IN THE COURT OF COMMON PLEAS
DAUPHIN COUNTY, PENNSYLVANIA

IN RE:	:	**SUPREME COURT OF PENNSYLVANIA**
	:	**98 M.D. MISC. DKT. 2017**
THE FORTY-SECOND STATEWIDE	:	
	:	**DAUPHIN COUNTY COMMON PLEAS**
INVESTIGATING GRAND JURY	:	**NO. CP-22-M.D-1249-2017**
	:	
	:	**NOTICE NOS. 18 AND 19**

ORDER ACCEPTING AND FILING
INVESTIGATING GRAND JURY REPORT NO. 1

AND NOW, this 1st day of March, 2019, upon examination of Investigating Grand Jury Report No. 1 and finding that said report is within the scope of the Grand Jury's authority, properly proposes recommendations for legislative, executive and administrative action in the public interest based upon stated findings, is based upon facts received in the course of an investigation authorized by the Investigating Grand Jury Act, 42 Pa. C.S. § 4541 *et seq.*, and is supported by the preponderance of the evidence, it is hereby **ORDERED:**

1. That Investigating Grand Jury Report No. 1 is accepted by the Court with the direction that the original be filed as a public record with the Court of Common Pleas of Dauphin County.

2. That the Attorney for the Commonwealth deliver copies of the Report to the following:

   A. The Members of the Pennsylvania House of Representatives;

   B. The Members of the Pennsylvania Senate;

   C. The Governor of the Commonwealth of Pennsylvania;

   D. The Secretary of the Department of Human Services for the Commonwealth of Pennsylvania.

BY THE COURT:

The Honorable J. Wesley Oler, Jr.
Supervising Judge
Forty-Second Statewide Investigating Grand Jury

IN THE COURT OF COMMON PLEAS
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IN RE:	:	**SUPREME COURT OF PENNSYLVANIA**
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REPORT NO. 1

We, the members of the Forty-Second Statewide Investigating Grand Jury, duly charged to inquire into offenses against the criminal laws of the Commonwealth of Pennsylvania, have received facts and evidence during the course of an investigation pursuant to Notice of Submission of Investigation Nos. 18 and 19, and have proposed recommendations for legislative, executive, and administrative action in the public interest. So finding, with no fewer than twelve concurring, we do hereby adopt this Report for submission to the Supervising Judge.

[redacted]

Foreperson
The Forty-Second Statewide Investigating Grand Jury

DATED: 1 day of March, 2019

I. INTRODUCTION

We, the members of the Forty-Second Statewide Investigating Grand Jury, requested an investigation into the Pennsylvania Medical Assistance (MA) program after the Pennsylvania Office of Attorney General submitted two independent Medicaid Fraud investigations to us pursuant to Notice of Submission of Investigation Nos. 18 and 19, regarding individuals who were alleged to be fraudulently billing for health care services that were not provided to care-dependent Pennsylvanians. We reviewed evidence in both cases and issued presentments, recommending that criminal charges be filed against those who were allegedly responsible for fraud and abuse within the system.[1] These cases concerned us and prompted us to conduct an investigation into how to identify and prevent fraud occurring within the MA program. During this investigation, we heard testimony from state regulators, law enforcement officials, managed care organizations, and private health care providers about the MA program, its complexities and many subdivisions. The evidence from these witnesses exposed deficiencies within the program. In addition, we heard evidence of specific cases of fraud that illustrate these deficiencies and determined state regulators and law enforcement lack the tools to effectively oversee and investigate fraud within the MA program.

We, the Grand Jury, heard testimony that the goal of the MA program is to protect the health and welfare of individuals while safeguarding state and federal taxpayer funds through effective oversight. Over the last 20 years, the health care system afforded recipients new community-based health services to promote independent living in lieu of traditional residential health care facilities. Specific examples include home nurses, personal care attendants who assist with activities of daily living, and support staff workers who assist those with intellectual disabilities. In addition, MA offers behavioral health services and other community-based treatment options, such as wraparound services, aimed at assisting individuals

[1] We recommended that criminal charges be filed against TH and BM/RP. The cases involving TH and BM/RP are summarized below.

to better adapt in society. We found that these programs are easily manipulated to facilitate fraud because the level of supervision, training, and oversight that existed in traditional residential health care facilities does not exist in community-based settings.

Through the course of our investigation, we identified systemic issues within the MA program that permit the exploitation of care-dependent Pennsylvanians for financial gain and impact the quality of care provided. First, the MA system does not currently require the individual providing services to be identified on the claim submitted for payment. Second, MA claims submitted for payment do not require specific date and time information before payment is made. Third, the individuals providing these services lack the knowledge and training to provide quality care and to properly bill for those services.

These deficiencies create two critical issues for the MA program. First and most importantly, MA recipients may not be receiving the care that they require. Second, fraud compromises the integrity of the MA program, thus limiting resources to continue funding essential health care services.

Due to the tremendous growth and changes in the MA program, we, the Grand Jury, recognize that The Pennsylvania Department of Human Services (DHS) has an overwhelming task to provide quality healthcare for over 2.7 million MA recipients in Pennsylvania[2] while maintaining fiscal accountability. According to the Office of Inspector General, United States Department of Health & Human Services, Pennsylvania's Medicaid expenditures for fiscal year 2017 were $29 billion.[3] Despite DHS' best efforts, the current complexity of the MA program as well as the introduction of MCOs, fiscal intermediaries, and provider agencies has hampered DHS' ability to effectively administer the MA program. Also for fiscal year 2017, The Pennsylvania Office of Attorney General, Medicaid Fraud Control Section (MFCS)

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[2] "Medicaid and CHIP in Pennsylvania." Medicaid.gov: An official website of the United States government. **https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html**.

[3] Office of Inspector General, United States Department of Health & Human Services, Medicaid Fraud Control Units Fiscal Year 2017 Annual Report and Statistical Data; **https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2017-statistical-chart.pdf**.

identified, investigated, and prosecuted criminal fraud totaling $11.6 million.[4] We believe that our recommendations below will assist DHS in carrying out its mission under this new healthcare system and will provide the MFCS with the tools it needs to effectively combat fraud, resulting in increased criminal convictions and recoveries.

II. EXISTING LAWS AND REGULATIONS

The following statutes and regulations are pertinent to the issues addressed in this investigation and are relevant to the Grand Jury's recommendations as outlined in this report.

