



U.S. Department of Health and Human Services  
Office of Inspector General

# Personal Care Services

## **Trends, Vulnerabilities, and Recommendations for Improvement**

A Portfolio

# Office of Inspector General

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The OIG Portfolio offers new recommendations to improve program vulnerabilities detected in prior audits, evaluations, and investigations. The Portfolio synthesizes OIG's body of work in a program area and identifies trends in payment, compliance, oversight, or fraud vulnerabilities requiring priority attention and action to protect the integrity of Department of Health and Human Services (HHS) programs and the beneficiaries they serve.

# EXECUTIVE SUMMARY

The Office of Inspector General's (OIG) body of work examining Medicaid personal care services (PCS) has found significant and persistent compliance, payment, and fraud vulnerabilities that demonstrate the need for Centers for Medicare & Medicaid Services (CMS) to take a more active role with States to combat these issues.

In 2011, Medicaid costs for PCS totaled approximately \$12.7 billion, a 35-percent increase since 2005. Several Federal court decisions and Department of Health and Human Services policy initiatives aimed at providing more home and community-based options to Medicaid beneficiaries contribute to the increase in PCS use. As more and more State Medicaid programs explore home care options like PCS, it is critical that adequate safeguards exist to prevent fraud, waste, and abuse in PCS and other important home care benefits.

This document summarizes OIG's PCS work and, on the basis of the analysis of this work in the aggregate, offers recommendations to improve the integrity of Medicaid PCS.

## SUMMARY OBSERVATIONS

***Improper Payments Linked to Lack of Compliance.*** As of August 2012, OIG has produced 23 audit and evaluation reports since 2006 focusing on PCS. Although the objectives, methodologies, and scopes of these audits and evaluations differed, in many instances OIG found that PCS payments were improper because the services:

- were not provided in compliance with State requirements,
- were unsupported by documentation indicating they had been rendered,
- were provided during periods in which the beneficiaries were in institutional stays reimbursed by Medicare or Medicaid, and/or
- were provided by PCS attendants who did not meet State qualification requirements.

***Inadequate Controls To Ensure Appropriate Payment and Quality of Care.*** OIG work has demonstrated that existing program safeguards intended to ensure medical necessity, patient safety, and quality and prevent improper payments were often ineffective. In one or more audits or evaluations, OIG found:

- inadequate controls in the prior authorization processes (i.e., the processes to determine whether the beneficiaries qualify for PCS services before they are rendered);
- lack of prepayment controls (e.g., electronic edits to deny claims for PCS services that overlap with institutional stays);
- inconsistent standards for, and monitoring of, the qualifications of PCS attendants; and
- problematic billing practices (e.g., claims that lack details regarding dates of service and/or the identity of the PCS attendants providing services).

***PCS Fraud Is a Growing Concern.*** OIG’s Office of Investigations and many State Medicaid Fraud Control Units report that the increasing volume of fraud involving PCS has become a top concern. The most commonly reported schemes involve conspiracies between PCS attendants and Medicaid beneficiaries to submit claims for services that either were never provided or were not allowed under program rules. Investigators have noted that self-directed Medicaid service models (i.e., those in which beneficiaries have decisionmaking authority over certain services and take direct responsibility for managing their services with the system of available supports), especially those that allow beneficiaries significant control over the selection and payment of PCS attendants, are particularly vulnerable to these fraud schemes.<sup>1</sup>

## **RECOMMENDATIONS TO IMPROVE PROGRAM INTEGRITY**

On the basis of the body of OIG’s PCS work, we recommend that CMS take the following actions:

1. More fully and effectively use authorities available under section 1102 and Title XIX of the Social Security Act to improve regulatory oversight and monitoring of Medicaid PCS programs. Toward that end, CMS should promulgate regulations to:
  - a. Reduce significant variation in State PCS attendant qualification standards and the potential for beneficiary exposure to unqualified PCS attendants by establishing minimum Federal qualification standards applicable to all PCS reimbursed by Medicaid.
  - b. Improve CMS’s and States’ ability to monitor billing and care quality by requiring States to (1) either enroll all PCS attendants as providers or require all PCS attendants to register with their State Medicaid agencies and assign each attendant a unique identifier and (2) require that PCS claims include the specific date(s) when services were performed and the identity of the rendering PCS attendants.
  - c. Reduce significant variation in States’ PCS laws and regulations by creating or expanding Federal requirements and issuing operational guidance for claims documentation, beneficiary assessments, plans of care, and supervision of attendants.
2. Issue guidance to States regarding adequate prepayment controls. For example, CMS should identify a list of needed controls, including the necessary claims edits to prevent inappropriate PCS payments during periods when beneficiaries are receiving institutional care. CMS should also offer design instructions to better ensure the operability of prepayment controls.
3. Consider whether additional controls are needed to ensure that PCS are allowed under program rules and are provided.
4. Take action to provide States with data suitable for identifying overpayments for PCS claims during periods when beneficiaries are receiving institutional care paid for by Medicare or Medicaid. While we understand that CMS makes Medicare data available to States, more could be done to ensure that Medicare data are compatible with States’ systems; that States have the capacity to store the data necessary to identify improper Medicaid payments; and

that States may crosswalk Medicare and Medicaid data to identify potential instances of fraud, waste, and abuse.

5. Address recommendations contained in prior OIG reports that remain unimplemented. (See page 13 for a list of some prior recommendations related to PCS that remain unimplemented.)

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## BACKGROUND

Personal care services (PCS) provide assistance to the elderly, people with disabilities, and individuals with chronic or temporary conditions so that they can remain in their homes and communities. PCS are currently offered as either a State plan optional benefit or through various demonstrations and waivers<sup>2</sup> in all 50 States. (See Appendix A for related authorities.) States that provide PCS through State plans must comply with the general Medicaid program requirements outlined in section 1902 of the Social Security Act. States providing PCS through demonstration or waiver authorities must adhere to the terms of the application approved by CMS.

Recent data suggest rapid growth in PCS. In 2011, Medicaid costs for PCS totaled approximately \$12.7 billion, a 35-percent increase since 2005. Additionally, the U.S. Department of Labor, Bureau of Employment Statistics, in its *Occupational Outlook Handbook, 2010-11 Edition*, projected that employment of personal and home health aides will grow by 46 percent by 2018, much faster than the average of 10 percent for all occupations.

A key factor in this increase was the United States Supreme Court decision in *Olmstead v. L.C.* 527 U.S. 581 (1999), which held that unjustified institutionalization of people with disabilities is a violation of the Americans With Disabilities Act. The Department of Health and Human Services has promoted States' efforts to provide Medicaid beneficiaries who are elderly or have disabilities with the choice of remaining in their homes and communities, as opposed to moving to nursing homes or other institutional care options. For example, the Patient Protection and Affordable Care Act (ACA) of 2010 removed barriers to providing home and community-based services by allowing additional State plan amendment options, increasing States' timeframes to elect and renew PCS as a care option, and streamlining processes for accessing home and community-based services. The ACA also

### PERSONAL CARE SERVICES, A PRIMER

**What are PCS?** PCS consist of nonmedical services supporting activities of daily living, including bathing, dressing, light housework, money management, meal preparation, and transportation. PCS are provided to vulnerable care-dependent persons, typically those who are elderly or infirm and/or have disabilities.

