal intermediary is not an employer.

Example Six – Intermediary Agency Consumer-Directed Model, with Consumer and Agency as Joint Employers

In this consumer-directed program, the public entity administers an intermediary agency model. The state sets reimbursement rates for all Medicaid services within the public entity, including home care services. The minimum qualifications for home care workers are set by state regulation. The public entity does not supervise the work, set schedules, or control conditions of employment. The public entity contracts with agencies to provide home care services, and provides a bundled reimbursement rate from which the agency is free to set a wage rate and retain a portion for administrative costs. The public entity reserves the right to conduct certain functions, including visiting the agency to assess performance, conduct fiscal and quality audits, and review personnel files on a random basis.

Consumers may recruit and select a provider, and the agencies participating in the program then screen and hire the worker (the agency may also recruit potential providers). Both consumers and agencies retain the right to fire the workers, and the agencies generally handle any disciplinary issues involving the workers. Agencies also conduct the administrative functions and supervision of workers required by regulation, train the workers, and evaluate job performance. The agencies maintain all employment records, although copies of such records are also sent to the public entity administering the program. Consumers provide daily supervision, set the worker's schedule, and decide how and when certain tasks will be performed.

In this scenario, the agencies and consumers are employers, and it is likely that the public entity is not an employer. The public entity performs minimal functions required by regulation, while the agencies set the wage rate, hire and train workers, and supervise much of the work.

Example Seven – Cash and Counseling Consumer-Directed Program with a Wage Cap, with Consumer as Sole Employer

In this cash and counseling consumer-directed program, consumers are given the option to manage a flexible budget and decide what mix of Medicaid-allowable goods and services best meet their personal care needs. Consumers may use their budgets to hire personal care workers, purchase other services, purchase items, or make home modifications that help them live independently. The consumer retains authority over hiring and firing, negotiates the wage rate paid to the employee within a cap, and sets the terms and conditions of employment.

The public entity sets minimal qualifications for providers (by requiring a criminal background check and CPR/First Aid certification), determines eligibility and assesses need under the program, and then performs only ministerial payroll and tax functions through a fiscal intermediary, similar to those that commercial payroll agents perform for businesses, such as maintaining records, issuing payments, and addressing tax withholdings. The public entity also sets a cap on wages for all workers participating in the program so that consumers will have enough resources in their budget for the entire month, and to help ensure fiscal accountability as well as guard against exploitation. The cap for home care workers is at the agency reimbursement rate of, for example, $26 per hour. Thus, the consumer may pay anywhere from minimum wage to $26 per hour, and if the consumer elects to pay less than the cap, the remaining funds remain in the consumer's individual budget.

In this scenario, the consumer is likely the sole employer of workers hired through such a program.

Example Eight – Public Entity, Managed Care Organization, and Intermediary Agency Consumer-Directed Program, with Consumer and Agency as Joint Employers

This public entity contracts with a managed care organization (MCO) to provide health care services, including home care services, to Medicaid recipients. The public entity pays the MCO a per consumer monthly rate, and from that total budget the MCO contracts with various providers in its network, including home care agencies. Within this network are several agencies participating in a consumer-directed intermediary agency program. The MCO pays the agencies a bundled rate. The agency then sets the wage rate; authorizes a certain number of hours based upon an assessment; pays health insurance, workers' compensation, and unemployment insurance premiums; and also may choose to authorize overtime. The participating agencies permit consumers to hire and fire their own workers, and consumers set the provider's schedule and provide all day-to-day supervision.

In this scenario, on these specific facts, it is likely that the agencies and the consumers are joint employers, and that the MCO and public entity are likely not joint employers. The MCO merely pays the bundled rate to the agencies, and the agencies perform all other indicia of employment. However, any slight change in the particular facts could change the analysis.

Example Nine – Public Entity, Managed Care Organization, and Intermediary Agency Program, with Consumer, Managed Care Organization, and Agency as Joint Employers

This public entity contracts with a managed care organization (MCO) to provide health care services, including home care services, to Medicaid recipients. The public entity pays the MCO a per consumer monthly rate, and from that total budget the MCO contracts with various providers in its network, including home care agencies. Within this network are several agencies participating in a consumer-directed intermediary agency program. The MCO pays the agencies a bundled rate but requires the agencies to pay workers a particular hourly wage. The MCO also sets comprehensive provider qualifications and requires providers to attend training provided by the MCO on a regular basis. The agencies authorize a certain number of hours based upon an assessment; pay health insurance, workers' compensation, and unemployment insurance premiums; assist the consumer if disciplinary matters regarding the provider arise; provide back-up workers when needed; and may choose to authorize overtime. The participating agencies permit consumers to hire and fire their own workers, consumers set the providers' schedules, and consumers provide all day-to-day supervision.

In this scenario, based on these specific facts, it is likely that the MCO, the agencies and the consumers are joint employers and that the public entity is likely not a joint employer. The MCO does far more than simply pay the bundled rate (as the MCO did in Example Eight) in this example, and indicia of employment is spread among the MCO, agencies, and consumers. However, any slight change in the particular facts could change the analysis.

---

[1] The effective date for the Final Rule is January 1, 2015.

[2] Throughout this document, the Department uses the term "consumer" to refer to an individual receiving home care services and "provider" to refer to a home care worker providing services.

Where to Obtain Additional Information

For additional information, visit our Wage and Hour Division Website: http://www.wagehour.dol.gov and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4USWAGE (1-866-487-9243).

This publication is for general information and is not to be considered in the same light as official statements of position contained in the Department's regulations.

Wage and Hour Division (WHD)

Administrator's Interpretation No. 2014-2 (PDF)

June 19, 2014

Issued by ADMINISTRATOR DAVID WEIL

SUBJECT: Joint employment of home care workers in consumer-directed, Medicaid-funded programs by public entities under the Fair Labor Standards Act.

In the Final Rule, Application of the Fair Labor Standards Act to Domestic Service, 78 FR 60454 (Oct. 1, 2013),[1] the Department modified the "third party employment" regulation, 29 CFR 552.109, to prohibit third party employers of domestic service employees—i.e., employers other than the individuals receiving services or their families or households—from claiming the companionship services exemption from minimum wage and overtime or the live-in domestic service employee exemption from overtime. 78 FR at 60480-85.[2]

Private agencies, non-profit organizations, or public entities[3] may be third party joint employers of domestic service employees, and in particular home care workers, under the Fair Labor Standards Act (FLSA or "the Act"), 29 U.S.C. 201 *et seq.* Although the Final Rule did not change any of the longstanding case law or the Department's guidance about joint employment, the regulatory changes prohibiting third party employers from claiming the companionship services and live-in domestic service employee exemptions will require each public or private agency that administers or participates in a consumer-directed, Medicaid-funded home care program to evaluate whether it is an employer under the FLSA.

The Department's outreach to the regulated community and engagement with the Department of Health and Human Services (HHS), including the Centers for Medicare and Medicaid Services (CMS), on implementation of the Final Rule have indicated that additional guidance about the application of the FLSA's joint employment principles, and specifically, how these principles apply to consumer-directed, Medicaid-funded programs, would be useful. The structures of these programs vary by state, and states often have several programs with differing models; as such, each third party involved in each program must be individually evaluated for joint employer status.

Part I of this Administrator's Interpretation provides background on general joint employment principles; in particular, it describes the "economic realities" test for determining whether an entity is an employer under the FLSA. Part II addresses consumer-directed programs specifically, and analyzes the most common

questions arising from these programs, including which parties are likely employers, how federal regulation of Medicaid programs affects the economic realities analysis, what the implications are for public entity joint employers administering consumer-directed programs, and how the most relevant factors of the economic realities test weigh when considering various types of consumer-directed programs. Part III considers several hypothetical examples drawn from actual programs.

The Department emphasized in the preamble of the Final Rule that the question whether a particular entity will be considered an employer under the economic realities test depends on the specific facts and circumstances of the particular program, as well as the law of each Circuit Court of Appeals. The Department has, however, attempted to address the most common types of programs in this guidance. The Department believes that in most, but not all, consumer-directed models, a third party will be a joint employer of a provider. As noted in the Final Rule, potential third party joint employers may include a public entity, private agency, or non-profit organization.

I. Joint Employment and the Economic Realities Test

Under the FLSA, the term "employee" means "any individual employed by an employer," where "employ" means "to suffer or permit to work," and "employer" includes "any person acting directly or indirectly in the interest of an employer in relation to an employee." 29 U.S.C. 203(d), (g). These definitions, and therefore the scope of employment relationships the Act covers, are exceedingly broad.

The Department's regulation regarding joint employment under the FLSA provides that a single worker may be "an employee to two or more employers at the same time." 29 CFR 791.2(a); *see also Baystate Alternative Staffing, Inc. v. Herman*, 163 F.3d 668, 675 (1st Cir. 1998) ("The FLSA contemplates several simultaneous employers, each responsible for compliance with the Act."). In such cases, the employee's work for the joint employers during the workweek "is considered as one employment," and the joint employers are responsible, both individually and jointly, for FLSA compliance, including paying overtime compensation for all hours worked during the workweek. 29 CFR 791.2(a).

Whether an entity is an employer under the FLSA is governed by longstanding case law from the U.S. Supreme Court and other federal appellate courts interpreting the Act. In any joint employment analysis, it must be determined whether there is an employment relationship between the employee and each of the alleged employers. Courts have consistently explained that the employment relationship under the FLSA is much broader than the common-law concept of master and servant. Additionally, the determination whether an employer-employee relationship exists does not depend on "isolated factors but rather upon the circumstances of the whole activity," *Rutherford Food Corp. v. McComb*, 331 U.S. 722, 730 (1947), and the touchstone is "economic reality," *Goldberg v. Whitaker House Cooperative, Inc.*, 366 U.S. 28, 33 (1961).

The "economic realities" test examines a number of factors to determine whether a worker is economically dependent on a purported employer, thus creating an employment relationship. The factors to be considered include whether the alleged employer has the power to hire and fire the employees, supervises and controls the employees' work, determines the rate and method of payment, maintains employment records, and controls where the work is performed, as well as whether the work performed is an integral part of business or of a rote or repetitive nature. Moreover, because the ultimate question is one of economic dependence, the factors are not to be applied as a checklist, but rather the outcome must be determined by a qualitative rather than a quantitative analysis. *See* 29 CFR Part 791; 29 CFR 500.20(h); *Charles v. Burton*, 169 F.3d 1322 (11th Cir.), *cert. denied*, 528 U.S. 879 (1999); *Lopez v. Silverman*, 14 F. Supp. 2d 405 (S.D.N.Y. 1998).