State Preclusion Provisions - 62 P.S. §1407(c)

(1) If the [Pennsylvania Department of Human Services] determines that a provider has committed any prohibited act or has failed to satisfy any requirement under section 1407(a), it shall have the authority to immediately terminate, upon notice to the provider, the provider agreement and to institute a civil suit against such provider in the court of common pleas for twice the amount of excess benefits or payments plus legal interest from the date the violation or violations occurred. The department shall have the authority to use statistical sampling methods to determine the appropriate amount of restitution due from the provider.

(2) Providers who are terminated from participation in the medical assistance program for any reason shall be prohibited from owning, arranging for, rendering or ordering any service for medical assistance recipients during the period of termination. In addition, such provider may not receive, during the period of termination, reimbursement in the form of direct payments from the department or indirect payments of medical assistance funds in the form of salary, shared fees, contracts, kickbacks or rebates from or through any participating provider.

(3) Notice of any action taken by the department against a provider pursuant to clauses (1) and (2) will be forwarded by the department to the Medicaid Fraud Control Unit of the Department of Justice and to the appropriate licensing board of the Department of State for appropriate action, if any. In addition, the department will forward to the Medicaid Fraud Control Unit of the Department of Justice and the

[4] Id.

appropriate Pennsylvania licensing board of the Department of State any cases of suspected provider fraud.

Federal Exclusion Provisions[5]

1. The United States Department of Health and Human Services, Office of Inspector General (OIG) has the authority to exclude individuals and entities from Federally funded health care programs pursuant to section 1128 of the Social Security Act (Act) (and from Medicare and State health care programs under section 1156 of the Act) and maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals/Entities (LEIE). Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties (CMP).

2. **Mandatory exclusions:** OIG is required by law to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses: Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare, Medicaid, SCHIP, or other State health care programs; patient abuse or neglect; felony convictions for other health care-related fraud, theft, or other financial misconduct; and felony convictions relating to unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

3. **Permissive exclusions:** OIG has discretion to exclude individuals and entities on a number of grounds, including (but not limited to) misdemeanor convictions related to health care fraud other than Medicare or a State health program, fraud in a program (other than a health care program) funded by any Federal, State or local government agency; misdemeanor convictions relating to the unlawful manufacture, distribution, prescription, or dispensing of controlled substances; suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; submission of false or fraudulent claims to a Federal health care program; engaging in unlawful kickback arrangements; defaulting on health education loan or scholarship obligations; and controlling a sanctioned entity as an owner, officer, or managing employee.

[5] The United States Department of Health and Human Services, Office of Inspector General. **https://oig.hhs.gov/exclusions/**.

National Provider Identifier (NPI) - 45 CFR §162.406

The standard unique health identifier for health care providers is the National Provider Identifier (NPI). The NPI is a 10-position numeric identifier, with a check digit in the 10th position, and no intelligence about the health care provider in the number.

(1) The NPI must be used as stated in §162.410, §162.412, and §162.414.

(2) The NPI may be used for any other lawful purpose.

National Provider System - 45 CFR §162.408

The National Provider System (NPS) shall do the following:

(a) Assign a single, unique NPI to a health care provider, provided that—

(1) The NPS may assign an NPI to a subpart of a health care provider in accordance with paragraph (g); and

(2) The Secretary has sufficient information to permit the assignment to be made.

(b) Collect and maintain information about each health care provider that has been assigned an NPI and perform tasks necessary to update that information.

(c) If appropriate, deactivate an NPI upon receipt of appropriate information concerning the dissolution of the health care provider that is an organization, the death of the health care provider who is an individual, or other circumstances justifying deactivation.

(d) If appropriate, reactivate a deactivated NPI upon receipt of appropriate information.

(e) Not assign a deactivated NPI to any other health care provider.

(f) Disseminate NPS information upon approved requests.

(g) Assign an NPI to a subpart of a health care provider on request if the identifying data for the subpart are unique.

Electronic Visit Verification (EVV) System for Personal Care Services and Home Health Care Services - 45 U.S. Code §1396b(l)

Section (1) establishes an escalating reduction in the federal percentage paid to states if states do not require use of an electronic visit verification (EVV) system for personal care services by 2020 and for home health care services by 2023.

Section (5) specifies that the EVV system must include electronic verification of personal care and home health care visits, including:

a. The type of service performed;
b. The individual receiving the service;
c. The date of the service;
d. The location of the service delivery;
e. The individual providing the service;
f. The time the service begins and ends.

III. FINDINGS OF FACT

A. BACKGROUND

As the health care industry evolved in recent years, MA services migrated from residential/nursing home-based services to community-based services, whereby independent contractors and individual employees provide services such as personal care, home nursing, wraparound, and support staff services in the community. This evolution is due primarily to the enactment of the Americans with Disabilities Act of 1990 and the 1999 decision of the United States Supreme Court in *Olmstead v. L.C.*[6]. The Americans with Disabilities Act extended civil rights to people of all ages with disabilities and the United States Supreme Court, in *Olmstead,* established that states must offer services in community-based settings that are appropriate to an individual's needs. Pennsylvania's MA program has greatly increased its variety of services and overall costs since 1999, due to several factors including increased eligibility and an aging population.

DHS is the regulatory authority that oversees the MA program. Prior to the late 1990s, all MA claims submitted by providers were billed directly to DHS[7] and were paid on a fee-for-service basis. All MA providers contracted directly with DHS and were assigned a unique MA provider identification number (MAID). The MAID identified the MA service provider and was required to be included on every

[6] 527 U.S. 581 (1999).

[7] DHS was formerly known as the Department of Public Welfare.

MA claim submitted to DHS for payment. DHS maintains all MA claims data electronically through a system called PROMISe. The MFCS, as a law enforcement and health oversight authority, has access to all MA claims data through PROMISe.

As the MA system migrated from residential/nursing home-based services to community-based services, provider agencies emerged. Provider agencies utilize employees or independent contractors to provide services; however, these individuals do not receive a MAID because they do not contract directly with DHS. Rather, the employee or independent contractor providing the services submits documentation to the provider agency detailing the dates, times, and services rendered to MA recipients. The provider agency then submits a claim to MA, using its MAID, for the services performed by the individual employee or independent contractor. These claims do not identify the individual who directly performed the services or the dates and times when the services were performed. Moreover, there is no systematic way to identify the employees and/or independent contractors for the provider agencies. Although law enforcement can access the Pennsylvania Department of Labor and Industry (L&I) database to determine if individuals providing services are working at one or more provider agencies, many of these individuals are independent contractors rather than employees. As independent contractors, they are not paid wages and thus do not appear in the L&I employment database. The L&I employment records therefore do not reveal where the independent contractors are working.