**Who provides PCS?** Typically, an attendant provides PCS. In many States, PCS attendants work for personal care agencies, which are enrolled in the Medicaid program and bill for services on the attendants' behalf. Some States require attendants to register or enroll with the State, but most do not. States may define specific qualification requirements for attendants, such as minimum age, education, and health status.

**What are coverage rules for PCS?** Medicaid covers PCS for eligible individuals through Medicaid State plan options and/or through Medicaid waiver and demonstration authorities approved by CMS. (See Appendix A for a list of authorities.) Medicare does not provide reimbursement of PCS.

Under Federal law, PCS must be provided in a home or another location specified by the State and must follow a plan of care subject to approval and/or authorized by the State Medicaid agency. Although there are no Federal requirements for PCS attendants, States are required to develop qualifications or requirements for attendants to ensure quality of care.



provided additional funding for programs supporting home care goals, such as the Money Follows the Person demonstration and the Community First Choice Option programs.

As of August 2012, the Office of Inspector General (OIG) has produced 23 audit and evaluation reports since 2006 on PCS, which consistently have found payment, compliance, and oversight vulnerabilities, as well as quality-of-care concerns. (See Appendix B for a list of related PCS audit and evaluation reports and Appendix C for a list of prior OIG recommendations related to PCS that remain unimplemented by CMS and States.) Federal investigators and State Medicaid Fraud Control Units (MFCUs) have also observed an increase in suspected PCS fraud. What follows are summary observations based on vulnerabilities detected in OIG audits, evaluations, and investigations, as well as recommendations for corrective actions based on the body of OIG's PCS work.

OIG work referenced throughout this document was conducted in accordance with the professional standards applicable to audits, evaluations, and investigations.

## SUMMARY OBSERVATIONS

### Improper Payments Linked to Lack of Compliance With Documentation, Plans of Care, Medical Supervision, and Qualification Requirements

As of August 2012, OIG has completed seven statewide audits and one citywide audit of PCS payments. Another statewide audit is in progress. Since 2009, seven of the eight completed audits have identified over \$582 million in questioned costs. Table 1 lists the error rates,<sup>3</sup> questioned costs, and set-aside costs<sup>4</sup> from each of the eight completed audits:

**Table 1: Error Rates, Questioned Costs, and Set-Aside Costs for PCS in Seven States and One City**

State	Error Rate <sup>5</sup> (Percentage)	Questioned Costs <sup>6</sup>	Set Aside Costs <sup>7</sup>
Maryland <sup>8</sup>	0%	\$0	\$0
West Virginia <sup>9</sup>	1.00%	\$19,830	\$0
Nebraska <sup>10</sup>	2.31%	\$168,652	\$4,482,438
New Jersey <sup>11</sup>	40.35%	\$145,405,192	\$0
New York <sup>12</sup>	31.78%	\$100,335,472	\$15,325,689
New York City <sup>13</sup>	18.01%	\$275,327,274	\$0
North Carolina <sup>14</sup>	16.31%	\$41,734,368	\$0
Washington <sup>15</sup>	20.17%	\$19,438,693	\$30,323,597

The seven audits that found overpayments noted several types of deficiencies:

- Hours claimed in the billings were not supported by documentation.<sup>16</sup>
- PCS services failed to meet State assessment and/or prior authorization requirements.<sup>17</sup>
- PCS services did not meet State supervision requirements.<sup>18</sup>
- PCS attendants did not meet State qualification and/or training requirements.<sup>19</sup>

- Claims included periods during which beneficiaries received institutional care covered under Medicare or Medicaid.<sup>20</sup>

These States often failed to provide oversight to prevent improper payments in several ways, including:

- insufficient resources to adequately monitor their PCS programs, especially once they began to experience substantial growth;<sup>21</sup>
- inadequate controls in the States' prior authorization processes (i.e., the processes to determine whether beneficiaries qualify for services before they are rendered);<sup>22</sup>
- ineffectiveness of accrediting organizations to which the States delegated authority to ensure compliance with applicable State regulations;<sup>23</sup>
- failure to conduct monitoring site visits of PCS agencies that employed attendants, leaving the role of oversight largely to beneficiaries;<sup>24</sup> and
- inadequate controls to prevent paying improper PCS claims, including instances when PCS were claimed while the beneficiaries received institutional care.<sup>25</sup>

Separately, a 2010 OIG evaluation examining PCS in 10 States over a 1-year period found that 18 percent of paid claims for Medicaid PCS in a universe totaling \$724 million were inappropriate because the required qualifications for PCS attendants were undocumented.<sup>26</sup> The most often undocumented qualifications were age, education, and the results of background checks. Although the insufficient documentation may be an indicator that PCS attendants or agencies did not maintain or have ready access to documents containing this information, it could signal that the sampled PCS attendants did not meet State qualifications designed to ensure patient safety and high quality of care.

### **Inadequate Controls To Ensure Appropriate Payment and Quality of Care**

***Inadequate Controls To Prevent PCS Payments During Institutional Care.*** PCS are generally not eligible for Federal financial participation when provided to a beneficiary receiving services as an inpatient or a resident at a hospital, nursing home, or other institution.<sup>27</sup> However, OIG work has documented many instances when PCS providers received payment during periods when the beneficiary purportedly received institutional care service.

#### **INTERVIEWS WITH MEDICAID BENEFICIARIES REVEAL QUALITY-OF-CARE CONCERNS**

In interviews conducted in connection with two OIG audits of PCS in New York City and New York State, the majority of sampled Medicaid beneficiaries interviewed (40 of the 65 beneficiaries in New York City and 38 of the 55 in New York State) reported to OIG quality-of-care problems with their PCS attendants. The most serious allegations included physical abuse or threats of abuse, property theft, and patient abandonment. One beneficiary reported that an attendant abandoned her on two occasions – in the street and in the subway – because the attendant's shift had ended.

Without proper control and oversight mechanisms, unqualified attendants could expose beneficiaries to substandard quality of care and injury.

An audit examining paid PCS claims over a 30-month period in Nebraska identified 464 instances in which PCS providers billed and were improperly paid for PCS during the

beneficiaries' inpatient hospital stays.<sup>28</sup> A 2008 evaluation of PCS payments in the first quarter of 2006 found that the five States reviewed paid nearly \$500,000 for PCS on dates when beneficiaries were institutionalized in Medicaid-funded facilities.<sup>29</sup> This review cited problems with the States' claims payment systems, including unsuccessful prepayment edits, which could have contributed to the estimated \$11 million in potentially improper payments over the 3-month period.<sup>30</sup>

Numerous OIG and MFCU investigations have focused on potentially false PCS claims during periods of beneficiary institutionalization, resulting in convictions of PCS attendants and their employers.<sup>31</sup>

***Insufficient Qualification Safeguards.*** To be eligible for Federal financial participation, PCS must be provided by a qualified individual.<sup>32</sup> Although there are no Federal requirements that specify qualifications for PCS attendants, States are required to specify qualifications or requirements for PCS attendants to ensure quality of care. A 2006 evaluation of State requirements for PCS attendants revealed 301 different sets of requirements nationwide.<sup>33</sup> The most common requirements were background checks; training; supervision; minimum age; health status (e.g., that the attendant test negative for tuberculosis); and education (e.g., attainment of a high school diploma). The report noted that the wide variation among States and within the same State may make it difficult to ensure compliance with requirements. Additionally, a 2010 evaluation of compliance with qualification requirements in 10 States found that PCS attendant qualifications were undocumented for 18 percent of Medicaid PCS claims.<sup>34</sup> Additional Federal regulations that set minimum qualifications could improve consistency among States and better ensure that beneficiaries receive PCS from qualified PCS attendants.