II. Consumer-Directed Medicaid Programs and Joint Employment

A. Background

In "consumer-directed," Medicaid-funded programs, consumers (or their representatives if applicable) have decision-making authority over some services and take direct responsibility for managing their services with

the assistance of a system of available supports. The consumer-directed service delivery model is an alternative to more traditionally delivered and managed services, such as an agency delivery model that includes little or no consumer control.

In the discussion of joint employment included in the preamble to the Final Rule, the Department explained how the economic realities test would apply to two types of consumer-directed programs, each exemplifying one end of the joint employer continuum. In the first example, the Department described a cash and counseling program in which the consumer was likely the sole employer because she alone had a great deal of control over the employee and the work performed. She retained budget authority, negotiated the wage rate with the direct care worker, was wholly responsible for day-to-day duty assignments, and had the sole power to hire and fire the direct care worker. *See* 78 FR at 60483-84. In the second example, the Department described a state "public authority" model in which the public entity was likely a joint employer with the consumer because the public entity set the wage rate, decided the method of payment, reviewed worker time sheets, and determined what tasks workers were to perform (even as the consumer also exercised considerable control over the employee and the work performed). *See* 78 FR at 60484.

Although these examples provided guidance as to some types of consumer-directed programs, a wide range of such programs exist around the country and even within states. A determination whether any particular public entity will be considered an employer under the FLSA will involve an application of the economic realities test to all of the facts and circumstances of a particular program. Additionally, the economic realities factors applied by courts vary somewhat among the Circuit Courts of Appeal. Thus, any assessment of whether a public entity is a joint employer necessarily involves a weighing of all the facts and circumstances, and there is no single factor that is determinative, *see Rutherford Food Corp.*, 331 U.S. at 730, nor is there any "mathematical formula" that can be applied, *Antenor v. D & S Farms*, 88 F.3d 925, 933 (11th Cir. 1996). Furthermore, "courts have found economic dependence under a multitude of circumstances where the alleged employer exercised little or no control or supervision over the putative employees." *Antenor*, 88 F.3d at 933 (citations omitted).

There is limited federal appellate case law explicitly addressing whether a public entity is a joint employer in a consumer-directed, Medicaid-funded program. In *Bonnette v. California Health & Welfare Agency*, 704 F.2d 1465 (9th Cir. 1983), the Ninth Circuit concluded that three California state welfare agencies and three county agencies were, for purposes of the FLSA, joint employers of workers providing in-home care to individuals with disabilities and seniors based on an analysis of the economic realities of the situation. The court noted that the public entities had significant involvement in supervising the workers' performance, controlled the rate and method of payment, paid the employees' wages (directly or indirectly through the consumers), exercised considerable control over the structure and conditions of employment by making the final determination, after consultation with the recipient, of the number of hours each worker would work and exactly what tasks would be performed, and supervised the workers when problems arose. *Id.* The court thus concluded that the state and its agencies were the workers' employers. *Id.; see also Guerrero v. Superior Court*, 213 Cal. App. 4th 912 (Cal. App. 2013). In *Harris v. Quinn*, 656 F.3d 692 (7th Cir. 2011), a case concerning a "fair share" provision of a collective bargaining agreement, the Seventh Circuit determined that personal assistants paid by the state through a Medicaid-funded program were, because of the control the state exercised over their employment, employees of the state under a common-law test (which is much narrower than the broad FLSA employment test), *cert. granted*, 134 S. Ct. 48 (Oct. 1, 2013) (No. 11-681). The court reasoned that because "the State does have significant control over virtually every aspect of a personal assistant's job"—including setting the qualifications for employees, evaluating consumers' choice of assistants, refusing payment for employees who do not meet the state's standards, approving a mandatory service plan that lays out a personal assistant's job responsibilities and work conditions, annually reviewing each personal assistant's performance, setting salaries and work hours, paying for training, and paying all wages—the state was plainly an employer. 656 F.3d at 697-98.

B. Which Third Parties May Be Employers

As noted in the Final Rule, the fact-specific economic realities test should be applied to all situations to assess whether there is an employment relationship or joint employment. Depending on the structure of a

consumer-directed program, different public entities may be potential employers. For example, a state itself, a statewide agency that oversees Medicaid programs, or a county department of aging could all be potential joint employers of home care workers providing services through a consumer-directed program.

Furthermore, an employment analysis is necessary regardless of the name used by the third party (*e.g.*, fiscal/employer agent, Agency with Choice, fiscal intermediary, registry, or employer of record) or worker (*e.g.*, personal care attendant, registry worker, independent provider, or independent contractor). As the Department has repeatedly noted, with respect to exemption status, job titles are not determinative. *See, e.g.*, 29 CFR 541.2; Wage & Hour Div. (WHD), Division Field Operations Handbook (FOH) § 22a04 (rev. 661 Nov. 29, 2010), available at http://www.dol.gov/whd/FOH/FOH_Ch22.pdf; WHD Fact Sheet #17A: *Exemption for Executive, Administrative, Professional, Computer & Outside Sales Employees Under the Fair Labor Standards Act (FLSA)* (rev. July 2008), available at http://www.dol.gov/whd/overtime/fs17a_overview.pdf. This principle holds true for determining employment status as well.

Thus, the same analysis will be utilized for the entire range of consumer-directed programs and should be applied to state or county entities, managed care organizations, fiscal intermediaries, private agencies, and non-profit organizations alike.

C. Federal Regulation of Medicaid Programs

Consumer-directed, Medicaid-funded programs are regulated by federal laws and regulations setting forth various legal requirements with which states must comply. Within this framework, however, states have discretion to decide how to structure each consumer-directed program, and how much control to exercise over home care providers. The source of this control in various consumer-directed programs established by public entities, namely Medicaid laws and regulations, needs to be understood and appropriately appreciated when determining the existence of an employment relationship. There are many different variations of consumer-directed programs that are compliant with the FLSA. Thus, the manner in which states choose to implement these federal mandates must be closely examined and considered in assessing whether a public entity is an employer.

Specifically, federal Medicaid law and regulations require a state administering any Medicaid-funded program to perform a range of functions as a condition for participation in the Medicaid program. For example, the state must set general eligibility criteria for consumers, determine whether individuals meet these criteria, conduct an assessment of each consumer's needs, and develop individualized plans of care together with the consumer. In addition, the state must implement measures designed to prevent fraud and abuse, which may include setting basic qualifications for providers to participate in the Medicaid program (e.g., requiring providers to pass a criminal background check and have no history of fraud), conducting on-site visits, and developing a process for reporting and investigating abuse, neglect, and/or exploitation of consumers. The state must demonstrate to CMS that it has processes in place for each required administrative function.

Additionally, federal Medicaid rules mandate that states assure the financial accountability of services. Any state participating in Medicaid is required to submit to the Secretary of Health and Human Services a "plan for medical assistance," 42 U.S.C. 1396, that establishes a system for reimbursing health care providers, including providers of home and community based services, for services provided to Medicaid participants. Medicaid requires states to set rates for services, including in-home personal care services, and CMS must approve the state's rate setting methodology. In addition, for some programs (in particular, for 1915(c) home and community based services waivers), the state must demonstrate cost neutrality, meaning that a state must prove to CMS that the cost of serving consumers in the community using the waiver does not exceed the costs of placing those consumers in institutions. See 42 U.S.C. 1396n(c)(6). As such, states set rates within parameters designated by the federal Medicaid system that may differ from the parameters that govern the private sector.

Again, under an economic realities analysis, all of the facts and circumstances of the relationship between a provider and the state must be evaluated, and no single factor is determinative. Relevant factors that must

be considered when evaluating whether a state administering a consumer-directed program is an employer include the various legal requirements with which consumer-directed programs must comply, and how programs choose to comply with those requirements. *See, e.g., Godlewska v. HDA*, 916 F. Supp. 2d 246, 261 (E.D.N.Y. 2013) (explaining that the oversight actions of the city "stem entirely from the nature of the business of providing heavily regulated, government-funded health services to patients in their homes") (internal quotation marks and citation omitted). Indeed, the federal Medicaid regulations provide a broad framework of legal requirements for Medicaid programs, including consumer-directed programs. States, however, have considerable discretion in designing and implementing their own programs within this framework. For instance, some programs choose to comply with the federal regulations by implementing low-control functions and processes, and permitting the consumer considerable discretion to perform nearly all employer functions; as explained below, the facts of those scenarios relevant to the economic realities test will likely not be strong indicators of employer status. In other state programs, however, the state chooses to comply with Medicaid's legal requirements by exercising a high degree of control over the terms and conditions of a provider's employment. As described in the factor-by-factor analysis below, in these circumstances, the state's exercise of control will weigh in favor of a determination of employer status.

Because the state is the public entity required by the federal Medicaid program to perform these functions, other public entities, such as a county or municipal government, that perform additional functions beyond those required by the federal Medicaid program, or that have been given discretion and choose to implement high-control mechanisms for assuring compliance, should be aware that these functions may be viewed as strong indicators of employer status.

D. Implications of Joint Employment for Public Entities

As with any other employer, if a public entity is determined to be a joint employer, that entity is then responsible for compliance with the requirements of the FLSA. The Act requires that employers pay employees at least the minimum wage for all hours worked, including any time spent traveling between worksites, and overtime compensation for all hours worked over 40 in a workweek, including, in the consumer-directed program context, combined hours spent working for more than one consumer as part of the joint employment by the third party entity. As noted in the Final Rule and emphasized in subsequent guidance, the Rule did not change any of the Department's longstanding travel time or overtime rules.

Under the Department's regulations, normal travel from the employee's residence to his or her workplace is not hours worked regardless of whether the employee works at a fixed location or at different job sites. 29 CFR 785.35; *see* WHD Opinion Letter W-454, 1978 WL 51446 (Feb. 9, 1978). Thus, if a direct care worker travels to a consumer's home directly from her own home and returns directly home from a consumer's home, this commuting travel time generally does not need to be paid. *Id.* Employees who travel to more than one worksite for an employer during the workday, however, must be paid for travel time between each worksite. 29 CFR 785.38; see WHD Opinion Letter W-454, *supra*.

Additionally, an employee to whom the FLSA applies must be paid one and one-half times her regular hourly rate for all hours worked over 40 for any employer. 29 U.S.C. 207. Therefore, an employee who works for multiple consumers of a single joint employer must receive compensation at the overtime rate for any hours worked over 40, aggregating the time worked across consumers for the joint employer. For example, if a worker spends 30 hours per week providing home care services to consumer A and 20 hours a week providing home care services to consumer B, any entity that is joint employer with both consumers—whether a private agency, a state, or both—is responsible for ensuring that the worker receives overtime compensation for the 10 hours over 40 worked each week.

