



Monitoring Fraud, Waste, & Abuse in HCBS Personal Care Services



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Training Objectives

- Understanding definitions of personal care services (PCS) and self-directed services.
- Understanding various fraud, waste, and abuse (FWA) vulnerabilities within the PCS program.
- Identifying proper ways to construct policies and procedures for PCS and fraud prevention.
- Learning strategies to address linkages between fraud and PCS program vulnerabilities.

Major Lessons Learned from PCS Fraud Cases

- PCS fraud is of concern in Medicaid due to the high rate of utilization of the service.
- PCS fraud can involve collusion among multiple people, making it difficult to detect.
- Billing for services that were never rendered or billing for services supposedly rendered when patient was instead in institutional care are some of the more common instances of fraud.
- Educating both providers and the general public is an essential measure to the prevention of Fraud, Waste, and Abuse (FWA) in PCS.

Personal Care Services Definition

Definition of Personal Care Services

➤ Components of PCS

- PCS consists of non-medical services supporting Activities of Daily Living (ADL), such as movement, bathing, dressing, toileting, personal hygiene. PCS can also offer Instrumental Activities of Daily Living (IADL), such as meal preparation, money management, shopping, telephone use, etc.

➤ Service Providers of PCS

- Typically, an attendant provides PCS. An attendant can be someone unrelated to the individual or a family member. Rules for attendant qualifications are set by the State. States can offer family members or legal guardians the option to become an attendant.

➤ 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.

Personal Care Services Definition

Definition of Personal Care Services - Continued

- PCS service delivery has two options: agency-directed or self-directed.
- **Agency-directed**
 - Traditional delivery model
 - A qualified PCS agency hires, fires, pays and trains PCAs to provide services to individuals.
- **Self-directed**¹
 - Alternative to the traditional delivery model
 - Individuals or their representatives have decision-making authority over PCS services and take direct responsibility to manage their services with the assistance of a system of available supports.

Personal Care Services Definition

Definition of Personal Care Services - Continued

- In self-direction, individuals may have the option, and therefore the responsibility, for managing all aspects of service delivery in a person-centered planning process including, but not limited to:
 - “Employer Authority” of recruiting, hiring, training and/or supervising providers.
 - “Budget Authority” of how Medicaid funds in a participant budget are spent.

Self-Direction Services Definition and Overview

Self-Direction Services Overview

- 1915(c) Technical Guide pgs. 191-219: States have the **option** to let individuals, or their representatives, have decision-making authority over certain services and take direct responsibility to manage the provision of those services and their associated budgets.
 - Individuals receive assistance in their self-direction duties through a system of available supports.
- Provides an alternative to traditionally delivered services, such as an agency delivery model.
- Self-directed services are offered as either a State Plan optional benefit or through various demonstrations and waivers in all 50 states.

Components of Self-Direction

Individualized Budget when elected by the State

- *42 CFR 441.470* - A service budget must be developed and approved by the State based on the assessment of need and the person-centered service plan.
- Amount of funds that are under the control and direction of the individual varies from person to person – each budget is specific to the individual.
- Budget plan is developed using a person-centered planning process and is individually tailored in accordance with the individual's needs and preferences as established in the person-centered service plan.

Components of Self-Direction

Information Assistance in Support of Self-Direction

- *42 CFR 441.464* - Individuals requiring personal care are informed of feasible alternatives, including elements of self-direction compared to non-self-directed Personal Attendant Service, and of potential responsibilities in self-direction models.
 - When these supports are covered as a waiver service, the individual has free choice among all willing and qualified providers of these supports.
 - These services must be specified in Appendix C-3, including the scope of supports furnished and the relevant provider qualifications.
- States are required to provide or arrange for the provision of a system of supports that respond to an individual's need for assistance with their:
 - Development of a person-centered plan and individualized budget.
 - Management and execution of the individual's services, and “employer” and “budget” responsibilities.

What is Fraud, Waste and Abuse?

Fraud

- A knowing misrepresentation of the truth or concealment of a material fact to induce another to act to his or her detriment. Includes any intentional or deliberate act to deprive another of property or money by guile, deception, or other unfair means.²
- Example: Knowingly submitting claims for services that were not rendered.