***Billing Policies That Impair Program Integrity Efforts.*** OIG work on PCS has identified two distinct problems with State billing policies. First, PCS claims often do not specify the dates when the services were actually provided, and second, PCS claims do not identify the attendant that provided the service(s).

***Dates of Services Not Identified on Claims.*** The 2008 evaluation revealed that the claims data in three of five States reviewed could not be used to accurately identify overlapping claims. These States allow PCS providers to submit claims through a process commonly referred to as "span billing." In general, span billing allows providers to submit one claim requesting payment for multiple instances of PCS provided over a range of dates (week or month), without specifying dates when the services were actually provided. The inability to identify service dates on claims presents a significant oversight challenge because the State cannot determine whether, for example, PCS overlap with dates when the beneficiaries received institutional care services.<sup>35</sup>

The problematic consequences of span billing were seen in an evaluation focusing on PCS claims for services in excess of 24 hours per day and between 16 and 24 hours per day.<sup>36</sup> This review examined PCS claims in 5 States and identified 871 paid claims in 4 States that were for services provided in excess of 24 hours per day to a single beneficiary. It also identified over 2,000 other paid claims that totaled or nearly totaled 24 hours per day, a volume of services that could raise program integrity concerns.

During ad hoc interviews with MFCU directors in two States that allow span billing, the directors reported that they have recommended to their Medicaid agencies that span billing be prohibited. These MFCU directors reported that span billing prevents their investigators from obtaining necessary evidence to pursue fraud cases against PCS attendants and agencies. In

some PCS fraud cases, investigators rely on evidence that compares the dates of services listed on Medicaid claims to dates when the PCS attendants were engaged in conflicting activities (e.g., other job, travel). When specific dates of service are not included on claims, fraud investigations could be significantly hindered. Additional Federal regulations requiring that all States require the dates of services on claims would improve Federal and State program integrity efforts.

*PCS Attendants Not Identified on Claims.* Most States do not require PCS attendants to register with the State Medicaid programs and therefore do not assign PCS attendants unique identifiers to be included on claims.<sup>37</sup> As a result, conducting attendant-specific data mining and analysis in such States is difficult. Further, in the absence of information identifying the attendants, States are challenged to implement edits that would prevent payments or trigger prepayment reviews of claims associated with high-risk or excluded PCS attendants.<sup>38</sup> Similarly, the absence of the identity of the attendant on PCS claims forms creates significant challenges to law enforcement efforts to investigate potentially fraudulent claims. For this reason, numerous MFCUs have recommended to their State Medicaid agencies that PCS attendants be assigned unique identifiers that would appear on claims forms.<sup>39</sup> If States registered or enrolled PCS attendants and required attendant identifiers on claims, State and Federal program integrity staff could search for and follow up on questionable billing patterns (e.g., billings for more than 24 hours in a day or for other impossible or improbable numbers of hours) and implement edits to prevent improper claims.

### **PCS Fraud Is a Growing Concern**

OIG and the MFCUs have noted an increasing amount of fraud cases involving PCS. As of 2010, MFCUs had more open investigations involving PCS fraud than any other type of Medicaid service, with more than 1,000 investigations nationwide. In a recent survey, MFCUs cited fraud occurring in home and community-based settings, consisting mostly of PCS fraud, as a top fraud concern affecting their States.<sup>40</sup>

Cases investigated by OIG's Office of Investigations (OI) and discussions with multiple MFCUs indicate that the most common fraud schemes involve conspiracies between PCS attendants and beneficiaries. In a growing number of instances, the beneficiaries are being charged as co-conspirators because they accepted cash or other benefits in exchange for participating in the fraud. These cases appear to be especially prevalent in States using CMS-approved home and community-based service waivers that allow relatives of beneficiaries to be their PCS attendants.<sup>41</sup> In many of these cases, investigation reveals that the beneficiaries do not appear to have the medical conditions or physical limitations documented on their assessments and therefore are not eligible for PCS.<sup>42</sup>

#### **FRAUD EXAMPLE**

##### **OWNER OF PCS AGENCY SENTENCED FOR DEFRAUDING MEDICAID OUT OF MORE THAN \$650,000**

As a result of a joint investigation by Federal and State officials, John Alemoh Momoh, owner and operator of Hopecare Service, Inc., was sentenced to 2 years of incarceration and ordered to pay \$656,876 in restitution to Medicaid.

Between May 2007 and March 2008, Momoh submitted claims that inflated the number of PCS hours provided to Medicaid beneficiaries. Momoh also submitted false claims for services that were not rendered, were provided by an unqualified individual, and were not medically necessary.

Additionally, OI and the MFCUs are encountering a new fraud scenario in States with self-directed Medicaid service models (i.e., those in which beneficiaries have decisionmaking authority over certain services and are directly responsible for managing their services with the system of available supports) and particularly in those States that send payment for PCS services directly to the beneficiaries instead of the attendants.<sup>43</sup> Although State Medicaid programs in these States require beneficiaries to give the payments to the PCS attendants, cases in which beneficiaries submit false claims for services that were never provided are now being prosecuted. In such cases, the beneficiaries typically forge the PCS attendants' names and then deposit the checks into their own bank accounts.<sup>44</sup> In States allowing self-directed PCS models, additional controls may be necessary to ensure that services both are necessary and are provided.

Fraud is often difficult to detect by reviewing documentation alone. The majority of the overpayments identified in OIG audits are the consequence of missing documentation that services were performed, assessments were conducted, training and qualification requirements were met, and plans of care were completed. In contrast, fraud is often proven by showing that the existing documentation of such activities by PCS attendants and providers is false (see the fraud example on the previous page).

At present, most fraud cases involving PCS come to the attention of law enforcement only through referrals from individuals who know the persons committing the acts. However, if the availability and quality of PCS data were improved, data could be analyzed to identify and follow up on aberrancies and questionable billing patterns. For example, PCS attendants and agencies that commit fraud often bill for impossibly or improbably large volumes of services; for services that conflict with one another (e.g., a PCS attendant purports to provide many hours of services to multiple beneficiaries on the same dates); or for services that could not have been performed as claimed because of geographical distances between beneficiaries purportedly served by the same PCS attendant on the same day. If claims contained more specific details, including the exact dates of service and the identity of the PCS attendants, such irregular billings could be more easily and systematically discovered through claims analysis by State program integrity units.