To complicate matters further, in the late 1990s, DHS contracted with multiple Managed Care Organizations (MCOs) to act as fiscal intermediaries between DHS and the providers/provider agencies. Currently, MCOs oversee the DHS' HealthChoices, Community HealthChoices, and Behavioral HealthChoices programs through which millions of Pennsylvanians receive care. HealthChoices and Community HealthChoices deliver primarily physical health services to MA recipients. Behavioral HealthChoices delivers mental and behavioral health services to MA recipients. MA recipients select their

physical health MCO, but the behavioral health MCO (BHMCO) is determined by the county in which the MA recipient resides. The MCOs contract with the DHS-enrolled MA providers/provider agencies whose employees or independent contractors render the services to the MCOs' recipients. Under this system, the providers/provider agencies submit the MA claims directly to the MCO with whom the recipient is enrolled. That MCO pays the provider/provider agency for the services, who in turn pays its employees/independent contractors who performed the services. Again, the MA claims submitted to the MCOs do not identify the individual who directly performed the services or dates and times when the services were performed. This information is retained by the provider agency.

Under their contract with DHS, the MCOs are responsible for preventing fraud within their enrolled provider and recipient network. However, because DHS and its contracted MCOs do not receive the supporting paperwork that forms the basis of the MA claims, they must conduct audits of the provider agency in order to ensure fiscal accountability. The audits are often incomplete because the information includes only providers and provider agencies within their network and recipients enrolled with their MCO. Providers/provider agencies can be enrolled with multiple MCOs. Additionally, employees and independent contractors can provide services through multiple provider agencies. For example, an independent contractor Behavioral Specialist Consultant (BSC) can contract with three provider agencies that provide wraparound services to MA recipients. A BSC could provide services to three MA recipients who are living in three different counties and are enrolled with three different BHMCOs. After providing the services, the BSC submits documentation to the provider agency servicing that particular recipient, which could be any one of the three provider agencies. Each provider agency submits MA claims to the particular recipient's BHMCO. Without conducting provider agency audits of each of the three agencies, the BHMCOs cannot identify the individuals who provided the BSC services to its recipients and thereby cannot detect potentially overlapping billing. Further, each BHMCO's audit of its own provider agencies

will not identify overlapping billing with the other BHMCO's provider agencies. As a direct result, a BSC is able to defraud multiple BHMCOs without detection.

Distinct from the MCO delivery of services, DHS also contracts with different fiscal intermediaries who process claims for "consumer model" services. Under the consumer model, MA recipients hire whomever they choose to provide the authorized services, such as attendant care and support services. A surrogate, such as a family member or close friend, can be selected to make those choices in the event the recipient is incapable of doing so. The MA recipient or surrogate is the employer and is responsible for training and ongoing supervision of the approved services. The individual providing services submits documentation to the fiscal intermediary detailing the dates, times, and services provided. In turn, the fiscal intermediary submits the claim either to DHS or the MCO under the fiscal intermediary's provider number. Again, the claims submitted to MA do not identify the actual individuals who are providing the services, nor do the claims detail the start and end times of the services.

B. GRAND JURY PRESENTMENTS

We, the Grand Jury, initiated this investigation into systemic fraud within the MA program after issuing presentments in two Medicaid Fraud cases. The first case involved a paraplegic young man whose mother, TH, was hired by a home health provider agency to provide personal care services to him. TH fraudulently reported to the provider agency that she performed services during dates and times when she could not have done so, because her son was in a hospital or was at work. The provider agency submitted claims to MA without the specific dates and times that TH reported providing services for her son, since those details were not required under the existing system. Oversight authorities therefore had to obtain specific records from the provider agency to prove TH's fraudulent billing. If the MA claims for personal care services contained the specific dates and times, DHS could have identified the overlapping services and prevented payment of these fraudulent claims through pre-payment programmatic edits.

The second case involved a young man, LW, who was diagnosed with autism. Due to his aggressive outbursts, LW was voluntarily removed from his home and transferred to a MA provider-run residential facility. While at the facility, LW received treatment for his mental health conditions and 24-hour supervision and care from trained staff. LW was also authorized to receive support services to assist him in safely interacting within the community. LW's mother, BM, served as LW's surrogate and directed his community-based support services. BM hired her friend, RP, to provide support services for LW and conspired with her to defraud the MA program. To facilitate the fraudulent billing, BM requested that RP pre-sign timesheets and progress notes, which BM then completed and submitted for MA reimbursement through the fiscal intermediary. RP was paid for services that she never provided and split the proceeds with BM. If RP had received standardized training specific to community support services, she would have been aware of the billing requirements and she would not have been able to claim ignorance of her responsibilities. Not only did BM and RP defraud the MA program, but they also deprived LW of the community interaction he needed. Because he was deprived of necessary community interaction, he regressed in treatment.

C. CASE EXAMPLES

As set forth more fully below, we also heard testimony about several Medicaid Fraud investigations that highlight systemic issues within the MA program.

Unlicensed psychiatrist prescribing controlled substances and treating MA recipients

The first case example involved Dr. H, a Pennsylvania psychiatrist, who was convicted of Medicaid Fraud and violating the Controlled Substance, Drug, Device and Cosmetic Act for providing psychiatric services and prescribing controlled substances to MA recipients during a time when he was not licensed. Dr. H worked for three provider agencies, rendering services to hundreds of MA recipients. The recipients were enrolled with two separate BHMCOs. Although Dr. H had an assigned National

Provider Identifier (NPI) number, the MA claims submitted to the BHMCOs did not identify Dr. H as the individual who performed the service. Rather, the claims only identified the provider agencies. As such, the BHMCOs, DHS, and the MFCS could not detect that Dr. H was being paid for MA services while unlicensed. Additionally, because Dr. H was an independent contractor rather than an employee, MFCS agents were unable to use L&I employment records to determine where Dr. H was working. Fortuitously, Dr. H testified truthfully before a statewide investigating grand jury that he had contracted with two other provider agencies. The MFCS used this information to obtain grand jury subpoenas for records from these agencies. After reviewing over 25 boxes of documents received in response to these subpoenas, the MFCS was able determine the dates, times, and recipients Dr. H allegedly treated when he was not licensed. If the MA provider agencies had been required to identify on all claims the actual individual who provided the services, the BHMCOs and/or DHS could have detected Dr. H's fraudulent claims earlier, possibly prior to payment being issued, and the MFCS could have more efficiently completed its investigation.