In circumstances in which public entities are joint employers, they must also consider their obligations under other federal laws, including the Americans with Disabilities Act (ADA), 42 U.S.C. 12101 *et seq.*, and the Supreme Court's decision in *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999), as they are developing policies to comply with the FLSA. As noted in the Final Rule, the Department fully supports the ADA's and *Olmstead's* requirement that government programs provide needed services and care in the most integrated setting appropriate to an individual, and recognizes the important role that home and community based

services have played in making that possible. *See* 78 FR at 60486. If a public entity as a joint employer of its home care workers puts in place new policies that have the impact of reducing or otherwise disrupting a consumer's services, the state must ensure that the policy does not place the affected individuals at serious risk of institutionalization. *See id.* This could include making exceptions to the policy or providing alternative services to individuals who otherwise would be placed at serious risk of institutionalization. *Id.* (citing October 22, 2012 Letter from DOJ and OCR to Washington State, available at www.ada.gov/olmstead/documents/ltr_gov_gregoire.docx); *accord M.R. v. Dreyfus*, 663 F.3d 1100 (9th Cir. 2011) (finding that a state violates the ADA and *Olmstead* when policies place individuals at serious risk of institutionalization). The Department of Justice has made information about a state's obligations under the ADA and *Olmstead* available at www.ada.gov/olmstead.

Economic Realities Factors As Applied to Public Entities[8]

This section discusses the most commonly applied economic realities test factors and assesses the significance of various ways states may design and implement aspects of their consumer-directed programs. The Department has analyzed whether each of these program variables is a "strong," "moderate," or "weak" indicator of an employment relationship.

Although this guidance focuses on the most common factors that may make a public entity an employer, all of the relevant facts and circumstances must be assessed to make a determination about employment status. Additionally, courts may consider multiple other factors when evaluating the economic dependence of a worker on a purported employer.[9]

1. Power to Hire and Fire

The ability to hire and fire is generally considered a strong indicator of employer status.

Provider Qualifications

In consumer-directed programs, even where a consumer makes all specific hiring decisions, the state sets certain provider qualifications as mandated by federal Medicaid requirements. The setting of very basic qualifications in order to assure consumer safety, such as requiring a criminal background check and First Aid or CPR certification, should be considered a weak indicator of employer status. These basic provider qualification requirements are akin to licensing requirements common at the state and local level, compliance with which does not, by itself, suggest the existence of a joint employment relationship between, for example, a security guard who is required to obtain his own license prior to being hired, and a security agency and the state or local security licensing agency.

In contrast, more extensive provider qualifications, such as fulfilling comprehensive, state-administered training requirements (beyond training required for relevant licenses), should be considered a strong indicator of employer status.

Hiring Decisions

If a public entity permits the consumer to recruit, interview, and hire any provider who meets basic qualifications (or maintains an open registry to which the consumer can refer his or her preferred provider for inclusion), that fact will not weigh in favor of employer status of the public entity. If a public entity runs a registry and permits a consumer to only hire from the closed registry, that fact will be a moderate-strength indicator of employer status of the public entity. If the public entity must co-interview or approve a provider based on criteria beyond the previously discussed setting of basic qualifications, those facts should be considered strong indicators that the public entity is a joint employer.

Firing Decisions

In consumer-directed programs, consumers nearly universally retain the right to fire any individual worker from providing services in his or her home at any time. If a public entity may exclude providers from working within the Medicaid program only in situations dictated in federal Medicaid requirements—i.e., if the worker is determined to have committed fraud or is found after an investigation to have abused a consumer—that fact should be considered a weak indicator of employer status. If, however, a public entity reserves the right to remove a worker at any time from the household, or can fire a worker for poor performance, then these facts would be strong indicators of employer status. Whether an entity rarely, if ever, exercises a retained right to fire is not particularly relevant to employment analysis. *See, e.g., Ruiz v. Fernandez*, 949 F. Supp. 2d 1055, 1064 (E.D. Wash. 2013) (explaining that the frequency with which the entity exercised its right to fire is not indicative of employment; the fact that the entity had the power to fire is what is relevant to the economic realities test); *see also Herman v. RSR Sec. Servs. Ltd.*, 172 F.3d 132, 139 (2d Cir. 1999) (observing that joint employer's exercise of limited or occasional control did not remove employment relationship from protections of the FLSA).

2. Control over the Wage or Other Employment Benefits

States administering consumer-directed programs exert control over wages in different ways. Some states have a set wage for home care workers, while others set a "wage range" or a "cap" for home care worker pay. Other states set a reimbursement rate, rather than a wage, for personal care services.

The critical inquiry as to whether an entity is a joint employer under the FLSA is not which employer the worker is more dependent on, but rather the economic reality of each individual worker-employee relationship. *See, e.g., Torres-Lopez v. May*, 111 F.3d 633, 640 (9th Cir. 1997). The ability to determine the method and rate of payment is an essential factor in the joint employment analysis.

Setting a Wage Rate

The Department believes that setting a wage rate is so fundamental to the ultimate question of economic dependence that any entity that sets a wage rate will likely be considered an employer. The Department re-emphasizes, however, that the economic realities test is a multi-factorial analysis in which all factors must be considered in order to analyze the ultimate question of economic dependence.

It will thus be considered a strong indicator of employer status if a public entity administering a consumer-directed program sets the wage rate for home care workers. In the private sector, where a larger entity contracts work out to a smaller entity that hires employees, determining the wages of that employee has been considered a highly determinative factor in the economic realities test. There is substantial case law in the agricultural context finding joint employment with an entity based, at least in part, on influence over the pay rate. For example, in *Barrientos v. Taylor*, 917 F. Supp. 375 (E.D.N.C. 1996), the court found joint employment because a farm labor contractor's dependence on the cash from the farm owner allowed him no discretion in setting the pay rates for plaintiffs, concluding that "[e]ssentially, the [farm owner] dictated what plaintiffs would receive." *Id.* at 382-83. In *Hodgson v. Griffin & Brand, Inc.*, 471 F.2d 235 (5th Cir. 1973), the Fifth Circuit identified several facts which indicated that an employment relationship existed: the farmer set the workers' pay, determined whether to pay on an hourly or piece-rate basis, and deducted Social Security contributions. *Id.* at 238, *cert. denied*, 414 U.S. 819 (1973).

Reimbursement Rates

All states are required to set rates for Medicaid-approved services, including home care services. All providers of Medicaid-funded services, including agencies, non-profit organizations, and individuals, are subject to the approved reimbursement rates.

Reimbursement rates included in a contract for consumer-directed home care services between a state and another third party entity, such as an agency or fiscal intermediary, do not directly correlate with worker wages. These rates often include costs other than wages (such as administrative costs, overhead, worker

benefits, profit for the agency, etc.), and the third party sets the wage after taking the rate and these costs into account. Where the third party ultimately controls the hourly wage paid to workers, such reimbursement rates do not, by themselves, convert a public entity to a joint employer. *See, e.g., Aimable v. Long & Scott Farms*, 20 F.3d 434, 442 (11th Cir.) (rejecting argument that farm owner was a joint employer, because contractor alone determined what portion of his revenue to expend on labor, housing and equipment, and "most importantly" determined what wages to pay workers), *cert. denied*, 513 U.S. 943 (1994). Moreover, a third party entity would be free to pay its workers differing amounts, or to reward seniority or excellent performance with additional bonuses. This reasoning parallels that which applies to reimbursement rates for procedures performed by a doctor; the setting of such rates (taken alone) do not convert the state into an employer of the doctor, due to the attenuation between the per-procedure reimbursement rate and the doctor's wage rate.

In contrast, in the context of home care services in a consumer-directed program in which no private agency or other third party other than a public entity is involved (or in which the third party's involvement is limited such as in the case of a fiscal intermediary that only processes payroll), the reimbursement rate for home care workers is essentially what the hourly wage will be and may allow no discretion to set a wage rate. The reimbursement rate likely only differs from the hourly wage in that it might include the employer's social security or unemployment tax contribution that will later be deducted from the wage. Additionally, state plans require providers to accept Medicaid reimbursements as payment in full, without any supplemental payments from consumers (aside from applicable deductibles, coninsurance or copayments). *See* 42 CFR 447.15. In this situation, the public entity is exerting considerable, if not complete, control over the amount of money a worker can earn. These situations, in which the consumer and any private third party do not have any discretion in adjusting the wage earned by the home care worker, should be considered a strong indicator that the public entity is an employer.

Setting a Cap or Wage Range

Many programs that do not set a specific wage or rate instead include a wage range or "cap" on wages or reimbursement rates in order to comply with federal Medicaid regulations mandating that a state implement safeguards to prevent the premature depletion of the participant-directed budget. *See* 42 CFR 441.464. In addition to the regulatory requirements concerning fiscal accountability, this cap/wage range can also help consumers manage their budgets so that they have resources for the entire month and serve as a tool to guard against consumer exploitation. The setting of a "cap" or wage range is a factor to consider as part of an economic realities analysis; however, the Department believes that a true cap or range, as described below, would be a weak indicator of employer status.

A true cap or range (1) provides a consumer with meaningful discretion to determine how much to pay home care workers within his or her individual budget; and (2) allows a consumer choice in how to spend unused funds that are available as a result of using a lower wage rate on other authorized Medicaid expenditures. In contrast, if a cap/range essentially functions as a wage rate, and the consumer has little discretion to actually set a wage, the Department would view this type of a cap as more similar to a predetermined wage rate, and thus would view this type of cap as a strong indicator of employment status of the public entity.

3. Hours and Scheduling

In certain consumer-directed programs, a consumer retains complete control (within his or her individual budget) over scheduling, including the number of work hours, for home care workers. This factor should be considered a weak indicator of employer status for the public entity, because the consumer is able to freely decide when, how often, and for how long the provider will work.

In programs in which the public entity sets an explicit number of hours for which the consumer may receive home care services from which the consumer may not deviate, and the consumer controls the scheduling within that timeframe, this fact should be considered a moderate indicator of employer status for the public entity.

If the public entity specifies certain hours or specific weekly schedules to be worked, that fact is a strong indicator that the public entity is an employer.

4. Supervises, Directs, or Controls the Work

Day-to-day supervision of providers is an important factor to be considered in conducting an economic realities analysis. The Department emphasizes, however, that economic dependence rather than simple control is the ultimate inquiry.

In programs in which the consumer has sole control over the worker, the tasks that are performed (within the limits of Medicaid-authorized services), how the tasks are performed, and when the tasks are performed, and the public entity does not supervise or direct the day-to-day work in any manner, but rather only performs minimal functions focused on the well-being of the consumer (rather than any assessment or management of the provider), these facts would be weak indicators that the public entity is an employer.