## **RECOMMENDATIONS TO IMPROVE PROGRAM INTEGRITY**

On the basis of the body of OIG's PCS work, we recommend that CMS take the following actions:

1. More fully and effectively use authorities available under section 1102 and Title XIX of the Social Security Act to improve regulatory oversight and monitoring of Medicaid PCS programs. Toward that end, CMS should promulgate regulations to:
  - a. Reduce significant variation in State PCS attendant qualification standards and the potential for beneficiary exposure to unqualified PCS attendants by establishing minimum Federal qualification standards applicable to all PCS reimbursed by Medicaid. For example, CMS could establish minimum age and education standards and requirements for screening attendants (e.g., criminal background and Federal and

- State exclusion checks). These standards could be informed by work currently being conducted by the CMS-funded National Direct Service Workforce Resource Center (the Resource Center), which plans to develop a set of core competencies for workers providing long-term services. CMS could also consider the results of its National Background Check program, which has awarded selected States with funding to design a comprehensive national background check program for jobs involving direct patient care.
- b. Improve CMS's and States' ability to monitor billing and care quality by requiring States to (1) either enroll all PCS attendants as providers or require all PCS attendants to register with their State Medicaid agencies and assign each attendant a unique identifier and (2) require that PCS claims include the specific date(s) when services were performed and the identity of the rendering PCS attendants.
    - c. Reduce significant variation in States' PCS laws and regulations by creating or expanding Federal requirements and issuing operational guidance for claims documentation, beneficiary assessments, plans of care, and supervision of attendants.
  2. Issue guidance to States regarding adequate prepayment controls. For example, CMS should identify a list of needed controls, including the necessary claims edits to prevent inappropriate PCS payments during periods when beneficiaries are receiving institutional care. CMS should also offer design instructions to better ensure the operability of prepayment controls.
  3. Consider whether additional controls are needed to ensure that PCS are allowed under program rules and are provided. For example, as part of its State Plan and waiver application process, CMS could require States to identify specific safeguards to prevent the fraud schemes highlighted in this report.
  4. Take action to provide States with data suitable for identifying overpayments for PCS claims during periods when beneficiaries are receiving institutional care paid for by Medicare or Medicaid. While we understand that CMS makes Medicare data available to States, more could be done to ensure that Medicare data are compatible with States' systems; that States have the capacity to store the data necessary to identify improper Medicaid payments; and that States may crosswalk Medicare and Medicaid data to identify potential instances of fraud, waste, and abuse.
  5. Address recommendations contained in prior OIG reports that remain unimplemented. (See Appendix C for a list of some prior recommendations related to PCS that remain unimplemented.)



## AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

We made five recommendations in the report. CMS concurred with our fourth recommendation but did not indicate whether it concurred with our first, second, or third recommendations. Our fifth recommendation related to addressing prior unimplemented OIG recommendations. CMS indicated that it will incorporate those recommendations when developing action plans to address recommendations from this report. CMS generally agreed that more needs to be done at the Federal and State level to ensure appropriate billing for provided PCS.

More specifically, with regard to recommendation 1.a., CMS noted that in 2011 it funded the development of the *Road Map of Core Competencies for the Direct Service Workforce*; the direct service workforce will include PCS attendants. CMS expects this project to produce a set of service worker competencies by 2014, which CMS will then encourage States to adopt for use in their PCS programs. The agency also stated that it will continue to work with States on the National Background Check program.

We support CMS's work to develop core competencies that include minimum standards that any PCS attendant must have in order to be considered qualified to render PCS. However, on the basis of OIG's work documenting that States and local jurisdictions have developed over 300 PCS attendant requirements in the absence of Federal qualification requirements, we remain concerned that States will not adopt any core competencies unless CMS requires them to do so. For that reason and because of the overpayments for unqualified PCS attendants identified in prior work, we continue to recommend that CMS establish minimum Federal qualification standards applicable to all Medicaid-reimbursed PCS.

In relation to recommendation 1.b. (1), CMS stated that it will explore and identify the potential costs and benefits of States' either enrolling all PCS attendants as providers or requiring that attendants register with their State Medicaid agencies. In addition, CMS indicated that it would explore and identify improvements to claims documentation that facilitate accurate payments and the detection of fraud and abuse. We reiterate that CMS's and States' ability to monitor billing and care quality could be improved by assigning PCS attendants unique identifiers through either an enrollment or registration process and by requiring these identifiers, as well as the specific dates of service, on claims. We continue to recommend that CMS promulgate related regulations.

In relation to recommendation 1.c., CMS outlined regulations that are part of the Community First Choice (CFC) benefit that the agency reported would standardize requirements for both care plans and assessments. CMS noted that the same requirements appear in its proposed regulations for home and community-based services provided under sections 1915(c) and 1915(i) of the Social Security Act. We appreciate that in new programs, such as CFC, CMS is working to address some of the issues we have raised in this report. We ask that in its final management decision, CMS provide further explanation as to how the regulations it referenced will serve to standardize States' care plans and assessments. We augmented our report to recommend that CMS issue guidance outlining expectations regarding how the regulations CMS referenced

should be implemented to achieve standardization and improvements in claims documentation, beneficiary assessments, plans of care, and supervision of attendants.

In relation to our second recommendation, CMS stated that it intends to issue guidance to remind States of their obligation to review their own data to identify payment and utilization aberrations. CMS also stated that it will begin using its own data sources to better identify claims outliers, review those findings regularly with States, provide technical assistance to States on implementing those practices, share the findings of our report with States, and work with national long-term-care associations to improve program integrity in Medicaid PCS. We would appreciate CMS's providing a timetable for implementation of each of these activities in its final management decision.

In relation to our third recommendation, CMS stated that it plans to provide States with guidance on educating PCS providers on the program integrity issues identified in our report. CMS indicated it will also consult with stakeholders and attempt to create and publish guidance for States about program integrity controls through various technical assistance vehicles. We request that in its final management decision, CMS provide a timeline for development and completion of these activities. Furthermore, CMS identified several fraud protections it believes currently exist in its self-directed waiver service models. While we agree that the existing protections CMS described are important, they have not succeeded in preventing the vulnerabilities found in our reviews, audits, and investigations. We continue to recommend that CMS consider additional controls to ensure that PCS are allowed under program rules and are provided.

CMS concurred with our fourth recommendation and indicated that it will work with the Medicare and Medicaid Coordination Office to identify additional data-sharing approaches with States for dually eligible beneficiaries to prevent overpayments for PCS claims.

In response to our fifth recommendation, CMS stated that prior OIG recommendations that are contained in Appendix C appear to be largely encompassed within the first four recommendations in this report. CMS therefore said that it will incorporate its response to the prior recommendations as part of its actions to address our first through fourth recommendations. OIG continues to consider the prior recommendations as unimplemented and encourages CMS to take actions that address all recommendations in this report as well as our prior recommendations. OIG will consider whether specific actions taken by CMS address the PCS issues and recommendations identified in this report and the reports listed in Appendix C.

We ask that in its final management decision, CMS more clearly indicate whether it concurs with our recommendations 1(a)-(c), 2, 3, and 5.



## **APPENDIX A –Personal Care Services – Related Authorities Under Title XIX of the Social Security Act**

States can provide personal care services (PCS) to eligible Medicaid beneficiaries through State plan and waiver programs. States that provide PCS through State plan programs must comply with the general Medicaid program requirements in section 1902 of the Social Security Act. States can also provide PCS through 1115 demonstration; 1915(a) and 1915(b) managed care and freedom of choice; 1915(c) home and community-based services waiver; 1915(j) self-directed personal assistant services; 1915(k) community first choice programs; and 1915(i), which allows PCS under a State amendment option.