Prison social worker billing for unrendered personal care services for father and unrendered support services for mentally challenged man

ME was convicted of defrauding the MA program of $31,000.00 while ME was simultaneously employed as: 1) a personal care attendant for WE, her MA recipient father; 2) a support staff worker for JD, a mentally-challenged MA recipient; and 3) a social worker in a local prison. The investigation was initiated after a relative complained that JD was not receiving services. Although JD had the mental capacity of a child, he was tasked with the responsibility of training ME and directing his own services. In this case, the MFCS was unable to establish that JD trained ME on how to provide services appropriately. Had ME been required to undergo standardized training, ME could not have denied knowledge of appropriate treatment and billing requirements. Using L&I employment records, MFCS agents determined that ME was also working for WE and at the prison. After obtaining and comparing records from ME's three employers, the MFCS established that ME reported providing services to both

MA recipients during times when she was working at the prison, providing services to both recipients during overlapping times, and providing services to her father after his death. DHS was unable to detect this fraud because the MA claims did not identify ME as the individual providing the services and did not specify the dates and times the services were allegedly rendered. Rather, the MA claims identified only the provider agencies and the number of units of service. The MFCS was able to establish that ME did not provide the necessary services to WE and JD when she was working at the prison, but only after obtaining and comparing employment records from ME's three employers. Had there been a requirement that MA claims identify that ME provided the service and the specific dates and times when services were purportedly rendered, DHS would have been able to identify ME's fraud across the different MA programs earlier. In addition, DHS could have prevented some of the fraudulent payments through the use of pre-payment edits and quickly taken steps to assure that WE and JD received future services from a different provider.

Licensed behavioral health worker billing for services not rendered to children

The MFCS garnered the conviction of LB, a licensed BSC, for over $211,000.00 in Medicaid Fraud for her failure to provide necessary therapy for children. LB provided BSC services through three behavioral health agencies during times when she was also employed as a substitute Special Education teacher at a local school district. LB submitted timesheets to all three agencies indicating that she was providing services which overlapped with each other and/or with her work as a teacher. This meant that LB was not providing essential services for at least one child at any given time. Because the claims submitted by the agencies did not identify LB as the individual providing the services, or the dates and times when LB reported providing the services, the BHMCO was unaware of LB's employment with multiple provider agencies and her failure to provide services. The fraud was discovered after a particular BHMCO required all of its provider agencies to submit a list of licensed BSCs and their caseloads. While

reviewing these reports, this BHMCO discovered that LB had a large caseload and was affiliated with multiple agencies within its network. The BHMCO obtained a sampling of documentation LB had submitted to the provider agencies that showed the actual dates, times, and clients for whom LB reported providing services. Once the BHMCO determined that LB was submitting documentation for overlapping dates and times, the BHMCO reported the allegations to DHS and the MFCS. Following a lengthy investigation conducted with the resources of a statewide investigating grand jury, the MFCS determined that LB was also working at the school and the substantial fraud was discovered. Had there been a mandate that MA claims identify LB as the individual providing the services, as well as the specific dates and times of the services, the BHMCO would have been able to detect LB's fraud more quickly, preventing $211,000.00 in fraudulent payments and ensuring the recipients received the services they needed.

Mother using MA funded workers for household chores rather than care for daughter who was diagnosed with autism

MC was convicted of $100,000.00 in Medicaid Fraud where she was the surrogate for her daughter (MCd) who was diagnosed with autism. MCd's severe disabilities required that she have two workers present at most times. MCd also was receiving wraparound services through a provider agency and in-home schooling. As the surrogate, MC was responsible for overseeing MCd's consumer model support services, and, as such, hired and trained MCd's caregivers. MC's fraud was discovered after one of the former support staff workers called various agencies to report the inappropriate services she was asked to provide. An investigation by a statewide investigating grand jury revealed that MC altered timesheets and directed the workers to provide unauthorized services such as painting the house, feeding the dog, and running household errands, rather than providing the care that MCd needed. MC kept a binder with a checklist of different household duties, trained the workers to go through the checklist each day, and instructed them to perform tasks wholly unrelated to MCd's care. In addition, MC fabricated documents by having workers sign blank timesheets at the start of their employment and then used these timesheets

to falsely report that her husband and son provided services for MCd. MC had the workers "sign in" on a spreadsheet in her computer, which the workers believed to be the proper way to report their services. Since MC was responsible for training these individuals as their "employer" and DHS had no standardized training module, the workers were unaware of how to properly document the services they provided. With standardized training, the workers would have known that the tasks MC was requiring the workers to perform, such as painting the house, were not authorized services. Additionally, through standardized training, the workers would have been informed about how and where to report these violations.

Personal care attendant billing two agencies for services on same dates and times

The MFCS secured a conviction of SH, a personal care attendant, after she claimed to be providing services to two MA recipients on the same dates and during the same time periods. SH provided services to one recipient through a provider agency, while the other recipient hired SH through the consumer model. Since the claims did not identify SH as the individual providing the services and did not specify the dates and times SH allegedly performed services, MA oversight authorities did not know that SH was fraudulently claiming to be providing services to both recipients at different locations simultaneously. Had there been a requirement that all MA claims identify the individual providing the services as well as the specific dates and times, DHS would have been able to prevent payment of the fraudulent claims through use of a pre-payment edit. Moreover, if SH had been appropriately trained, oversight authorities could more readily hold her accountable for her fraudulent billing. Without standardized training, however, SH could easily allege that she received conflicting information from the provider agency and consumer model programs, thereby complicating prosecution for her fraudulent activity.