In programs in which the public entity more explicitly identifies (perhaps in a plan of care) the specific permissible tasks and limits the worker to performing those exact tasks, and the public entity engages in quality management activities that are more similar to daily supervision (for example, a case manager/service coordinator makes regular, on-site visits and assesses the provider's performance beyond ensuring the safety of the consumer), these factors should be viewed as moderate indicators that the public entity is an employer.

Strong indicators that the public entity is an employer include: if the public entity mandates the list of specific permissible tasks **and** the time allocated for performance of each task, if the provider is required to inform both the consumer and the program contact of tardiness or absences, if the program contact intervenes or mediates issues between the consumer and providers, if the program provides for a grievance procedure for workers, if the program conducts regular performance reviews, if the program requires ongoing public-sponsored training, or if the provider must sign in and sign out directly with the public entity.

5. Performs Payroll and Other Administrative Functions

In many programs, the public entity or a fiscal management agent performs payroll or other administrative functions on behalf of the consumer. As noted in the Final Rule, functions that are similar to the tasks performed by commercial payroll agents for businesses, such as maintaining records, issuing payments, addressing tax withholdings, and ensuring that workers' compensation insurance is maintained for the worker on behalf of the consumer, are weak indicators that the entity is an employer.

6. Other Factors

This list is meant to be illustrative. There are multiple other factors a court may consider to be relevant in evaluating whether an employment relationship exists. These factors may include, for example, whether the purported employer provides equipment for the worker to use or whether the purported employer provides mandatory training. All of the facts relevant to whether a worker is economically dependent upon a purported employer should be assessed.

III. Hypothetical Examples

Hypothetical One – High Control Consumer-Directed Programs, with Public Entity and Consumer as Joint Employers

In this consumer-directed program, the public entity collectively bargains with a union representing home care providers. The public entity exercises control by providing extensive required training, offering paid time off, furnishing equipment, creating a procedure for redress of grievances, setting a wage rate, and offering a

benefits package. The public entity also retains some control over hiring and firing by completing performance evaluations and reserving the right to terminate a worker for poor performance. A fiscal intermediary processes payroll and tax withholding.

The Department believes that in such programs, the public entity administering the program is a joint employer of the provider along with the consumer. The fiscal intermediary, performing purely ministerial functions, would not be an employer.

Other public programs in which the home care providers are not parties to a collective bargaining agreement but in which the public entity nonetheless demonstrates similar levels of control over the providers' working conditions will also be considered joint employers. For example, some programs are structured such that a case manager is involved in determining the worker's schedule or directing the method of work, or the public entity sets a wage rate for providers. In programs such as these, with similar levels of control as described above, the public entity will be considered a joint employer with the consumer.

Hypothetical Two – Cash and Counseling Program with a Wage Cap, with Consumer as Sole Employer

In this cash and counseling program, consumers are given the option to manage a flexible budget and decide what mix of Medicaid-allowable goods and services best meet their personal care needs. Participants may use their budgets to hire personal care workers, purchase other services, purchase items, or make home modifications that help them live independently. The consumer retains authority over hiring and firing, negotiates the wage rate paid to the employee within a cap, and sets the terms and conditions of employment.

The public entity sets minimal qualifications for providers (by requiring a criminal background check and CPR/First Aid certification), determines eligibility and assesses need under the program, and then performs only ministerial payroll and tax functions through a fiscal intermediary, similar to those that commercial payroll agents perform for businesses, such as maintaining records, issuing payments, and addressing tax withholdings. The public entity also sets a cap on wages for all workers participating in the program so that consumers will have enough resources in their budget for the entire month, and to help ensure fiscal accountability as well as guard against exploitation. The cap for home care workers is at the agency reimbursement rate of, for example, $26 per hour. Thus, the consumer may pay anywhere from minimum wage to $26 per hour, and if the consumer elects to pay less than the cap, the remaining funds remain in the consumer's individual budget.

In this scenario, the consumer is likely the sole employer of workers hired through such a program.

Hypothetical Three– Consumer-Directed State Plan Program, with Consumer and Public Entity as Joint Employers

In this consumer-directed state plan program, the consumer posts a job announcement and selects applicants to interview. The consumer conducts interviews and chooses a provider, but the case manager must approve the hiring decision. The consumer provides all day-to-day supervision and controls the schedule as well as the manner in which work is performed. The consumer and public entity case manager conduct regular performance evaluations, and either the case manager or consumer may decide to fire the provider for poor performance. The program also has required, ongoing, comprehensive, state-sponsored training requirements. The public entity sets a reimbursement rate for home care services, from which the consumer may not deviate. Payroll and withholdings are processed through a fiscal intermediary of the consumer's choice.

In this scenario, the public entity and the consumer are likely joint employers of the provider. The fiscal intermediary is not an employer.

Hypothetical Four –Intermediary Agency Model, with Consumer and Agency as Joint Employers

In this program, the public entity administers an intermediary agency model. The state sets reimbursement rates for all Medicaid services within the public entity, including home care services. The minimum qualifications for home care workers are set by state regulation. The public entity does not supervise the work, set schedules, or control conditions of employment. The public entity contracts with agencies to provide home care services, and provides a bundled reimbursement rate from which the agency is free to set a wage rate and retain a portion for administrative costs. The public entity reserves the right to conduct certain functions, including visiting the agency to assess performance, conduct fiscal and quality audits, and review personnel files on a random basis.

Consumers may recruit and select a provider, and the agencies participating in the program then screen and hire the worker (the agency may also recruit potential providers). Both consumers and agencies retain the right to fire the workers, and the agencies generally handle any disciplinary issues involving the workers. Agencies also conduct the administrative functions and supervision of workers required by regulation, train the workers, and evaluate job performance. The agencies maintain all employment records, although copies of such records are also sent to the public entity administering the program. Consumers provide daily supervision, set the worker's schedule, and decide how and when certain tasks will be performed.

In this scenario, the agencies and consumers are employers, and it is likely that the public entity is not an employer. The public entity performs minimal functions required by regulation, while the agencies set the wage rate, hire and train workers, and supervise much of the work.

Hypothetical Five – Public Entity, Managed Care Organization, and Intermediary Agency Program, with Consumer and Agency as Joint Employers

This public entity contracts with a managed care organization (MCO) to provide health care services, including home care services, to Medicaid recipients. The public entity pays the MCO a per consumer monthly rate, and from that total budget the MCO contracts with various providers in its network, including home care agencies. Within this network are several agencies participating in a consumer-directed intermediary agency program. The MCO pays the agencies a bundled rate from which the agency sets the wage rate; authorizes a certain number of hours based upon an assessment; pays health insurance, workers' compensation, and unemployment insurance premiums; and also may choose to authorize overtime. The participating agencies permit consumers to hire and fire their own workers, and consumers set the provider's schedule and provide all day-to-day supervision.

In this scenario, on these specific facts, it is likely that the agencies and the consumers are joint employers, and that the MCO and public entity are likely not joint employers. The MCO merely pays the bundled rate to the agencies, and the agencies perform all other indicia of employment. However, any slight change in the particular facts could change the analysis.

Hypothetical Six – Public Entity, Managed Care Organization, and Intermediary Agency Program, with Consumer, Managed Care Organization, and Agency as Joint Employers

This public entity contracts with a managed care organization (MCO) to provide health care services, including home care services, to Medicaid recipients. The public entity pays the MCO a per consumer monthly rate, and from that total budget the MCO contracts with various providers in its network, including home care agencies. Within this network are several agencies participating in a consumer-directed intermediary agency program. The MCO pays the agencies a bundled rate but requires the agencies to pay workers a particular hourly wage. The MCO also sets comprehensive provider qualifications and requires providers to attend training provided by the MCO on a regular basis. The agencies authorize a certain number of hours based upon an assessment; pay health insurance, workers' compensation, and unemployment insurance premiums; assist the consumer if disciplinary matters regarding the provider arise; provide back-up workers when needed; and may choose to authorize overtime. The participating agencies permit consumers to hire and fire

their own workers, consumers set the providers' schedules, and consumers provide all day-to-day supervision.

In this scenario, based on these specific facts, it is likely that the MCO, the agencies and the consumers are joint employers and that the public entity is likely not a joint employer. The MCO does far more than simply pay the bundled rate (as the MCO did in Hypothetical Five) in this example, and indicia of employment is spread among the MCO, agencies, and consumers. However, any slight change in the particular facts could change the analysis.

Hypothetical Seven – Consumer-Directed Waiver Program, with Consumer as Sole Employer

In this consumer-directed waiver program, the public entity sets forth basic hiring requirements (such as a criminal background check or CPR/First Aid certification) and retains the limited right to remove a provider from the program if it is determined, after an investigation, that there has been fraud or abuse. The public entity also sets a wage rate range for services that is approved by CMS. The wage rate range for home care workers is from $10 per hour to $24 per hour. A consumer can hire anyone who meets minimal qualifications and the consumer retains the ability to fire for any reason. The public entity retains the right, pursuant to Medicaid regulations, to terminate a provider from the program in circumstances of fraud or abuse. A budget is developed annually by the consumer with the help of a case manager. It is the responsibility of the consumer to keep up with financial statements to determine whether monthly spending should be adjusted. The consumer sets the worker's schedule, determines the tasks to be performed, and supervises how the work is performed. The consumer reviews and approves the worker's payroll, and the provider's tax withholdings are deducted from the individual consumer's budget (not any general state fund). The consumer has a choice between three fiscal intermediaries that perform payroll and other administrative functions. The public entity does not provide any paid time off, equipment, mandatory training, or contributions to health insurance premiums.

In this scenario, the consumer is likely the sole employer of the worker. Any slight change in the specific facts of this hypothetical may change the analysis.

---

[1] The effective date for the Final Rule is January 1, 2015.

[2] For additional information, *see* Fact Sheet 79E: Joint Employment in Domestic Service Employment Under the Fair Labor Standards Act.

[3] Public entities include instrumentalities of state, county, or municipal governments or special- purpose entities created by a state, county, or municipal government.

[4] The joint employment regulation further explains that an employee has joint employers if "the employers are not completely disassociated with respect to the employment of a particular employee and may be deemed to share control of the employee, directly or indirectly, by reason of the fact that one employer controls, is controlled by, or is under common control with the other employer." 29 CFR 791.2(b)(3). On the other hand, if the employers "are acting entirely independently of each other and are completely disassociated" with respect to an employee who works for both of them, each employer may disregard all work performed by the employee for the other when determining its own responsibilities under the FLSA. 29 CFR 791.2(a). Thus, the focus of the joint employment regulation is the degree to which the two possible joint employers share control with respect to the employee and the degree to which the employee is economically dependent on the purported joint employers.