## APPENDIX B - List of Related OIG Reports

Report	Issue Date
States' Requirements for Medicaid-Funded Personal Care Service Attendants ( <a href="#">OEI-07-05-00250</a> )	December 2006
Review of Personal Care Services Claimed by the Center for Living and Workings, Inc. ( <a href="#">A-01-06-00011</a> )	October 2007
Payments Made in Error for Personal Care Services During Institutional Stays ( <a href="#">OEI-07-06-00620</a> )	August 2008
Medicaid-Funded Personal Care Services in Excess of 24 Hours per Day ( <a href="#">OEI-07-06-00621</a> )	October 2008
Partnership Review of Medicaid Claims Processed by Cerebral Palsy and Stavros for Personal Care Attendant Services Provided to Beneficiaries during Inpatient Stays ( <a href="#">A-01-08-00001</a> )	November 2008
Review of Medicaid Personal Care Services Claims Made by Providers in New York City ( <a href="#">A-02-07-01054</a> )	June 2009
Review of Medicaid Personal Care Service Claims Submitted by Independence First, Inc. and Claimed by Wisconsin From July 1, 2006, Through June 30, 2008 ( <a href="#">A-05-09-00093</a> )	April 2010
Review of Medicaid Personal Care Service Claims Submitted by Dane County Department of Human Services and Claimed by Wisconsin From July 1, 2006, Through June 30, 2008 ( <a href="#">A-05-10-00018</a> )	September 2010
Review of Medicaid Personal Care Service Claims Submitted by Clarity Care, Inc., and Claimed by Wisconsin From July 1, 2006, Through June 30, 2008 ( <a href="#">A-05-10-00019</a> )	October 2010
Review of Medicaid Personal Care Services Claims Made by Providers in New York State ( <a href="#">A-02-08-01005</a> )	October 2010
Review of Personal Care Services Provided by Tri-State Home Health and Equipment Services, Inc., in the District of Columbia ( <a href="#">A-03-08-00207</a> )	November 2010
Inappropriate Claims for Medicaid Personal Care Services ( <a href="#">OEI-07-08-00430</a> )	December 2010
Review of Federal Reimbursement Claimed by North Carolina for Medicaid Personal Care Services Claims Submitted by Shipman Family Home Care, Inc. ( <a href="#">A-04-09-04041</a> )	February 2011

Review of New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health ( <a href="#">A-06-09-00062</a> )	March 2011
Review of Medicaid Personal Care Services Claimed by Washington State ( <a href="#">A-09-09-00030</a> )	June 2011
Review of Medicaid Personal Care Services Claims Submitted by Providers in North Carolina ( <a href="#">A-04-10-04003</a> )	June 2011
Nebraska Medicaid Payments for Personal Care Services ( <a href="#">A-07-10-03152</a> )	July 2011
Review of Personal Care Services Claimed Under Maryland's Medicaid State Plan ( <a href="#">A-03-11-00200</a> )	November 2011
Review of Medicaid Personal Care Claims Submitted by Providers in New Jersey ( <a href="#">A-02-09-01002</a> )	December 2011
Review of New Mexico Medicaid Personal Care Services Provided by Heritage Home Healthcare ( <a href="#">A-06-09-00063</a> )	May 2012
Review of New Mexico Medicaid Personal Care Services Provided by Clovis Homecare, Inc. ( <a href="#">A-06-09-00117</a> )	June 2012
Review of Louisiana Medicaid Personal Care Services Provided by American Pride Caregivers, LLC ( <a href="#">A-06-09-00107</a> )	June 2012
West Virginia Complied With Certain Federal Requirements for Most of the Personal Care Services Claimed for Its Aged and Disabled Waiver Program ( <a href="#">A-03-11-00205</a> )	June 2012

## APPENDIX C – List of Certain Unimplemented Recommendations for Personal Care Services\*

### Recommendations To CMS

1. Work with States to reduce erroneous Medicaid payments for personal care services (PCS) provided during institutional stays (*Payments Made in Error for Personal Care Services During Institutional Stays*, [OEI-07-06-00620](#)) (CMS concurred.)
2. Enforce existing Federal Medicaid payment policies prohibiting Medicaid reimbursement for PCS provided over a range of dates if the range includes dates on which the beneficiary was institutionalized (*Payments Made in Error for Personal Care Services During Institutional Stays*, [OEI-07-06-00620](#)) (CMS did not concur.)
3. Work with States to ensure that agencies and attendants are aware of attendant qualification and documentation requirements and that Medicaid claims for PCS provided by attendants with undocumented qualifications are not paid (*Inappropriate Claims for Medicaid Personal Care Services*, [OEI 07-08-00430](#)) (CMS concurred.)

### Recommendations To Specific Medicaid State Agencies

4. Implement prepayment controls to monitor PCS claims for compliance with State requirements (*Review of Personal Care Services Provided by Tri-State Home Health and Equipment Services, Inc., in the District of Columbia*, [A-03-08-00207](#)) (The Department of Health Care Finance concurred.)
5. Provide more effective monitoring of PCS attendants' compliance with qualification requirements (*Review of Personal Care Services Provided by Tri-State Home Health and Equipment Services, Inc., in the District of Columbia*, [A-03-08-00207](#)) (The Department of Health Care Finance concurred.)
6. Strengthen controls by developing policies and procedures for more substantive documentation and prepayment and postpayment claim review to ensure that PCS claims are reviewed and paid in accordance with Federal and State requirements (*Nebraska Medicaid Payments for Personal Care Services*, [A-07-10-03152](#)) (The Department of Health & Human Services concurred.)

\*This list does not include overpayment recovery recommendations included in some OIG reports.

## APPENDIX D – Agency Comments



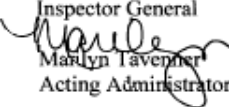
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** OCT - 3 2012

**TO:** Daniel R. Levinson  
Inspector General

**FROM:**   
Marilyn Tavenner  
Acting Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Vulnerabilities in Personal Care Services: The Office of the Inspector General Portfolio" (OIG-12-12-01)

Thank you for the opportunity to review and comment on the draft report, "Vulnerabilities in Personal Care Services: The Office of the Inspector General (OIG) Portfolio" (OIG-12-12-01). According to the OIG report, the purpose of the report was to summarize OIG's personal care services (PCS) work, and, on the basis of the analysis of this work in the aggregate, to offer recommendations to improve the integrity of Medicaid PCS. The Centers for Medicare & Medicaid Services's (CMS's) comments to the OIG findings and recommendations are detailed below.

### OIG Recommendation

On the basis of the body of OIG's PCS work, OIG recommends that CMS take the following actions:

1. More fully and effectively use authorities available under section 1102 and Title XIX of the Social Security Act to improve regulatory oversight and monitoring of Medicaid PCS programs. Toward that end, CMS should promulgate regulations to:
  - a. Reduce the significant variation in state PCS attendant qualification standards and the potential for beneficiary exposure to unqualified PCS attendants by establishing minimum federal qualification standards applicable to all PCS reimbursed by Medicaid. For example, CMS should establish minimum age and education standards and requirements for screening attendants (e.g., criminal background and federal and state exclusion checks). These standards should be informed by work currently being conducted by the CMS-funded National Direct Service Workforce Resource Center, which plans to develop a set of core competencies for workers providing long-term services. CMS should also consider the results of its National Background Check program, which has

awarded selected states with funding to design a comprehensive national background check program for jobs involving direct patient care.

- b. Improve CMS's and state's ability to monitor billing and care quality by requiring states to: (1) either enroll all PCS attendants as providers or require all PCS attendants to register with their State Medicaid Agencies and assign each attendant a unique identifier, and (2) require that PCS claims include the specific date(s) when services were performed and the identity of the rendering PCS attendants. Collectively, these actions would better ensure that states could perform meaningful data analysis for both program integrity and quality-of-care purposes.
- c. Reduce significant variation in states' PCS laws and regulations by creating or expanding federal requirements for claims documentation, beneficiary assessments, plans of care, and supervision of attendants.