Mother and daughter billing for services not provided to numerous recipients across various MA programs

SW and her mother, BW, were convicted of conspiring to defraud the MA program of over $45,000.00. SW was a mental health worker providing services to numerous MA recipients through four

different behavioral health provider agencies. Only through a search of L&I employment records was the MFCS able to discover that SW also worked as a personal care attendant for her grandmother, DM, during the same time period. After the MFCS obtained and compared the date and time documentation that SW had submitted to the five different provider agencies, the MFCS determined that she had reported providing mental health services to more than one recipient at the same time and also providing mental health services at the same time as personal care services for DM. The MFCS further determined that SW and BW, DM's surrogate, conspired to submit fraudulent time records for personal care services while DM was hospitalized and in a long-term-care facility. This case underscores the importance of uniformly implementing the unique provider identifier and billing specificity recommendations across all MA programs in order to effectively identify and prevent multi-faceted fraud. Again, had there been a requirement that all MA claims identify the individual providing the service as well as the specific dates and times of services rendered, DHS would have been able to detect the fraud SW was committing across different DHS programs more quickly. Additionally, recipients would have received the services that they needed and the amount of fraudulent payments would have been minimized. As referenced in prior cases, the date and time requirement on all MA claims would have allowed MA, through pre-payment edits, to quickly discover that DM was hospitalized and deny payment for the personal care services that could not have been provided.

D. DEFICIENCIES IDENTIFIED

These Medicaid Fraud case examples highlight three primary issues. First, those responsible for oversight currently do not have effective ways to identify the individuals actually providing services to MA recipients. In contrast to previous years when those providing services to MA recipients had MAIDs which were listed on all claims to the MA program, most MA services are currently provided by individuals who are not enrolled providers and whose identities are not contained on MA claims. DHS,

MCOs, and law enforcement are unable to determine whether an individual is working for multiple provider agencies by reviewing claims data or searching the L&I employment database. Furthermore, when MA claims fail to identify the actual provider of services, it is impossible to detect, through a review of claims, if claims should be denied because these individuals were excluded from providing MA services by the federal and/or state governments.

Second, the MA program does not require claims to identify the specific dates and times when services were performed. The absence of daily start and end times on claims prevents the efficient detection of fraud. DHS analysts, MCO investigators, and law enforcement must request documentation from provider agencies and review voluminous records in order to properly investigate allegations of fraud. This process requires oversight authorities to open a case, assign investigators, and potentially utilize the resources of an investigating grand jury to compel the production of documents. If dates, as well as start and end times, are required on all MA claims, oversight authorities would be able to more efficiently investigate Medicaid Fraud. Moreover, DHS and MCOs could implement pre-payment reviews/edits for billed services with overlapping dates and times, and reject fraudulent claims.

Third, individuals providing services do not receive standardized training on proper care, critical incident/fraud reporting, or appropriate billing practices. The lack of standardized training endangers vulnerable recipients and inhibits state regulators and law enforcement in proving fraud within the MA program. Certain MCOs and provider agencies have created their own training modules. One fiscal intermediary is currently mandating training for consumer model personal care attendant services and has sought to standardize that training throughout the Commonwealth. However, standardized training is not being mandated for other types of MA services. The failure to mandate standardized training for individuals providing services results in incomplete, inaccurate, or conflicting information. Without clear and consistent training programs, MA regulators and law enforcement are often unable to prove that

individuals providing services were on notice as to their responsibilities and the program requirements. This makes it difficult to establish knowledge of treatment and billing responsibilities and impedes efforts to hold individuals accountable for their fraudulent acts.

The issues outlined above also complicate investigations where provider agencies are implicated in MA fraud. Provider agencies bill for large amounts of services and receive substantial reimbursement. As such, fraudulent provider agencies can potentially steal from the MA program and deprive many recipients of necessary care. Fraudulent provider agencies can exploit the same billing gaps outlined above for large-scale fraud. Importantly, supporting documentation is retained only by provider agencies, making it difficult to investigate allegations of fraud. A request for records alerts those agencies to the investigation and can lead to the destruction and/or falsification of supporting documentation. By requiring that provider agencies include the unique identifier and dates and times of all services on each MA claim, oversight authorities would have immediate access to information necessary to prove provider fraud. Additionally, the lack of standardized training for all individuals providing the services allows agencies to allege that individuals providing those services were mistaken and/or solely responsible for the fraud. With standardized training, provider agencies that are committing fraud could not escape culpability by pointing the finger solely at the individuals directly providing services.

E. WAYS TO ADDRESS THE DEFICIENCIES

State Provider Identifier – "SPI"

We, the Grand Jury, recommend the creation of a unique identification system to identify all individuals providing services within the MA program and that the individuals who are providing services be specified on all MA claims submitted for payment. We recommend that this system, called a "State Provider Identification" (SPI), be legislatively mandated so as to guarantee uniform implementation throughout the Commonwealth. The regulatory and law enforcement officials tasked with overseeing the

MA program would then immediately know the identity of the individual responsible for rendering those services. As highlighted in the MFCS case examples, oversight authorities could then efficiently investigate fraud when individuals work for more than one MA provider agency. The MFCS would not have to burden provider agencies with requests for documents merely to identify the individuals who provided services for MA recipients; this information would be contained in the claims data. DHS and MCOs would be able to program analytical "edits" in their systems to conduct regular pre-payment reviews of the electronic MA claims to prevent payment for fraudulent overlapping billing. Further, the SPI could link to the Pennsylvania Department of State (DOS) licensure registry and state and federal health care exclusionary registries to confirm eligibility. Those individuals providing the services who currently have an NPI would not have to register for an SPI, but could instead input their unique NPI numbers on their MA claims. To differentiate NPIs and SPIs, we recommend a unique identifier[8] such that NPI and SPI numbers would never overlap. Ultimately, through this recommendation, we aim to have all MA claims identify the individuals who perform MA services using their unique NPI/SPI identifier.

Date and Time Billing Requirements

We, the Grand Jury, also recommend a legislative mandate that all MA claims include the specific date as well as start and end times of all services rendered. Date and time-specific information is already contained on MA hospital claims, including the dates and times of admission and discharge. It is recommended that similar date and time specificity be required on all claims submitted to the MA program. With this additional information contained on all claims, DHS and MCOs could program edits and run queries to detect and prevent fraudulent billing. DHS and law enforcement officials tasked with investigating Medicaid Fraud would also have immediate access to specific dates and times for which services were reported and could analyze claim data to efficiently prove instances of overlapping billing.

[8] Such as PASPI-#####.