Waste

- Overutilization, underutilization, or misuse of resources. Waste typically is not an intentional act.³
- Example: Costs incurred when an individual is receiving more units or hours of service than needed, e.g., when an individual's health improves but their intensity of supports remains the same.

What is Fraud, Waste and Abuse?

Abuse

- Provider practices that are inconsistent with sound fiscal, business, or medical practice, and results in unnecessary cost to the Medicaid program or payment for services that are not medically necessary or fail to meet professionally recognized health care standards.³
- Example: A PCS provider bills for services during an individual's institutional stay. This is abuse because the PCA provider should have been aware of the rules, which specify that services cannot be billed during an institutional stay.

Biggest difference between Fraud vs. Waste and Abuse:

- Intent to deceive

Significance of Personal Care Services in HCBS

Why is FWA prevention in personal care service significant?

- Improper Medicaid PCS payments costs taxpayers, strains state budgets, and could result in PCS waiver programs becoming limited and ultimately, discontinued.

42 CFR 441.301(c)(2)(xii) states:

- “...Commensurate with the level of need of the individual, and the scope of services and supports available under the State’s 1915(c) HCBS waiver, the written plan must...**Prevent the provision of unnecessary or inappropriate services and supports.**”
- While an individual is wasting and/or abusing the Medicaid services and supports, the funding for another individual will be unavailable.

Significance of Personal Care Services in HCBS

Why is FWA prevention in personal care service significant? (Continued)

- Service costs and utilization continue to increase:⁴
 - Medicaid costs for PCS increased 35% from 2005-2011, totaling \$12.7 billion.
 - Increasing focus on home care options for State Medicaid programs.
- According to 2011 OIG report:⁵
 - Audit of two states recommended to refund more than \$61.1 million to Federal Government.
 - Improperly qualified PCA attendants providing services costs approximately \$724 million in 10 States.
 - One state has spent more than \$100 million Federal tax dollars between 2004 – 2006 as a result of improper Personal Care Service claims.

Summary of HHS OIG Personal Care Services Portfolio Findings

There were two main issues that OIG's detailed findings stemmed from:

- Improper payments linked to lack of compliance.
- Inadequate controls to ensure appropriate payment and quality of care.

Improper Payments Linked to Lack of Compliance ⁶

1. Services were not provided in compliance with State requirements.
2. Services did not have the proper documentation to indicate that they had been rendered.
3. Services were provided during periods when the individuals were in institutions without authorization for the retention payments.
4. PCS attendants did not meet State qualification requirements.

Summary of HHS OIG Personal Care Services Portfolio Findings

Inadequate Controls to Ensure Appropriate Payment and Quality of Care⁶

5. Inadequate controls in the prior authorization processes.
6. Lack of prepayment controls / problematic billing practices.
7. Differing standards for and monitoring of the qualifications of PCS attendants.

1. Services not Provided in Compliance with State Requirements

How do these issues manifest?

- Each state has its own requirements for PCS services (generally documented in Medicaid Manuals or State's administrative laws) dictating how services must be delivered.
 - Example: States have its own requirements for documenting PCS. A state can require all personal care services to be documented in a standard format.

State Program Managers / Waiver Administrators' Actions

- Review the state's existing provider manuals and regulations.
 - See "State Oversight" section for more detail.

2. Services Unsupported by Documentation

How do these issues manifest?

- Services documented as rendered when they were never provided.
- Services rendered but undocumented.
- Poor retention of documentation.

State Program Managers / Waiver Administrators' Actions

- Require PCAs to document and verify that the services have been rendered by signature, voice-recognition call logs, etc.
- Review fiscal intermediaries' data, as well as their policies and procedures in place for the delivery of service.
- Perform ongoing, unannounced audits and provider quality reviews.
- **Strengthen rules for record retention by including clear, concise language and stricter penalties for non-compliance.**

2. Services Unsupported by Documentation

State Fiscal Agents' Actions

- Review claims data focusing on:
 - Late submission
 - Frequent adjustments
 - Over-utilization at end of billing periods
 - Largest claim amounts for a single facility
- Stop and/or recoup payments in instances of missing documentation.
- Provide trainings about acceptable documentation rules.