#### **CMS Response**

- 1a. PCS are often the front line service that most significantly prevents individuals from requiring institutional services. The use of these services is growing, and yet a shortage of personal care attendants nationwide often challenges system capacity to meet this critical need. CMS agrees that more needs to be done at the federal and state level to assure appropriate billing for the services provided. CMS is currently working to reduce variation and improve access to qualified attendants by the completion and/or continuation of several initiatives that address the variation in states' PCS attendant qualifications.

#### ***National Direct Service Workforce Resource Center***

As noted in the OIG report, CMS funded the National Direct Service Workforce Resource Center to develop the *Road Map of Core Competencies for the Direct Service Workforce* project in FY 2011. A key component of this project is the development of a set of nationally validated core (or common) competencies. These competencies would serve as the basis for competency-based training programs for workers providing long-term services and supports in different settings to different populations, and would help to reduce variation in state PCS attendant qualifications standards. The schedule for this initiative is as follows:

- Phase I of the project provides an inventory and overview of competency initiatives developed in the U.S.
- Phase II is an analysis of direct service worker competencies, including discussion of ways in which competency sets are utilized and implemented within the direct service workforce.
- The final set of competencies is expected to be tested, validated and published by 2014.

After publication, CMS will encourage the use/adoption in state Medicaid PCS programs nationwide. This initiative will provide more consistent expectations and qualifications for PCS attendants and improve their ability to avoid unintentional billing errors.

***National Background Check Program***

The CMS will continue to work with states on the National Background Check (NBC) program. The program's purpose is to identify efficient, effective, and economical procedures for conducting background checks. While some states already require background checks for certain categories of personal care attendants, such as some personal care attendants in waiver programs, many do not.

The CMS awarded more than \$38.6 million to 17 states to design comprehensive applicant background check programs for jobs involving direct patient care, including PCS workers in Medicaid Home and Community-Based Services Programs (HCBS), and has engaged a national contractor to assist all states in these efforts. The NBC for each prospective employee must include a criminal history search of both state and Federal Bureau of Investigation (FBI) records, as well as other state resources such as Nurse Aide Registry. On July 24, 2012, CMS released a new funding opportunity for states to apply by October 31, 2012 (<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/BackgroundCheck.html>). At a minimum, participating states will be required to make provisions for home and community-based providers to participate, whether that participation is mandated by state law or voluntary.

**1b.** The CMS will develop cross-cutting strategies with the Data Systems' Group (DSG), the Financial Management Group (FMG), the Center for Program Integrity (CPI) and the Disabled and Elderly Health Programs Group (DEHPG) within CMS to evaluate effective methods to monitor billing and care quality. In consultation with stakeholders, CMS will explore and identify the potential costs and benefits of State Medicaid Agencies of either enrolling all PCS attendants as providers or requiring PCS attendants to register with their State Medicaid Agencies, and also explore and identify improvements to claims documentation that facilitate accurate payments and detection of fraud and abuse.

The CMS notes that for those states that currently use Financial Management Services (FMS) in Medicaid HCBS programs with options for participant self-direction, FMS requires an Employee Identification Number (EIN) for all attendants being paid through the FMS thereby preventing an attendant from billing under two different names or identities. Further, we clarify that within the self-directed model of state plan PCS (section 1915j of the Social Security Act), and in the Community First Choice benefit (section 1915k of the Social Security Act), there is no waiver of the provider agreement requirement; therefore, the



state must enroll personal care attendants as Medicaid providers, even if they are friends or family members of the beneficiary. This affords greater oversight of claims at a State Medicaid Agency level.

**1c.** The CMS has promulgated the final rule for the new Community First Choice (CFC) benefit, under 1915(k) and is finalizing rules for HCBS provided under Sections 1915(c) and 1915(i) of the Social Security Act. In the CFC final rule, CMS standardized the requirements for both person-centered planning and beneficiary assessments, and proposed these same requirements in the 1915(c) and 1915(i) proposed rules. The relevant language in the final CFC rule and two proposed rules states in part: “(b) The person-centered plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports” . . . “ . . . the plan must: . . (3) Reflect the clinical and support needs as identified through an assessment of functional need. . . (12) Prevent the provision of unnecessary or inappropriate care.”

#### **OIG Recommendation**

The OIG recommends CMS issue guidance to states regarding adequate prepayment controls. For example, CMS should identify a list of needed controls, including the necessary claims edits, to prevent inappropriate PCS payments during periods when beneficiaries are receiving institutional care. CMS should also offer design instructions to better ensure the operability of prepayment controls.

#### **CMS Response**

Through the joint efforts of DSG, FMG, CPI and DEHPG, CMS will evaluate various methods to ensure that states have adequate and appropriate prepayment controls in place, such as identifying a list of needed payment controls or assessing a state’s capability to collect and analyze data in a manner that alerts states to potential problem areas. In addition, CMS has plans to strengthen federal and state data processes for claims data generally, which will also improve oversight of PCS. CMS intends to issue guidance to remind states of their obligation to review their own data to identify payment and utilization aberrations. CMS will also begin to use its own data sources to better identify claims outliers and will review these findings regularly with states. CMS will provide technical assistance to states regarding how to implement these practices. CMS will also share with State Medicaid Agencies the findings of the OIG report and work with the major national long term care associations to ensure adequate documentation of the provision of PCS, accurate claims reporting, and ways to identify and prevent fraud and abuse.

With regard to OIG’s expressed concern about the provision of Medicaid PCS during periods when beneficiaries are receiving institutional care, CMS notes that HCBS provided through 1915(c) waivers permit personal assistance retainer payments to enable a state to hold PCS for a



short period of time while a person is hospitalized or absent from his or her home as long as the state clearly indicates its intent to do so in its HCBS waiver application.

#### **OIG Recommendation**

The OIG recommends CMS consider whether additional controls are needed to ensure that PCS are allowed under program rules and are provided. For example, as part of its State Plan and waiver application process, CMS could require states to identify specific safeguards to prevent the fraud schemes highlighted in this report.

#### **CMS Response**

The CPI and DEHPG will provide assistance to states in preventing improper payments for PCS by developing guidance State Medicaid Agencies can use to educate PCS providers regarding the importance of the program integrity issues identified in OIG's report, such as adequate supporting documentation for services provided, attendant qualifications and the required supervision of PCS attendants. CMS will also consult with stakeholders to identify additional controls that states might implement, and, if applicable, will publish information about those controls through various technical assistance vehicles, including but not limited to the HCBS Waiver Application and Technical Guide.

The CMS notes that we currently implement various controls and safeguards to protect individuals receiving PCS and reduce fraud under the self-directed service models represented under the 1915(c), (j) and (k) authorities. The Technical Guide for the 3.5 Version of the HCBS 1915(c) Waiver Application provides an overview of FMS and other controls to assure accurate payments and to prevent fraud and abuse. An example of these safeguards/controls excerpted from the Technical Guide is provided below:

The 1915(c) waiver authority does not permit making payments for services directly to a waiver participant, either to reimburse the participant for expenses incurred or enable the participant to directly pay a services provider. Instead, payments must be made through an intermediary organization that performs financial transactions (paying for goods and services or processing payroll for participants' workers included in the participant's service plan) on behalf of the participant. An FMS entity plays this role when the waiver includes the Employer Authority or Budget Authority opportunity. Under the Employer Authority, when a participant functions as the employer of direct support workers, FMS are an important safeguard for participants and workers alike. The provision of Fiscal/Employer Agent FMS ensures that federal, state and local employment taxes and labor and workers' compensation insurance rules related to household employment and payroll are implemented in an accurate and timely manner and, if included in a state's Fiscal/Employer Agent FMS model, that invoices for goods and services included in the participant's service plan are paid appropriately and in a timely manner. The provision of Agency with Choice (co-employer) FMS ensures that the necessary employer-related duties and tasks, including payroll, are carried out. FMS provided under these two models is an important safeguard for participants because it ensures that participants are in compliance with federal and state tax, labor, workers' compensation insurance and Medicaid regulations.