Lastly, when investigating fraud committed by provider agencies, authorities would be able to identify dates and times by reviewing claims data without requesting documentation from the target agencies alerting them of an investigation. This would prevent target agencies from falsifying or destroying incriminating documents.

The MFCS would have identified the fraud in LB's case much more quickly if it had immediate electronic access to the date and time information on all claims. In particular, the MFCS would not have needed to request an extraordinary amount of documentation from the three provider agencies and school districts involved. The MFCS would not have had to review every page of that information and compare the documents from each agency and school to chart the dates, start and end times, agencies, and recipients for whom LB reported providing services. The MFCS would not have had to then chart the overlaps between those sources to determine the total amount of LB's fraud.

Moreover, with date and time billing information required on all claims, DHS and MCOs would be able to perform pre-payment reviews and deny claims that fraudulently overlapped with each other. These programmatic edits would prevent payment for fraudulent claims when a MA recipient is hospitalized, as in the cases of TH and SW/BW.

Standardized Training

Lastly, we, the Grand Jury, recommend that standardized training for all individuals providing MA services be legislatively mandated. Untrained persons endanger care-dependent Pennsylvanians, and those who do not understand their billing obligations can compromise the integrity of the MA program. Requiring standardized training prior to services being provided ensures quality care for recipients and defines expectations for proper billing.

We recommend that all individuals be required, at the time of application for an SPI, to enroll in training for their specific provider type (*i.e.* personal care, home nursing, wraparound, and support staff

services.) We recommend that these standardized training modules explain the appropriate types and levels of care specific to the service being rendered. This training should explain appropriate standards of care and common issues workers might encounter when providing those services. In addition, the training should detail the proper manner in which individuals providing MA services can alert authorities to report immediate threats to the health, safety, or welfare of MA recipients or fraud within the MA program. Furthermore, the training should include instruction on billing requirements and include the types of services that can properly be claimed for reimbursement for that position. The training should detail the types of services that cannot be claimed for reimbursement and provide examples of scenarios where a recipient would be ineligible to receive those services. It should also explain the documentation that is required for reimbursement.

A lack of standardized training impacted some of the case examples presented to this Grand Jury. In the case of ME, MA recipient JD was responsible for training ME even though he had the mental capacity of a child. There was no standardized training, and the MFCS was unable to prove JD trained ME on how to provide services appropriately. ME could not have feigned ignorance of appropriate treatment and billing requirements had she been required to undergo a standardized training program. Similarly, had there been standardized training for the individuals providing services to MC's daughter, they would have known they were not authorized to perform services such as painting the house and other tasks that did not directly relate to her care. In addition, they would have known that the actual dates, as well as start and end times, had to be reported on their timesheets. Standardized training about the appropriate services and proper time reporting would have ensured that quality care was provided.

F. IMPLEMENTATION OF THESE RECOMMENDATIONS IN OTHER SETTINGS

Unique identifiers, specific billing requirements, and standardized training modules are successfully utilized in other settings to identify individuals providing services and to detect fraud. We,

the Grand Jury, heard testimony that the federal government is mandating Electronic Visit Verification (EVV) for all states. The EVV system tracks not only the individual providing the service, but also the type of services performed, the individual receiving the service, the date of the service, the location of the service, and the time the service begins and ends. However, this federal requirement extends only to personal care and home health care services and does not require the data to be submitted on claims. In Ohio, the state's regulatory agency has already implemented the EVV system. Ohio regulators and law enforcement shared that this system successfully and quickly assists in identifying fraud. We also heard testimony that in Washington, D.C., all personal care assistants are required to enroll directly with the D.C. Medicaid program in order to be reimbursed for their services. This enrollment, which started in April 2018, requires that all home health aides obtain an NPI for unique identified billing and that the NPI must be submitted on all claims. The D.C. Medicaid program also requires that all personal care and home health providers receive standardized training that certifies them to appropriately perform services.

We note that aspects of these recommendations have already been implemented in Pennsylvania. We heard testimony that DHS' billing system already includes fields for MA hospital claims so that a unique identifier for the "Billing Provider," "Rendering Provider," and "Attending Physician," as well as date and time specific information for the dates and times of admission and discharge, can be entered. Therefore, it is possible for DHS to expand the specificity requirements to all claims submitted for all MA recipients. Furthermore, DHS is beginning to implement an EVV system in connection with some MA waivers, proving that the use of standardized identifiers can be achieved elsewhere within MA programs. Without a mandate that MA claims contain fields for the individual providing services to MA recipients as well as the dates and times services are provided, the EVV detailed information will remain with the provider agencies and will allow all of the issues outlined above to continue to exist.

IV. RECOMMENDATIONS

To protect vulnerable Pennsylvanians receiving MA services, safeguard public funds, and provide DHS and its contractors with the tools to curtail and prevent fraud, we, the Grand Jury, make the following recommendations:

A. The Legislature should enact a statute mandating that any individual seeking to provide services paid for, in whole or in part, with MA funds who does not have a NPI be required to register with the Commonwealth of Pennsylvania and obtain a SPI prior to the performance of said services. The legislation should mandate that every claim for MA services identify the actual individual providing the services by requiring that the providing individual's NPI or SPI be placed on every claim.

B. The Legislature should enact a statute mandating that every claim for MA services document every date that a service was provided as well as the start and end times for each date of service.

C. The Legislature should require that DHS establish and mandate standardized training for all persons providing services utilizing SPI. The standardized training should be specific to the type of services being provided and focus on the required level of care the recipient is to receive and what services are appropriately billable under that program. The training should also provide information on how to contact Protective Services and where to report fraud within the MA program. The standardized training for each specific type of service ~~should~~ must be completed prior to providing services.

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF HUMAN SERVICES

March 26, 2019

The Honorable J. Wesley Oler, Jr.
Supervising Judge
The Forty-Second Statewide Investigating Grand Jury
County of Cumberland, Pennsylvania
1 Courthouse Square
Carlisle, Pennsylvania 17013

RE: Order Accepting Investigating Grand Jury Report No. 1 and Directing Further Action; Response of Teresa D. Miller, Secretary, Commonwealth of Pennsylvania, Department of Human Services.

Dear Supervising Judge Oler, Jr.:

This letter is submitted in response to Report No. 1 of the Forty-Second Statewide Investigating Grand Jury (the "Report").