[5] Although courts consistently consider the economic reality of the relationship between the worker and potential employer when making joint employment determinations in FLSA cases, the exact factors applied may vary. Some courts apply only the factors addressing the potential joint employer's control; however,

"[m]easured against the expansive language of the FLSA," this analysis "is unduly narrow, as it focuses solely on the formal right to control the physical performance of another's work." *See Zheng v. Liberty Apparel Co.*, 355 F.3d 61, 69 (2d Cir. 2003). These factors "may approximate the common-law test for identifying joint employers," but they "cannot be reconciled with the 'suffer or permit' language in the [FLSA], which necessarily reaches beyond traditional agency law." *Id.* Thus, although there may be several acceptable formulations of the economic realities factors used to determine the employee's economic dependence, a set of factors that addresses only control is not consistent with the breadth of employment under the FLSA.

[6] Throughout this document, the Department uses the term "consumer" to refer to an individual receiving home care services and "provider" to refer to a home care worker providing services through a consumer-directed program.

[7] The issues on appeal to the U.S. Supreme Court do not include whether the state of Illinois is an employer of home care workers for FLSA purposes.

[8] Administrator's Interpretation No. 2014-1 ("Shared Living AI") addressed the application of the FLSA to shared living programs, i.e., programs that facilitate home care arrangements "in which a consumer and provider share a home in order to allow the consumer to remain in his home and community." *Id.* at 2. The Shared Living AI emphasized that an economic realities analysis must be utilized in all shared living situations to assess whether a consumer or a third party could be an employer of a provider; in some shared living situations (typically in adult foster care or host home programs), a provider may be an independent contractor.

Adult foster care and host home programs are distinct from consumer-directed programs. In these types of shared living arrangements in a provider's home, a provider typically exercises control over the conditions of the work rather than taking direction from the consumer, and may have invested in the shared living arrangement, such as by making modifications to his or her home. In contrast, the very nature of a consumer-directed program creates an economically dependent relationship between a provider and a consumer, and potentially one or more third parties, as the consumer and any third party employers will necessarily be controlling the wage and other conditions of this work.

[9] This analysis is for FLSA purposes only. Most other federal laws apply different, narrower employment tests.

[10] If the provider is required to provide sign in and sign out times directly to a representative of the public entity (such as a case manager), this fact would be a strong indicator that the public entity is an employer; in addition, if the provider is required to utilize an electronic verification system and the consumer does not verify or approve provider timesheets, this fact will also be viewed as a strong indicator that the public entity is an employer. If, however, the provider is required to utilize an electronic verification system (for purposes of auditing or to generate payroll), but the consumer still retains the ultimate responsibility for verifying or approving provider timesheets, this fact will be viewed as a moderate indicator that the public entity is an employer.

The Brownsville Herald

State phases in new home health verification system

Courtesy photo

Posted: Friday, July 11, 2014 10:37 pm

State phases in new home health verification system By Christina R. Garza Staff Writer

In efforts to combat fraud by home care providers throughout the state, the Texas Health and Human Services Commission will implement a new Electronic Visit Verification system statewide Sept. 1.

"EVV is a telephone and computer-based system that electronically verifies that home care provider visits occur and documents the precise time service provision begins and ends," Texas Department of Aging and Disability Services spokeswoman Melissa Gale said.

The purpose of EVV is to verify that people are receiving the home health services for which they have been authorized to receive and for which the state is being billed. Gale explained.

According to DADS, the system is currently in place in seven regions throughout Texas but won't be implemented in CameronCounty until September. The EVV system will run through Sandata Technologies' Santrax EVV system, which is paperless and primarily uses home phone lines.

Computer Information officer, Max Rojas of Texas Visiting Nurse Services in Harlingen, recognizes the EVV technology is useful to some but believes a more practical, cost-effective implementation of visitation verification could be achieved using biometric methods like fingerprint identification.

In order to use the system, Rojas explained the provider will input the individual's landline home telephone number into the EVV system. After the number has been entered into the database, the system will determine if the EVV call

was made from the specified telephone line or from a different number. In instances where the phone numbers do not match, the system will flag the visit for additional system administrator attention.

Administrators will then contact the home care provider or client to investigate the discrepancy but in the end must rely on the honesty of the home care provider and agency.

"We've given a platform to every single company who was doing false claims complete power over it," Rojas said.

Rojas said this removes the fraud-liability from the home care provider agencies and places it directly on the attendant.

For those without landlines, Fixed Visit Verification systems feature a small device similar to a pager that uses a formula based on the time, date and client identification number to provide a digital readout to the attendant who then calls an automated system to enter the code.

Rojas said the estimated cost of the system at this time would be about 10 cents per call, with at least two calls per visit.

According to Gale, the net savings percentages of using the system have risen from nearly 3 percent to approximately 5 percent amounting to approximately $16 million saved in the fiscal year.

Felix Gutierrez, founder and CEO of Biometric Data Solutions in Dallas said that a biometric fingerprint device would reduce fraud because it could determine time, date and identification of the attending home care provider.

Gutierrez said another advantage of the device is it that is available for an unlimited number of uses.

The Dallas Morning News
Business Health Care

Health Care

Digital and mobile startups are fueling health care innovation in Dallas

By HANAH CHO hcho@dallasnews.com

Staff Writer

Published: 15 June 2013 04:44 PM
Updated: 17 June 2013 03:22 PM

Entrepreneurs across the country are transforming the health care industry through technology.

Digital and health information tech startups are growing as doctors, hospitals and administrators look for ways to provide better care and reduce costs under federal mandates.

Consumers, too, are embracing mobile tools to be healthy.

Dallas is no exception.

"D-FW has a tremendous amount of health information technology activity, far more than we give ourselves credit for," said Dr. Hubert Zajicek, co-founder of Health Wildcatters, a new seed accelerator for digital health startups in Dallas.

"An extremely competitive health care delivery market in the most rapidly growing top five American metro areas, combined with our strengths in technology and telecom, provides fertile grounds to grow and support the newest crop of innovative health care startups in Dallas," he said.

To get a picture of the activity, we talked with executives from three health care startups in D-FW:

http://www.dallasnews.com/business/health-care/20130615-digital-and-mobile-startups-are-fueling-health-care-innovation-in-dallas.ece

Vivify Health, a Plano company that developed a cloud-based platform for remote patient monitoring.

Axxess Technology Solutions, a Dallas company that uses cloud-based software to perform administrative functions for home health care agencies.

DealWell, a Dallas firm that has a website where people can shop for the best deals in health care services.

Vivify Health

For the last several years, Vivify has been developing its platform for remote patient monitoring and testing it with several hospitals and other partners, such as Texas Health Resources and AT&T Inc.

In May, the company announced it raised funds from venture firms Ascension Health Ventures and Heritage Group, whose partners include hundreds of hospitals. The startup, founded as Intuitive Health in 2009, also rebranded itself.

Regulatory filings put the investment at $3.4 million, but founder and CEO Eric Rock said the amount is much larger, though he declined to provide an exact number.

With the funds, Vivify plans to jump-start the marketing of its platform to users, such as hospitals, home health care agencies and physician practices. It also plans to offer a direct-to-consumer product soon.

Rock described Vivify's software as a tool that seeks to reduce hospital readmissions, improve care and reduce costs — challenges facing the health care industry amid reforms.

"Driven by extreme demands on the crumbling U.S. health care system, care must now be delivered outside the four walls of the hospital," Rock said.

Vivify's software, Rock said, is less costly and easier to use for both patients and providers because it uses common consumer devices, such as mobile tablets and computers. The platform also provides video conferencing, educational health videos and customized care plans.

Here's how it works: Using a tablet, for instance, patients log onto the Vivify platform from their home. Depending on the plan customized by a physician or provider, patients typically answer a daily health survey, keeping track of their weight, blood pressure and other vital signs. Vivify's platform can be integrated with other devices like a scale or a blood glucose meter.

http://www.dallasnews.com/business/health-care/20130615-digital-and-mobile-startups-are-fueling-health-care-innovation-in-dallas.ece

On the other end, doctors can monitor the patient's progress remotely.

Preliminary results from a pilot involving AT&T and Texas Health Resources using Vivify's platform have shown positive patient feedback and reduced readmissions for chronic heart patients, according to the Texas Health Research & Education Institute.

St. Vincent Health, Indiana's largest health system, is getting ready to launch a large-scale program to monitor patients using Vivify's software in July, said Dr. Alan D. Snell, St. Vincent's chief medical informatics officer.

On any given day, health care providers expect to monitor 500 patients who have complex chronic diseases, as well as those discharged with specific diagnoses such as heart failure, heart attack and pneumonia, Snell said.

St. Vincent chose Vivify as its software vendor because of "the flexibility of their platform and software, their analytic capabilities and their progressive view of where remote care management should be going," Snell said.

Vivify is Rock's third startup and second in health care.

Two previous ventures had successful exits. His first, ProHost, a table management system for restaurants, was sold to OpenTable. MedHost, focused on emergency room information systems, was also acquired.

Axxess

In six years, Axxess Technology Solutions has grown into an $8 million business.

Dallas-based Axxess provides cloud-based software that serves as the clinical, operational and administrative backbone for home health care agencies.

The home care market represents about $68 billion a year in U.S. health spending, according to McKinsey & Co. The consulting firm said in a study that technology can be the main driver for expanding the market.

Axxess CEO Niyi "John" Olajide saw the underserved technology market in the sector when he started his business as a one-person consultant a decade ago.

At that time, he was a telecommunications engineering student at University of Texas at Dallas. While visiting an aunt who was an administrator at a home care agency, Olajide noticed the computers were not set up under one network.

After inquiring about the issue, he was hired as an IT consultant. That job led to others, and Axxess was officially created in 2007.

http://www.dallasnews.com/business/health-care/20130615-digital-and-mobile-startups-are-fueling-health-care-innovation-in-dallas.ece

After realizing that Olajide was solving similar problems for his clients, Axxess decided to develop Web-based software that would help home care agencies automate their business. The product launched in 2011.

"We saw a need for that and set out for the home health care software market and haven't looked back since," Olajide said.

Administrators and health care providers can schedule patient visits, bill insurance providers and document patient care plans using Axxess' software. Since it is cloud-based, nurses can update patient files or access medication guides on any mobile device during a home visit.

For MedPro Health Providers, a home care agency outside of Chicago, using Axxess' software has reduced time on paperwork, cut the hassle of billing and made patient care coordination among the various providers easier, said chief executive Riz Villasenor.

"As we work with hospitals and other institutions, the ability to share information swiftly and the right information is also a big plus when you're working in an environment like health care," Villasenor said.

Today the startup has 800 customers in almost 40 states, serving about 150,000 patients.

Olajide bootstrapped the business and has not taken any outside investment. The startup has been profitable since 2011.

Now the firm, which has 53 employees, faces a different challenge.