Under the 1915(j) State Plan PCS optional program, CMS requires states to assure that necessary safeguards have been taken to protect the health and welfare of Medicaid beneficiaries served under this option and to assure the financial accountability for funds expended for self-directed services. At a minimum, participants are required to have sufficient supports available to them to manage their workers and budgets. CMS requires that states perform an evaluation of the need for personal care under the State Plan. CMS also requires that states have in place a risk management system that identifies potential risks to the participant and employs tools or instruments (for example, criminal and worker background checks) to mitigate risk. CMS further requires that states provide a support system to individuals prior to enrollment, and, as requested, throughout the period of an individual's enrollment, or when the state has determined that the individual is not effectively managing their services identified in their service plans or budgets. The support system is intended to inform, counsel, train, and assist participants with their employer-related responsibilities, including managing their workers and budgets and performing their fiscal and tax responsibilities.

Under the CFC option authorized by section 1915(k), the services authorized for individuals must be based upon their individualized assessment of functional need. CMS expects that the assessment will include a standardized set of data elements, key system functionality, and workflow that will be sufficiently comprehensive to support the determination that an individual would require attendant care services. The assessment of need must be conducted at least every 12 months, as needed when the individual's support needs or circumstances change significantly necessitating revisions to the service plan, or at the request of the individual, or the individual's representative, as applicable. States are required to use a person-centered service plan that is based on the assessment of the functional need. In essence, these CMS requirements are designed to ensure that the state provides ongoing oversight of the billing/payment process for these services.

#### **OIG Recommendation**

OIG recommends CMS take action to provide states with data suitable for identifying overpayments for PCS claims during periods when beneficiaries are receiving institutional care paid for by Medicare or Medicaid. While OIG understands that CMS makes Medicare data available to states, more could be done to ensure that Medicare data are compatible with states' systems, that states have the capacity to store the data necessary to identify improper Medicaid payments, and that states may crosswalk Medicare and Medicaid data to identify potential instances of fraud, waste, and abuse.

#### **CMS Response**

The CMS concurs with this recommendation and will work with the Medicare and Medicaid Coordination Office (MMCO) to identify additional data-sharing approaches with states for dually eligible beneficiaries to prevent overpayment for PCS claims and to enable states to better identify potential vulnerabilities for fraud and abuse. CMS notes that Medicare data regarding care coordination is currently available for states through the MMCO program, and states can access crossover claims information from Medicare in order to check for duplicate payments.

**OIG Recommendation**

OIG recommends CMS address recommendations contained in prior OIG reports that remain unimplemented, including:

- a. Work with states to reduce erroneous Medicaid payments for PCS provided during institutional stays.
- b. Enforce existing federal Medicaid payment policies prohibiting Medicaid reimbursement for PCS provided over a range of dates if the range includes dates on which the beneficiary was institutionalized.
- c. Work with states to ensure that agencies and attendants are aware of attendant qualification and documentation requirements and that Medicaid claims for PCS provided by attendants with undocumented qualifications are not paid.
- d. Implement prepayment controls to monitor PCS claims for compliance with state requirements.
- e. Provide more effective monitoring of PCS attendants' compliance with qualification requirements.
- f. Strengthen controls by developing policies and procedures for more substantive documentation and prepayment claim review to ensure that PCS claims are reviewed and paid in accordance with federal and state requirements.

**CMS Response**

The recommendations identified in Appendix C contained in prior OIG reports that remain unimplemented appear to be largely encompassed within the current recommendations; therefore, CMS will incorporate those recommendations in the action steps described above.

We appreciate the effort that went into this report and look forward to working with OIG in accomplishing the action steps described above.

## ENDNOTES

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<sup>1</sup> Additional information on self-directed Medicaid services is available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Self-Directed-Services.html>. Accessed on April 24, 2012.

<sup>2</sup> Section 1115 waivers give States flexibility to design and improve the Medicaid and Children's Health Insurance Program (CHIP) programs. Waivers let States test new or existing ways to deliver and pay for program coverage. The Centers for Medicare & Medicaid Services (CMS) conducts and sponsors a number of innovative demonstration projects to test and measure the effect of potential program changes. Additional information on section 1115 waivers and demonstrations is available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstration.html>. Accessed on August 15, 2012.

<sup>3</sup> We calculated the error rate for each review by dividing the point estimate for the estimated value of unallowable items by the value of the sampling frame. These amounts can be found in the sampling methodology within the appendix of each report.

<sup>4</sup> The questioned costs and the set-aside costs are the lower limits of 90-percent confidence intervals. These amounts can be found in the sampling methodology within the appendix of each report.

<sup>5</sup> We calculated the error rate for each review by dividing the point estimate for the estimated value of unallowable items by the value of the sampling frame. These amounts can be found in the sampling methodology within the appendix of each report.

<sup>6</sup> "Questioned cost" means a cost that is questioned by OIG because of (1) an alleged violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the expenditure of funds; (2) a finding that at the time of the audit, such cost is not supported by adequate documentation; or (3) a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable.

<sup>7</sup> Set-aside costs are generally costs that we believe are in error but the magnitude of which may not be statistically measurable or for which the criteria for determining the costs' propriety were not clearly set forth by the administering agency.

<sup>8</sup> *Review of Personal Care Services Claimed Under Maryland's Medicaid State Plan* (A-03-11-00200), November 2011.

<sup>9</sup> *West Virginia Complied With Certain Federal Requirements for Most of the Personal Care Services Claimed for Its Aged and Disabled Waiver Program* (A-03-11-00205), June 2012.

<sup>10</sup> *Nebraska Medicaid Payments for Personal Care Services* (A-07-10-03152), July 2011.

<sup>11</sup> *Review of Personal Care Claims Submitted by Providers in New Jersey* (A-02-09-01002), December 2011.

<sup>12</sup> *Review of Medicaid Personal Care Services Claims Made by Providers in New York State* (A-02-08-01005), October 2010.

<sup>13</sup> *Review of Medicaid Personal Care Services Claims Made by Providers in New York City* (A-02-07-01054), June 2009.

<sup>14</sup> *Review of Medicaid Personal Care Services Claims Submitted by Providers in North Carolina* (A-04-10-04003), June 2011.

<sup>15</sup> *Review of Medicaid Personal Care Services Claimed by Washington State* (A-09-09-00030), June 2011.

<sup>16</sup> *Review of Medicaid Personal Care Services Claims Made by Providers in New York State* (A-02-08-01005), October 2010; *Review of Medicaid Personal Care Services Claimed by Washington State* (A-09-09-00030), June 2011; *Review of Medicaid Personal Care Services Claims Submitted by Providers in North Carolina* (A-04-10-04003), June 2011; *Nebraska Medicaid Payments for Personal Care Services* (A-07-10-03152), July 2011; *Review of Personal Care Claims Submitted by Providers in New Jersey* (A-02-09-01002), December 2011; and *West Virginia Complied With Certain Federal Requirements for Most of the Personal Care Services Claimed for Its Aged and Disabled Waiver Program* (A-03-11-00205), June 2012.