According to the Report, the Grand Jury requested an investigation into the Pennsylvania Medical Assistance program ("MA" or "Medicaid") after the Pennsylvania Office of Attorney General ("OAG") submitted two independent MA fraud investigations involving fraudulent billing for health care services that were not provided to care-dependent Pennsylvanians. The Grand Jury recommended that criminal charges be filed in the two cases, and the cases prompted an investigation into how to identify and prevent fraud occurring in the MA program. The Report provides findings and recommendations, and the Court directed limited disclosure of the Report to the Secretary of the Department of Human Services ("DHS"), her Designee, and DHS counsel to permit the filing of a response. I appreciate this opportunity to provide a response and additional information to help inform and clarify the issues raised in the Report.

The issue of program integrity and fraud prevention is of paramount importance to DHS, and we maintain and are implementing comprehensive policies and procedures to prevent and address such issues when they are discovered. We appreciate and welcome the Report's recommendations and will strive to implement workable policies and procedures to reduce fraudulent conduct and prevent the depletion of limited resources.

Introduction

The Report contains a variety of findings, conclusions, and recommendations related to the MA program, including the delivery of services and claim payment process in home and community-based settings. DHS believes additional background information will help clarify some of the findings and factual foundation relied upon by the Grand Jury in reaching its conclusions and recommendations. Please note that this is not a comprehensive description of MA program services and structures but, rather, is intended to respond to certain findings and conclusions. I would be happy to provide any further information or clarifications upon request.

Background and Discussion

Overview

DHS administers and oversees a wide variety of health care and health care-related benefits to Pennsylvania residents who are eligible on a financial or categorical basis and in need of assistance. Available benefits include health care coverage provided through state-based programs and the MA program, which is jointly funded by the state and federal governments. The MA program uses fee-for-service and managed care structures to ensure delivery of necessary services to eligible individuals by qualified providers. The MA program offers many benefits related to physical and behavioral health care and other home and community-based service options that help individuals live in the community rather than more restrictive settings.

Home and community-based services have a longstanding history in Pennsylvania and have been used as an alternative to services delivered in traditional institutional (residential) health care facilities for over three decades to help individuals live productive lives in their communities. For example, home and community services for the long-term care population were legislatively authorized in 1986 and implemented in 1987 through a state-funded program, the Attendant Care Services Act, 62. P.S. § 3051 et seq., otherwise known as Act 150. The first Medicaid-funded home and community-based program began in 1996 with the OBRA Waiver. This federal waiver of Medicaid requirements allowed the state to cover and receive federal funding for home and community-based long-term care services for the elderly and those with disabilities who are at risk of institutionalized care.

The Report correctly notes that the MA program has grown over time, with expenditures of approximately $29 billion in fiscal year 2017. Pennsylvania, however, is not unique in this regard as the size and scope of Medicaid (including the development of new benefits, methods of service delivery and payment mechanisms) in much of the country has expanded over time. For example, from Fiscal Year (FY) 2010 to FY 2017, total nationwide Medicaid expenditures went from $397 billion to $596 billion. See, https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

The MA program provides health care and related services to approximately 2.9 million participants, enrolls tens of thousands of health care providers and processes millions of claims for payment every year. Although the task of monitoring the MA program may seem overwhelming, the amount of fraudulent activity in the program is relatively small compared to the total expenditures, number of participants covered and enrolled providers. For example, the statistic cited in the Report indicates that the OAG Medicaid Fraud Control Section prosecuted criminal fraud totaling $11.6 million, or about 0.04 percent, out of total MA program expenditures of $29 billion in Fiscal Year 2017.

Program integrity efforts are an integral part of the MA program, both internally at DHS and externally at the MCO level. At DHS these efforts include, but are not limited to, investigation of complaints, referrals and "tips" from DHS staff, MCOs and the public, claims editing to prevent payment of non-compensable claims, retrospective reviews of MA claims (fee-for-service and MCO claims), data-mining of paid claims to determine any suspect patterns or outliers, prior authorization, and pre-payment review of claims. DHS often refers cases of suspected fraud or abuse to the OAG for investigation, potential criminal prosecution and recovery of funds. DHS actively cooperates with the OAG in pursuing these matters.

MCOs independently maintain program integrity mechanisms that perform similar functions. Pursuant to federal law and their agreement with DHS, MCOs must establish a Fraud, Waste and Abuse Unit comprised of experienced Fraud, Waste and Abuse reviewers as required in 42 CFR §438.608(a)(1)(vii). This Unit must have the primary purpose of preventing, detecting, investigating, referring, and reporting suspected Fraud, Waste and Abuse that may be committed by Network Providers, Members, Caregivers, Employees, or other third parties with whom the MCO contracts.

DHS's program integrity efforts resulted in cost avoidance and recoveries of $681 million in Fiscal Year 2017-18, and a total of $2 billion since 2015. Through cost avoidance, DHS either prevents inappropriate payments from occurring in the first place or leverages other insurance sources before MA is billed. Recoveries involve recouping monies that were paid. For example, DHS retroactively reviews paid MA claims and recoups money from providers if services were inappropriately coded or the individual had other insurance that should have been billed before MA.

The vast majority of services and claims are appropriately provided. Nevertheless, the existence of any fraudulent activity is unacceptable, and DHS will continue to act independently and in cooperation with other entities to reduce the incidence and costs of fraudulent conduct.

Service Providers and Payment Structures

MA health care and related services are delivered through a variety of provider types; these include provider agencies, which have existed for many decades. For example, long term care provider agencies serve private-pay populations in home and community-based environments and have supported state or Medicaid-funded services since 1987. Other provider types include home health and home care providers (licensed by the Department of Health), and behavioral service providers (licensed by the DHS mental health office).

All certified or licensed providers must be enrolled and screened by the MA program to permit them to serve MA beneficiaries and receive Medicaid payment. See, 42 C.F.R. § 455.400 et seq.; Section 6401(b) of the Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152). Providers who enroll in the MA program receive a unique identification number, contained within a Master Provider Index ("MPI"). As a condition of enrollment, providers must comply with all applicable state and federal statutes and regulations and policies that pertain to the MA program. Further, providers agree to maintain supporting documentation and furnish any information related to claims payments. This applies to all Medicaid providers, including home care agencies that provide home and community-based services. If they fail to do so, they may be subjected to civil and criminal penalties, and may be banned from providing services to MA participants.