"We're always looking for talented people, and we can't find them fast enough to maintain our pace of growth and innovation," he said.

DealWell

The Internet has changed the way we shop for most everything.

One exception has been health care. Now, an increasing number of startups are trying to create marketplaces where consumers can shop around for the best deals for medical services.

Dallas-based DealWell is one such company.

The website officially launched in August to offer services in nine categories in the Dallas-Fort Worth region. They are chiropractic services, cosmetic surgery, dental,

eye exams/Lasik, hormone therapy, massage, medical imaging, medical/day spa, and weight loss and management.

"We're bringing price transparency and comparison shopping," said Geoffrey Fischer, DealWell's chief executive, whose experience includes working at Microsoft's MSN division. "We're making the market more efficient and helping customers get good deals."

The startup is backed by Plano-based Preferred Medical Holdings, a provider of MRI services in the region.

Every offer on the site is at least 20 percent off retail and as much as 85 percent in some cases. DealWell vets providers that sign up, checking their credentials.

Consumers can buy a deal or bid for a better one. Think of DealWell as being like Priceline for health and wellness services.

And unlike popular deal sites, offers do not expire and consumers can choose from a variety of providers for a single service, Fischer said.

Fischer declined to provide revenue but noted that sales have been increasing 25 percent monthly. Several thousand customers have bought a deal on the site.

DealWell takes a cut of each sale. Fischer declined to give an exact figure but noted that it was far less than the 50 percent split that deal sites like Groupon reportedly take.

DealWell providers also pay a small monthly fee to participate.

William A. Moore, clinical director of Dallas-based Advanced Skin Fitness and Advanced Men's Clinic, has been using DealWell since last fall.

Moore said the clinics have seen a "great return" from DealWell. In several cases, DealWell customers have bought additional services.

"They're not deal hopping," he said. "They seem to be a more loyal clientele."

Follow Hanah Cho on Twitter at @hanahcho.

By the numbers: Digital health care

73

Percent of doctors who believe health information technology will improve the quality of health care in the long term

43

Percent of physicians who use mobile health technology for clinical purposes

35

Percent of U.S. hospitals that have converted to electronic health records

44 million

Number of mobile health care and health apps downloaded in 2012

$1.4 billion

Amount of venture funding raised for digital health startups in 2012

SOURCES: Deloitte; U.S. Department of Health and Human Services; Juniper; Rock Health

http://www.dallasnews.com/business/health-care/20130615-digital-and-mobile-startups-are-fueling-health-care-innovation-in-dallas.ece

How Will CareWatch Impact Your Agency?

Cash will begin to flow freely. You'll stop worrying about paying caregivers on time.

Our telephony-based system ensures accurate, paperless timesheets.

CareWatch will significantly increase your accuracy in measuring mileage and travel time.

http://www.carewatch.com/electronic-visit-verification-solutions/

When your staff is in the field, communication will be much simpler with our extensive voice messaging features.

What is Electronic Visit Verification?

Electronic Visit Verification (EVV) is the means of electronically verifying that a caregiver is physically present with the patient. Today, most states and other payers rely on EVV as a more effective monitoring tool than a hand-signed document.

Secure Electronic Signatures

Each of your caregivers will choose a unique ID and password which they alone know and control. When they call the CareWatch system from the patient's phone to report arrival, departure and visit data, they enter their ID and password.

Patients Without Phones? No Problem.

If necessary, caregivers can use their cell phones to report arrival, departure, and visit data. To enable your agency to verify that the caregiver is with the patient, we provide you with a CareWatch EVV Token, a small electronic device similar in shape to a key. When pressed, the Token generates a one-time password. Prior to reporting data to CareWatch, the caregiver must press the Token and enter the one-time password shown on the display. This password is matched to the patient's record, verifying the caregiver is present. The Token can be affixed with a tamper-proof ziptie to the patient's bed or other item in the residence to ensure it isn't removed without authorization.

100% Reliable Technology

CareWatch uses Automatic Number Identification (ANI) technology. ANI enables us to capture the billing telephone number of patients even if the patient uses caller ID blocking because ANI delivers information electronically. This ensures that our system is 100% reliable in reporting patients' locations. Our system also time-stamps the arrival and departure calls every caregiver

makes. In addition, CareWatch uses the telephone number captured from the telephone company to match the patient's telephone number stored in the patient's record in your CareWatch database. This feature of our system means that when caregivers call CareWatch to report data, they don't have to key in the ID number of patients.

The CareWatch Family of Products

We've developed a family of products which together form a **complete visit management system** for home care agencies. The individual products are listed below. We'd love to show you an online demo to demonstrate how CareWatch will impact your bottom line and the quality of care your agency gives. Call us at **770-409-0244**, email sales@carewatch.com, or click here to complete a short form with your contact information.

cwIVR - your phone system application
Companion - your primary administrative tool
cwExchange - your synchronizing interface application for 3rd party billing and/or scheduling systems
cwRoutes - your module for calculating travel time and mileage between visits using computer mapping algorithms

Why Agencies Rely on CareWatch

"We have been with Carewatch for 9 years. Choosing their service was one of the best technology decisions we ever made. They have always been quick to address our concerns as well as adapt to changes in our clinical software. Their telephony product for our paraprofessional staff has saved money for our agency, insures compliance with state and federal regulations, and has streamlined

our processes. The service has been outstanding over the years!"
Donna DeBlois, KNO WAL LIN

"CareWatch has been a valuable business partner providing solutions that improve our efficiency, effectiveness, and save us money. We really appreciate that they have welcomed our suggestions and supported our evolving business requirements to provide timely, tailored solutions that meet our needs. Over the years, their development team has provided an ongoing stream of innovative ideas and custom enhancements that truly show they understand that to be successful, service is the most important measure of quality."
Roger Ness, Director, IT, Addus HealthCare, Inc

Up and Running in as Little as 24-48 Hours!

We start the process with a series of information-gathering sessions about your business - from care plans and billing and payroll codes to operational and compliance needs. Once we're equipped with this data, we map out which CareWatch components you need (with or without modifications) and install the software. Then we test, test, test to ensure that information flows correctly between your CareWatch system, our voice servers in Atlanta, and your billing/scheduling system.

Next, the CareWatch Training Team takes over. They are responsible for introducing your administrative staff to your new Electronic Visit Verification system and further customizing the software if necessary. We then train your supervisors to train your caregivers to use CareWatch. To ensure a painless and smooth rollout, we provide a comprehensive training kit featuring visual aids, videos and documentation on best practices.

Equally important? We provide as much hand-holding as you need -- and there are hundreds of agencies across the country who will attest to this!

Get in Touch
Email Us ■ **Sales: (800) 901-2454**
Support: (770) 409-0244
CareWatch Inc.
3483 Satellite Blvd
Ste 211 South
Duluth GA 30096

Five Facts about Electronic Visit Verification (EVV) for Home Health Agencies

Author: Lisa Dawson, *Axxess*
Date: March 2, 2015

Just as nutrition and exercise are vital to an individual's health, Electronic Visit Verification (EVV) is necessary for the business wellbeing of a home healthcare organization. An EVV system electronically verifies the date, time and location of the patient visit. Using an Electronic Visit Verification system creates a culture of compliance within a home health organization and helps agencies ensure they are submitting claims for visits that took place at the time and place indicated.

With healthcare trends moving towards reimbursement cuts and audits, home health agencies nationwide are benefitting from Electronic Visit Verification. Agencies that implement EVV systems find that they save on labor costs, specifically in Quality Assurance (QA) and payroll services. For home health agencies, this could mean survival in this ever-changing industry.

Here are five facts about Electronic Visit Verification:

1. Ease of Use. Implementing and using an Electronic Visit Verification system is easy. There's no software or hardware to install. When used with a mobile app on a device like a Smartphone or tablet, the EVV system will automatically track a clinician's location when they 'check-in' and 'check-out' at the patient's home. There's no need to be tech savvy with EVV; if someone can use a phone, they can use EVV.

2. Maximizing compliance. Clinicians are able to prove compliance when they 'check-in' and deliver care at the time and place needed. Agencies are compliant by providing electronic documentation of vital signs and services with time stamps. EVV gives you the proof of care in case of an audit. A mobile app with EVV time-stamps the clinician's visits. This captures accurate data for employee payroll processing and verifies if the clinician arrived at the scheduled time.

3. Some states mandate it. Many states already require home health care to have an electronic tracking system and most allow agencies to choose their own vendors. Electronic Visit Verification is already mandatory in Florida, South Carolina, Illinois, Tennessee and Texas. Several more states are considering mandating EVV, as the government works to reduce costs lost annually to medical fraud. The smartest move a home health agency can make now is to adopt EVV ahead of the curve.

http://www.axxess.com/blog/news_n_update/five-facts-about-electronic-visit-verification-evv-for-home-health-agencies/

4. Reduces errors. Electronic Visit Verification minimizes the risk of billing errors and misassumptions of fraud by guaranteeing that the patient was serviced thru GPS technology, thus having accurate visit verification.

5. Saves time and money. Electronic Visit Verification eliminates waste and redundant resources. QA providers at home health agencies will spend less time verifying visits. Visits can be seen immediately by agency professionals, which eliminate the need for 'spot checks.' In addition, the speed at which payments are processed and paid is accelerated with EVV. Speedier payments improve an agency's revenue cycle and allows for faster business growth.

http://www.axxess.com/blog/news_n_update/five-facts-about-electronic-visit-verification-evv-for-home-health-agencies/

InformationWeek
Healthcare CONNECTING THE HEALTHCARE TECHNOLOGY COMMUNITY

Healthcare
NEWS
11/5/2014
09:06 AM

Alison Diana
News

GPS Cuts Fraud, Costs For Home Healthcare

GPS-based electronic visit verification products such as Axxess and Celltrack help ensure caretakers actually visit patients' homes.

Now that more sick and disabled Americans live at home, payers and operators of residential healthcare providers are increasingly turning to technology to reduce fraud and ensure patients receive the care they need.

Nationwide, medical fraud costs tens of billions of dollars -- and home health fraud drains billions from the country's economy, said John Olajide, CEO of Axxess, in an interview. He's not exaggerating: Fraud and abuse in healthcare cost about $75 billion annually, according to the Institute of Medicine. The cost to untended patients can be immeasurable.

In 2012, Dr. Jacques Roy was charged with reportedly bilking $375 million from Medicare, in part by certifying more than 5,000 patients unnecessarily required home healthcare compared with the average of 104 for most physicians. About a year ago, Roberto Marrero pleaded guilty to, among other things, billing Medicare for therapy and other services that home-health patients did not need or receive, the IRS reported. In September, six south Florida residents were indicted for allegedly soliciting and receiving kickbacks from a now shuttered home-health agency.