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<sup>17</sup> *Review of Medicaid Personal Care Services Claims Made by Providers in New York State* (A-02-08-01005), October 2010; *Review of Medicaid Personal Care Services Claimed by Washington State* (A-09-09-00030), June 2011; *Review of Medicaid Personal Care Services Claims Submitted by Providers in North Carolina* (A-04-10-04003), June 2011; *Nebraska Medicaid Payments for Personal Care Services* (A-07-10-03152), July 2011; and *Review of Personal Care Claims Submitted by Providers in New Jersey* (A-02-09-01002), December 2011.

<sup>18</sup> *Review of Medicaid Personal Care Services Claims Made by Providers in New York City* (A-02-07-01054), June 2009; *Review of Medicaid Personal Care Services Claims Made by Providers in New York State* (A-02-08-01005), October 2010; *Review of Medicaid Personal Care Services Claims Submitted by Providers in North Carolina* (A-04-10-04003), June 2011; and *Review of Personal Care Claims Submitted by Providers in New Jersey* (A-02-09-01002), December 2011.

<sup>19</sup> *Review of Medicaid Personal Care Services Claims Made by Providers in New York State* (A-02-08-01005), October 2010; *Review of Medicaid Personal Care Services Claimed by Washington State* (A-09-09-00030), June 2011; *Review of Medicaid Personal Care Services Claims Submitted by Providers in North Carolina* (A-04-10-04003), June 2011; and *Review of Personal Care Claims Submitted by Providers in New Jersey* (A-02-09-01002), December 2011.

<sup>20</sup> *Nebraska Medicaid Payments for Personal Care Services* (A-07-10-03152), July 2011.

<sup>21</sup> *Review of Medicaid Personal Care Services Claims Submitted by Providers in North Carolina* (A-04-10-04003), June 2011.

<sup>22</sup> *Review of Personal Care Claims Submitted by Providers in New Jersey* (A-02-09-01002), December 2011.

<sup>23</sup> *Ibid.*

<sup>24</sup> *Nebraska Medicaid Payments for Personal Care Services* (A-07-10-03152), July 2011. Failure to conduct onsite reviews of providers was also identified as a cause of payment of improper claims in New York State and New York City. *Review of Medicaid Personal Care Services Claims Made by Providers in New York City* (A-02-07-01054), June 2009, and *Review of Medicaid Personal Care Services Claims Made by Providers in New York State* (A-02-08-01005), October 2010.

<sup>25</sup> *Review of Medicaid Personal Care Services Claimed by Washington State* (A-09-09-00030), June 2011; *Nebraska Medicaid Payments for Personal Care Services* (A-07-10-03152), July 2011; and *West Virginia Complied With Certain Federal Requirements for Most of the Personal Care Services Claimed for Its Aged and Disabled Waiver Program* (A-03-11-00205), June 2012.

<sup>26</sup> *Inappropriate Claims for Medicaid Personal Care Services* (OEI-07-08-00430), December 2010.

<sup>27</sup> For State Plan PCS, see Social Security Act § 1905(a)(24); 42 CFR § 440.167; regarding waivers, see 42 § 441.301(b)(1)(ii); 42 CFR § 440.70(c).

<sup>28</sup> *Nebraska Medicaid Payments for Personal Care Services* (A-07-10-03152), July 2011.

<sup>29</sup> *Payments Made in Error for Personal Care Services During Institutional Stays* (OEI-07-06-00620), August 2008.

<sup>30</sup> *Ibid.* The review also identified a large number of overpayments for PCS during dates when the beneficiaries were institutionalized in Medicare-paid facilities. The report recommended that CMS explore ways to ensure that State Medicaid programs have complete information on Medicare institutionalizations for dually eligible beneficiaries.

<sup>31</sup> A list of convictions may be found in OIG's compilation of "State Enforcement Actions." Available at <https://oig.hhs.gov/fraud/enforcement/state/index.asp>. Accessed on April 24, 2012.

<sup>32</sup> For State Plan PCS, see Social Security Act § 1905(a)(24); 42 CFR § 440.167; regarding waivers, see 42 CFR § 441.301(b)(1)(ii); 42 CFR § 440.70(c).

<sup>33</sup> *States' Requirements for Medicaid-Funded Personal Care Service Attendants* (OEI-07-05-00250), December 2006. The report noted that at the time of the review, there were 238 separate programs through which States were providing personal care services: 31 State plans and 207 Medicaid waivers.

<sup>34</sup> *Inappropriate Claims for Medicaid Personal Care Services* (OEI-07-08-00430), December 2010.



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<sup>35</sup> For example, if a beneficiary was institutionalized from October 1 through October 7 and 10 hours of PCS were billed for the date range October 3 through October 9, the State cannot determine whether the PCS were provided between October 3 and October 6, when the beneficiary was institutionalized, or between October 7 and October 9, when the beneficiary was at home.

<sup>36</sup> *Medicaid-Funded Personal Care Services in Excess of 24 Hours per Day* (OEI-07-06-00621), October 2008.

<sup>37</sup> At least four States require enrollment of at least some of their Medicaid personal care attendants. Minnesota enrolls all attendants providing both State plan and waiver PCS, regardless of whether the attendants are self-employed or are employees of PCS agencies. Iowa enrolls all attendants providing waiver PCS. (Iowa does not have a State plan PCS benefit.) For both State plan and waiver PCS, Ohio enrolls all PCS attendants who are not employees of PCS agencies. Florida requires enrollment of attendants who are not employees of PCS agencies and are providing services under the State PCS plan.

<sup>38</sup> OIG's List of Excluded Individuals/Entities (LEIE) provides information to the health care industry, patients, and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other Federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE. Additional information on excluded providers is available at <https://oig.hhs.gov/faqs/exclusions-faq.asp>. Accessed on August 15, 2012.

<sup>39</sup> MFCUs in Ohio, Washington, New Mexico, and Louisiana have notified OIG that they have made such recommendations.

<sup>40</sup> Based on MFCU responses to the survey conducted through the *US DHHS-OIG Public-Private information Sharing Project*, released through a Freedom of Information Act request in September 2011.

<sup>41</sup> Section 1915(c) Home and Community-Based Services waivers authorize States to provide long-term care in home and community-based settings rather than institutional settings. Additional information on these waivers is available at [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=1915\(c\)#waivers](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=1915(c)#waivers). Accessed on June 20, 2012.

<sup>42</sup> Based on interviews with State officials and recommendations submitted to States by MFCUs in Missouri, Louisiana, Ohio, and Washington.

<sup>43</sup> Additional information on self-directed Medicaid services is available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Self-Directed-Services.html>. Accessed on April 24, 2012.

<sup>44</sup> An example of beneficiary submission of false claims for PCS is described in, "West Springfield Woman Pleads Guilty, Sentenced in Connection with Stealing Over \$130,000 from Medicaid," May 3, 2011. Available at <http://www.mass.gov/ago/news-and-updates/press-releases/2011/woman-pleads-guilty-sentenced-stealing-130000.html>. Accessed on April 24, 2012.