Enrolled providers may receive Medicaid payments directly from the MA program on a fee-for-service basis and may also contract with one or more Managed Care Organizations ("MCOs") that deliver physical, behavioral health and, recently, long-term care service and support benefits. Community HealthChoices ("CHC") is the name of the DHS managed care program for long-term care services for individuals age 21 and over, approximately 94% of whom are dually eligible for Medicare and Medicaid (and who receive most physical care services paid by Medicare). CHC implementation started on January 1, 2018 and will not be fully implemented statewide until January 1, 2020.

In contrast to the "agency" model of long-term care, individuals who are eligible to receive approved MA long term care services and supports may choose to direct their own care under a "consumer" model. Under the consumer model the participant, or their surrogate or personal representative, hires direct care workers and is responsible for training and the ongoing supervision of approved services. A surrogate, or personal representative, is a legal guardian or other legally appointed personal representative, an income payee, a family member, or friend. They must fulfill the responsibilities set forth in a personal representative agreement, must demonstrate a strong personal commitment to the participant, assist in getting backup services if a worker is absent, and cannot be a paid support service worker for the participant. DHS contracts with fiscal intermediaries to process claims under the consumer model. In addition, consumer model direct care workers undergo a pre-service orientation overseen by the DHS financial management services vendor, which educates workers on how to submit timesheets used for claims submissions and educates workers on fraud and abuse issues.

Factual Findings

The Report contains several statements and factual findings based on the investigation of eight case examples of alleged fraudulent conduct. DHS agrees that the allegations cited in the case examples are worthy of serious consideration to improve the MA program. However, it is important to clarify certain statements contained in the Report.

The Report on page 2 states that programs are "easily manipulated to facilitate fraud because the level of supervision, training, and oversight that existed in traditional residential health care facilities does not exist in community-based settings." Fraud detection in community settings generally follows fraud detection procedures within facilities. All providers are encouraged to report fraudulent activity. Also, providers are required to maintain detailed service records and providers are subject to audits by DHS, the Office of State Inspector General, and the Office of the Attorney General to identify potential fraud with corrective actions taken when appropriate.

Page 2 of the Report also identifies "systemic issues within the MA program" that permit fraud and impact care. First, "the MA system does not currently require the individual providing services to be identified on the claim submitted for payment." This is not accurate in all circumstances. For example, some services, such as therapeutic services paid through long-term care waivers do include identification of individual practitioners on claims.

Second, "MA claims submitted for payment do not require specific date and time information before payment is made." Dates of service are submitted on all claims. Start and end times are not. However, the Report correctly notes that Electronic Visit Verification ("EVV") for personal care and home health care services is required by federal law. DHS is in the process of implementing EVV and implementation will be completed by January 1, 2020 for personal care services, and by January 1, 2023 for home health care services.

Third, "the individuals providing these services lack the knowledge and training to provide quality care and to properly bill for those services." Training on billing requirements and fraud and abuse are both part of the provider enrollment process for long term care providers, and Office of Developmental Programs ("ODP") waiver providers receive pre-enrollment training consistent with waiver and/or regulatory requirements contained in 55 Pa. Code Chapters 51 and the pending requirements of Chapter 6100. Also, for example, those providing personal assistance services in the consumer model receive pre-service orientation from the DHS financial services vendor.

Case Examples, Deficiencies, and Recommendations

The Report details two Medicaid fraud cases that were submitted to the Grand Jury by the OAG, that eventually resulted in the recommendation to file criminal charges against alleged perpetrators of health care fraud and further investigation into how to identify MA program fraud. The Report cites six (6) case examples of Medicaid fraud investigations that highlight systemic issues in the Medicaid program.

The cited case examples resulted in the identification of three (3) deficiencies. First, those responsible for oversight do not have effective ways to identify the individuals who provide services to MA participants. Second, the MA program does not require claims to identify the specific dates and times services were performed. Third, individuals who provide services do not receive standardized training on proper care, critical incident/fraud reporting, or appropriate billing practices.

To correct these deficiencies, the Report recommended that legislation mandate the creation of a unique identification system for all individuals providing MA services and that this identifier be used on all MA claims, that all MA claims include the specific dates and start/end times of services, and that standardized training be provided for all individuals who provide MA services.

First, all currently enrolled providers are given a unique identification number, or MPI. This is in addition to any other identifying information, such as a Board or agency licensure information. Enrolled providers are required to maintain all records of service delivery, with each record including the individual who rendered the service, and the date and time of the service, and they are subject to audit at any time.

It is correct that DHS billing systems for hospitals include unique identifiers that track the Report's billing recommendations and expansion is theoretically possible.

However, any effort to do so must consider the costs of systems modifications, the complexity of service provision, and administrative burdens on providers. Complicating factors can exist for many service types, including multiple staff simultaneously providing service, staff supervisors that may or may not provide direct service during shifts, and clinical staff providing administrative reviews. For example, in some ODP residential environments, as many as four (4) participants may receive services simultaneously from four (4) to five (5) staff who may consist of licensed nurses, staff supervisors or program specialists, and direct support professionals. The same residential agency may use an administrative nurse to conduct medication reviews for multiple locations and participants across the agency. Changing system structures has the potential to adversely impact providers and the quality of care they deliver to participants.

Second, the Report correctly notes that the pending EVV implementation will track the individual providing the service, the service location and date, and starting and ending times, which will successfully and quickly assist in identifying potential fraud in the primary areas of exposure for DHS: personal care and home health services. These areas have been specifically targeted by federal authorities and will be addressed by EVV, and it will permit extensive and efficient auditing. Further, this will apply to all direct care workers regardless of service model, would permit identification of duplicate submissions, and could be used to prevent Medicaid payment.

Lastly, with respect to the training recommendations, a variety of training requirements are already in place. In the long-term living area, direct care workers in the consumer model for personal assistance services receive a pre-service orientation with a module that covers fraud and abuse, and fraud reporting. Medicaid-enrolled providers must undergo training on proper billing practices including fraud reporting. Licensure requirements for many providers mandate training on proper care and are audited by regulatory agencies. ODP maintains substantial training requirements as more fully set forth above. Any effort to legislatively mandate training must consider the potential that it may duplicate or conflict with existing provider training requirements and may not keep pace with changes to services and service delivery.

Thank you for the opportunity to provide a response to the Report. Please contact me if additional information or clarification is required.

Sincerely,

Teresa D. Miller
Secretary