[Read how tech is attacking Ebola: Real-Time Analytics Can Help Stop Ebola.]

Sometimes, it's individual employees, not organizations, who commit fraud, said Olajide, whose company develops electronic visit verification (EVV) solutions.

http://www.informationweek.com/healthcare/gps-cuts-fraud-costs-for-home-healthcare/d/d-id/1317202

"These are all individuals taking advantage of lapses in the system. It's people taking advantage of loopholes in the system," he said. "They see opportunities to exploit..."

Government anti-fraud initiatives, task forces, and well-publicized campaigns that generated more than 1,000 convictions and $2 billion in recovered payments are cutting into fraud, said Olajide. And technologies that allow home health agencies to electronically monitor remote staff ensure better patient care, accurate billing, and compliance with payers' request for proof of service, he added.

That's why states like Texas and Illinois now mandate the use of electronic visit verification (EVV). The Illinois Department of Human Services Division of Rehabilitation Services, for example, began using EVV for its Home Services Program in January 2014. About 30,000 personal assistants will use the system, developed by Sandata, to serve 28,000 people with severe disabilities, the state said. In addition to tracking caregivers' location, it integrates with payroll and flags supervisors in cases of suspected neglect or abuse.

(Image: Alyssa L. Miller/Flickr)

GPS-based electronic visit verification that integrates with payroll software quickly and automatically allows agencies to determine nurses' paychecks, Marvin Javellana, chief operating officer at Better Care Home Health, told InformationWeek. The four-year-old agency specializes in high-acuity patients, meaning daily care is critical to their health, he said. At a time when more patients are being treated at home, Medicare began lowering reimbursements, further spurring Better Care's interest in EVV, said Javallana.

http://www.informationweek.com/healthcare/gps-cuts-fraud-costs-for-home-healthcare/d/d-id/1317202

"Now, when Medicare lowers your reimbursements you start to look at how to become more efficient," he said. "We really need to squeeze every single cent of what we're reimbursed. The adoption of this technology is not just about compliance. It's about survival. How are you going to survive in this industry right now if you're not efficient?"

GPS products also reduce caregivers' mileage, according to EVV developer Celltrak. After implementing CellTrak VisitManager, the Hospice of Cincinnati's staff managed more visits per location and staff safety improved, said Jeri York, master scheduler, in a statement.

Before Better Care used Axxess' EVV, nurses carried a timesheet for each patient, who was then asked to sign daily to confirm the nurse's visit. Nurses could, however, get patients to sign multiple days simultaneously, said Javallana. And caretakers could use voice over IP (VoIP) lines to pretend they were at a patient's home -- when they were actually far away, he noted.

The agency's EVV system, which runs as an app on an iPhone or Android, lets nurses log on only when they are near the patient. It's part of Axxess' electronic health record (EHR) and portal, so it automatically updates clients' vital statistics, photos, medications, signatures, and notes, further proving the nurse's presence, said Javallana.

"With a GPS solution, if you are not in that front door or a few hundred feet of that address, you cannot log in," he said.

The owners of electronic health records aren't necessarily the patients. How much control should they have? Get the new Who Owns Patient Data? issue of InformationWeek Healthcare today.

Alison Diana has written about technology and business for more than 20 years. She was editor, contributors, at Internet Evolution; editor-in-chief of 21st Century IT; and managing editor, sections, at CRN. She has also written for eWeek, Baseline Magazine, Redmond Channel ... View Full Bio

State of Alaska Department of Law

Press Release

Good Faith Services Owner Sentenced to 3 years for Fraudulently Billing Medicaid

December 11, 2015

The Alaska Department of Law, Medicaid Fraud Control Unit, announced today that 56-year-old Agnes Francisco was sentenced to 3 years of active incarceration, plus 10 years of probation. Judge William Morse also ordered Ms. Francisco to pay a $50,000 fine. Ms. Francisco pled guilty to Attempted Medical Assistance Fraud in association with her company, Good Faith Services, LLC, during the years 2008-2013.

At the same hearing, Good Faith Services, LLC, and Anchorage Adult Day Services, LLC, two companies in which Ms. Francisco held an ownership interest, were also sentenced for Medical Assistance Fraud. Good Faith Services, LLC, was ordered to pay a fine of $300,000 and restitution in the amount of $1.2 million. Anchorage Adult Day Services was ordered to pay a $20,000 fine.

Ms. Francisco admitted that she committed Medical Assistance Fraud in multiple ways. For example, she knowingly authorized employees to submit false timesheets, valued at $529,000, for services not provided to Medicaid recipients. Additionally, Good Faith Services billed Medicaid $1.03 million for services provided by employees who were not legally authorized to bill Medicaid. In total, 50 individuals were convicted of criminal offenses associated with Good Faith and seven individuals agreed to civil sanctions for similar conduct.

Assistant Attorney General Andrew Peterson said that "the State will diligently monitor the Medicaid program, and will vigorously prosecute those who steal from Alaskans." Judge Morse remarked that her crime was "extremely" serious, stunning in scope, rather than a case of honest mismanagement. The Judge stated that he intended to "send a message" that Medicaid fraud would not be tolerated. He described Ms. Francisco's company as a "cesspool of fraud."

The case was initiated by citizen complaint to the Alaska Department of Health and Social Services, and was jointly investigated by the Alaska Department of Law, Alaska Department of Health and Social Services, the U.S. Department of Health and Human Services, Office of Inspector General, Federal Bureau of Investigation, Immigration and Customs Enforcement Homeland Security Investigations, and the Social Security Administration. Mr. Peterson emphasized that this case is a great example of how state and federal collaboration can work to combat fraud and abuse in the Medicaid system.

http://www.law.alaska.gov/press/releases/2015/121115-MFCU-Francisco.html

The Alaska MFCU is part of the Attorney General's Office. The MFCU is responsible for investigating and prosecuting Medicaid fraud and abuse, neglect or financial exploitations of patients in any facility that accepts Medicaid funds. The information filed in the complaint can be found on the MFCU website.

CONTACT: Assistant Attorney General Andrew Peterson 907-269-6279 (Andrew.Peterson@Alaska.gov) for more information about this case or others handled by the Alaska MFCU.

http://www.law.alaska.gov/press/releases/2015/121115-MFCU-Francisco.html

State of Alaska, Department of Law

Press Release

Fraud Charges Brought Against 40 Individuals by the Alaska Department of Law and U.S. Attorney's Office

June 18, 2015

June 18, 2015 (Anchorage, AK) – The Alaska Attorney General's Office and the U.S. Attorney's Office announced today that 40 individuals were charged with crimes for medical assistance fraud, conspiracy to commit health care fraud, public assistance fraud and PFD fraud. The charges arose from alleged fraudulent conduct spanning back to 2007, amounting to more than $648,000 being taken from the public coffers.

These charges are the result of ongoing collaboration between various state and federal agencies through the Social Services Fraud Working Group. This group was designed to foster collaboration and efficiencies by bringing together representatives from all of the various state and federal agencies responsible for preventing waste, fraud and abuse within Alaska's Medicaid, public assistance and PFD programs. Over the past three years, these agencies were responsible for 167 convictions and restitution judgments totaling more than $5.2 million.

According to John Skidmore, division director for the Department of Law's Criminal Division, "These prosecutions deter waste, fraud and abuse within Alaska's social services programs by barring the convicted individuals from participating in the respective programs and sending a clear message to others about the consequence of committing fraud." John Skidmore emphasized that by working collaboratively and cracking down on scams committed against public programs, the agencies involved in the Social Services Fraud Working Group have not only stopped fraudulent actors from receiving public funds now or in the future, but also deterred others from doing the same.

Kevin Feldis, First Assistant United States Attorney, expressed that federal prosecutors are committed to working with their state partners to prosecute those seeking to profit at others expense by defrauding our national health care system. "We all lose when someone commits health care fraud, and we all have a role to play in reporting fraud when we suspect it is occurring."

Mr. Feldis noted that "the vast majority of people who provide health care services are doing it because they care about others, and the vast majority of those receiving Medicaid benefits are being greatly helped, but we must aggressively prosecute those few whose selfish acts of fraud threaten to undermine the entire system." Mr. Feldis also pointed out that "health care fraud costs us all money, in addition to often hurting individuals who do not receive the medical care they

truly need. It is completely appropriate that the state and federal governments are working together here in Alaska, and throughout the country, to stop these crimes."

"The OIG will continue to work with the Medicaid Fraud Control Unit, the U.S. Attorney's Office, and other state and federal law enforcement agencies to bring justice to those who commit Medicaid and Medicare fraud. Putting personal profit and financial gain before patients, as we have seen in these charges, will not be tolerated," stated Chris Schrank the Assistant Special Agent in Charge for the Department of Health and Human Services, Office of Inspector General (OIG). The OIG, in working with the U.S. Attorney's Office, has sent a Special Assistant United States Attorney to the District of Alaska to assist with health care fraud prosecutions.

The Alaska Department of Health and Social Services remains in constant communication with the Medicaid Fraud Control Unit and federal agencies to ensure bad actors are stopped as quickly as possible. "DHSS is proud to be a part of the successful Alaska Medicaid Fraud Control Unit. Together with our agency partners, we work to ensure that the highest percentage of Medicaid dollars provide necessary medical services to Alaskans," said Duane Mayes, director of the Division of Senior and Disabilities Services.

In some circumstances, it's not just the public coffers that are impacted. Medicaid and public assistance fraud result in real harm to the care recipients. For example, Sandy and Maurice Marulanda were both convicted in the spring of 2013 for endangering the welfare of a vulnerable adult. The convictions resulted from the failure by both individuals to care for a Medicaid recipient that suffered from diabetes. The recipient was found to be living in unsanitary conditions and ultimately suffered the loss of two toes due to his diabetes and poor physical condition. The Marulandas billed Medicaid for providing PCA services to the recipient, but in reality, were not providing any care.

The specific charges of fraud being brought this week are detailed below.

Medicaid Fraud

The State and federal investigations into medical assistance fraud were initiated based on referrals from the Department of Health and Social Services into fraudulent Medicaid billing by personal care attendants (PCAs). PCAs are home based health care providers that Medicaid pays to provide services of daily living to Medicaid recipients, which will allow recipients to stay in their home as opposed to an assisted living facility.

According to the charging documents, the State's investigation uncovered a number of fraudulent schemes being committed by PCAs working for eight different agencies that resulted in Medicaid paying for PCA services that were not provided. The alleged schemes included conduct such as billing Medicaid for PCA services while the provider or recipient was traveling out of the country or incarcerated, double billing for services allegedly provided simultaneously, or billing Medicaid while actually working for a private employer at the same time.

The State's charging documents allege that the 28 charged cases resulted in Medicaid paying over $563,000 for fraudulently billed PCA services. As a result of the State and federal charges, DHSS issued a Notice of Immediate Suspension of Medicaid Payments on June 18, 2015. Payment suspensions will remain in effect pending the outcome of the charges levied against each of the PCAs.

Conspiracy to Commit Health Care Fraud

The United States Attorney's Office announced that five Anchorage, Alaska residents, Juana Pascual Soriano 58, Priscilla Morales Jiminez 24, Francisco E Ciriaco Paredes 32, Taunis Soto Jiminez 44, and Julio DeLa Cruz 51, were charged with conspiracy to commit health care fraud. Soriano, Jiminez, Paredes and Jiminez all worked as personal care assistants allegedly providing care to four recipients who were related to DeLa Cruz. DeLa Cruz signed off on many of the timesheets on behalf of the recipients fraudulently attesting that the PCA services were provided at times when either the PCA or recipients were traveling internationally. In total, these five defendants allegedly submitted fraudulent claims for at least $67,000 for PCA services that were not rendered due to knowing misrepresentations.

Public Assistance and PFD Fraud

The Attorney General's Office also announced today that seven individuals were charged with public assistance fraud and permanent dividend fund (PFD) fraud. The charging documents filed allege that the public assistance fraud totaled $84,818 and the PFD fraud involved a Lt. Commander in the United States Coast Guard that falsified his military records in order to qualify for the PFD.

The information filed against each defendant is only a charging document and is not evidence of guilt. A defendant is presumed innocent and is entitled to a trial at which time the government must prove guilt beyond a reasonable doubt.

The following state and federal agencies collaborated on the investigations: the Medicaid Fraud Control Unit; the Department of Health and Social Services; the Department of Revenue Criminal Investigations Unit; the Department of Health and Human Services, Office of Inspector General; the Social Security Administration; the Federal Bureau of Investigation; and Immigration and Customs Enforcement, Homeland Security Investigations.

For more information on the charges announced today please contact: John Skidmore, Criminal Division Director at (907) 269-6379, or Kevin Feldis, First Assistant United States Attorney at (907) 271-3392.

The charges filed by the Medicaid Fraud Control Unit can be found on the MFCU website.

To report fraud, please contact:

- Medicaid
    - 1-907-269-6279

    - Alaska Depatment of Law Medicaid Fraud / Elder Abuse Complaint Form
    - Report Fraud: Office of Inspector General Hotline Operations
- PFD
    - 907-269-0385
    - PFD Fraud Reporting
- Public Assistance
    - 1-800-478-6406

http://www.law.alaska.gov/press/releases/2015/061815-FraudCharges.html

State of Alaska, Department of Law

Press Release

Good Faith Personal Care Attendant and Two Recipients Get Jail Time for Fraudulently Billing Medicaid

May 6, 2015

(Anchorage, AK) – The State of Alaska, Department of Law, Medicaid Fraud Control Unit (MFCU) announced today the successful prosecution of 31 year old Miki Kim for falsely billing Medicaid over $44,000 over a three year period for personal care attendant (PCA) services that she never actually provided.

MFCU investigators initiated an investigation in April 2012 into Medicaid fraud being conducted by employees, management and owners of Good Faith Services, LLC (Good Faith). Since the investigation was initiated, the State has filed criminal charges, civil sanctions, or both on 58 individuals associated with Good Faith, including the corporation, all three owners, both office billers and 10 of 13 client managers. Miki Kim worked for Good Faith as both a client manager and a PCA. As a client manager, Kim was responsible for advocating on behalf of Medicaid recipients to ensure they were receiving necessary services from their PCA.

Kim also worked as a PCA for numerous Medicaid recipients. The recipients informed MFCU investigators that Kim never provided any of the services that she billed Medicaid for providing. Moreover, the investigation revealed that Kim would move the recipients from one agency to another based upon offers of higher wages. This move would result in a disruption of services for the recipients and an opportunity for Kim to increase her fraudulent billing.

Based on the aforementioned evidence, Kim was convicted on May 4, 2015 for one count of Medical Assistance Fraud, a class C felony offense, for knowingly submitting claims to Medicaid with a reckless disregard that she was entitled to the payment. Kim was sentenced to serve 24 months in jail with 15 months suspended (9 months to serve), 10 years of probation and a restitution judgment of $29,000. The balance of restitution due will be ordered as part of the Good Faith sentencing. Kim will be barred from providing Medicaid related services for a minimum of 20 years based upon this judgment.

The MFCU also successfully prosecuted 85 year old Medicaid recipient Santos Vallangca and 72 year old Medicaid recipient Rema Vallangca for knowingly assisting in fraudulently billing Medicaid. The initial investigation into Good Faith revealed that Mr. and Mrs. Vallangca both signed timesheets claiming to have received Medicaid services in Alaska when their PCA was travelling internationally. Follow-up investigations revealed that the couple intentionally downplayed their physical abilities while being assessed by DHSS for PCA services in order to increase the number of hours and services provided. Mr. Vallangca then threatened his PCAs (his

daughter and grandson) with deportation if they refused to submit false bills to Medicaid alleging to be providing care to both he and Mrs. Vallangca. The PCAs were then required to give the money received from Medicaid to Mr. Vallangca. The PCAs admitted that they did not provide the majority of services billed to Medicaid for the Vallangcas and video evidence demonstrated that they did not need the authorized services. Based upon the statements of the defendants, witnesses and video evidence in this case, the total fraud committed by the Vallangcas could go as high as $150,000.

Santos Vallangca was convicted on May 6, 2015 for one count of Medical Assistance Fraud, a class C felony, for knowingly assisting another person in the submission of a false Medicaid claim. He was sentenced to serve 24 months in jail with 22 months suspended, $10,000 in restitution and five years of probation with special conditions prohibiting him from receiving consumer directed PCA services. Rema Vallangca was convicted on May 6, 2015 for one count of Medical Assistance Fraud, a class A misdemeanor, for knowingly assisting another person in the submission of a false Medicaid claim. She was sentenced to serve 180 days in jail with 160 days suspended, $10,000 in restitution (joint and several) and five years of probation with special conditions prohibiting her from receiving consumer directed PCA services. The balance of restitution due will be ordered as part of the Good Faith judgment. Sentencing in the Good Faith case is set for June 30, 2015.

The Alaska MFCU is part of the Attorney General's Office. The MFCU is responsible for investigating and prosecuting Medicaid fraud and abuse, neglect or financial exploitations of patients in any facility that accepts Medicaid funds. Information about the Kim and Vallangca cases filed by the Department of Law can be found on the MFCU website. The Good Faith, Kim and Vallangca cases were jointly investigated by the Alaska MFCU, DHSS, DHSS Agents with the Office of Inspector General, the FBI and Homeland Security Investigations Agents.

CONTACT: Assistant Attorney General Andrew Peterson at 907-269-6292. For more information about these cases or other cases handled by the Alaska MFCU, go to the MFCU website.

We Count on Home Care

Joint Employment

The Department has received questions from stakeholders regarding how the Final Rule may impact consumer-directed, Medicaid-funded programs. The Final Rule modified the "third party employment" regulation to prohibit third party employers of domestic service employees—i.e., employers other than the individuals receiving services or their families or households—from claiming the companionship services exemption from minimum wage and overtime or the live-in domestic service employee exemption from overtime. This regulatory change will require each public entity or private agency that administers or participates in a consumer-directed, Medicaid-funded home care program to evaluate whether it may be a joint employer under the Fair Labor Standards Act (FLSA).

In response to these questions, we have created a new Administrator's Interpretation and an updated fact sheet to help potential joint employers determine their obligations under the Fair Labor Standards Act. The guidance also includes seven detailed hypothetical examples with analyses, based on actual consumer-directed programs.

Fact Sheet #79E: Joint Employment in Domestic Service Employment Under the Fair Labor Standards Act (FLSA)

Administrator's Interpretation
No. 2014-02 »

Maxim Supports Standards for Electric Visit Verification

Electronic Visit Verification or EVV is a telephone and/or computer-based electronic technology used for the purpose of verifying and reporting the delivery of in-home services from the patient's home.

The adoption of an EVV system for a state's home health Medicaid population will improve billing accuracy, reduces gaps in care plans, and strengthens program integrity by reducing incidents of fraud and creating efficiencies for both the state and home care provider. As multi-state provider, operating in 41 states, we are currently implementing EVV services to varying degrees.

Flexibility is the Key

Maxim supports the adoption of a flexible Standards-Based EVV model that accomplishes the state's goals but allows companies that have an existing EVV solution to continue using those systems. We have found that system difficulties and higher administrative costs have occurred when states have adopted a closed – one vendor – model or have mandated a process that will not permit different systems to exchange information seamlessly. Ideally, we would want to continue using our existing systems without having to make significant administrative changes to align with whatever EVV vendor the state settles on.

Maxim recognizes that smaller home care companies may not be using an EVV system today so the state may need to contract with a vendor for those providers. The state is likely to save money if the vendor contract is limited to only smaller companies without an existing EVV and but having the larger providers use their existing system.

Standards for all EVV Systems

Maxim is supportive of EVV standards that all home care providers would be required to meet. A state could adopt such standards and require all home care providers that are using an EVV system to certify that their system meets the standards. To this end, we propose the following:

> *A system that allows verified electronic transactions to be transmitted from an approved EVV system in a standard format and within a timeframe specified by the state to the state's one designated database for the purpose of aggregating electronically verified transaction data from various provider systems.*
>
> *At a minimum, any approved Electronic Visit Verification (EVV) system shall:*
>
> *(a) Record the exact date services are delivered;*
> *(b) Record the exact time the services begin and exact time the services end;*
> *(c) Verify the location from which the services are registered;*
> *(d) Include a mechanism to verify whether their employees are present (e.g., at the beginning and end of a visit) at the location and time where services are to be provided for recipient;*
> *(e) Require a personal identification number unique to each caregiver and, if appropriate, a unique password established by said caregiver;*
> *(f) The system must have a proven biometric or other mechanism for the consumer of services to validate the delivery of service;*
> *(g) Be capable of producing reports of services delivered, tasks performed, recipient identity, beginning and ending times of service and date of service in summary fashion that constitute adequate documentation of service;*
> *(h) The system must be HIPAA compliant;*
> *(i) The system must insure at least daily back-up of all data collected;*

(j) Due to the mission critical nature of such a documentation system, it must demonstrate a viable disaster recovery mechanism allowing for its use within 12 hours of any disruption to services, subject to exceptional circumstances such as war and other disasters of national scope;

Conclusion

Partnering towards an EVV solution that meets the goals of the state as well as large and small home care providers will bring more accountability and efficiency into the Medicaid program; reduce fraud and abuse and saving money for both the state and provider.