CMS CO & RO Analysts

- Review the program integrity efforts in Appendix I-1 of waiver applications.

3. Services Provided During Periods of Institutional Stays without Authorization for the Retention Payment

How do these issues manifest?

- Personal care services are billed as rendered to an individual while he or she is in a hospital, a nursing facility, an intermediate care facility for individuals with intellectual and/or developmental disabilities (ICF/IDD), or an institution for mental diseases (IMD).
- States can allow retention payments to hold the place of the individual while the person is institutionalized.

State Program Managers / Waiver Administrators' Actions

- Establish a policy for exclusive billing when an individual is institutionalized.
- Establish an edit in the MMIS to reject any personal care service billings while an individual is institutionalized.
- Create an associated network that informs relevant parties when individuals are admitted to institutional care.

3. Services Provided During Periods of Institutional Stays without Authorization for the Retention Payment

State Fiscal Agents' Actions

- Review PCS claims data when service dates span more than 30 days.
 - Increases scrutiny on large spans of service dates and allows for a more focused review.
 - Dates of service when no services were rendered will not easily be shown if claims are submitted using a large span of service dates.

4. Services Provided by PCS Attendants who did not Meet State Qualification Requirements

How do these issues manifest?

- Staff members have not completed, have incomplete, or have outdated training certifications.
- Staff members have not undergone abuse screening as required by the State regulations.
 - Abuse screening rules vary by State.

4. Services Provided by PCS Attendants who did not Meet State Qualification Requirements

State Program Managers / Waiver Administrators' Proactive Actions

- *Establish a centralized data bank* including:
 - Registry of qualified staff
 - Assigned National Provider Identification numbers (NPIs),
 - The registration of the entity with the Medicaid agency
 - Excluded entity data as part of the centralized registry (In & out-of-state information, OIG's Exclusions Database (LEIE), etc.)
 - Comprehensive rules for minimum age and qualification requirements for each provider type

4. Services Provided by PCS Attendants who did not Meet State Qualification Requirements

State Program Managers / Waiver Administrators' Proactive Actions (cont.)

- *Create a policy that ensures that the State does not use providers with a history of criminal acts that might result in fraud and/or harm to individuals.*
 - Utilize OIG's LEIE, which identifies problematic providers in various States (http://oig.hhs.gov/exclusions/exclusions_list.asp) prior to/during enrollment; document this policy in Medicaid Manuals.
 - Perform background checks for all providers.
 - Determine criteria for consideration of convicted felons, e.g., consider nature of the crime, years of sentence, and any rehabilitated offender acts.
 - Determine and document which offenses would exclude an individual from becoming a PCS provider.

5. Inadequate Prior Authorization Processes

How do these issues manifest?

- Service unit over-authorization due to lack of prescribed guidelines.
- PCS services rendered without an associated authorization by the primary care physician or referring physician.

State Program Managers / Waiver Administrators' Actions

- Require documentation for level of care and service units as part of an individual's PCSP prior to rendering services.
- Establish edits and a billing system that prohibits payments for services beyond those authorized.

5. Inadequate Prior Authorization Processes

State Fiscal Agents' Actions

- Review claims data submitted intermittently for post payment review:
 - Flag providers who bill large numbers of units for individuals.
 - Analyze data for Fee for Service claims across the waiver and flag duplicate services.

Example

- A PCA was billing for services delivered to two individuals at the same time in different locations.

6. Inadequate Prepayment Controls & Problematic Billing Practices

How do these issues manifest?

- Missing prepayment control in electronic billing system (e.g., MMIS) involving following situations:
 - Duplicative billings for the same service
 - Duplicative billing during individual's institutional stays
- State's existing billing practices that could impair prepayment edit efforts:
 - Claims submission policies allow a wide range of service dates (i.e., larger than 30 days).

6. Inadequate Prepayment Controls & Problematic Billing Practices

Pre-Authorization Contractors, MMIS Contractors, State Fiscal Agents' Actions

- Develop MMIS edits that automatically deny unusual activity.
 - Duplicative billings for same service
 - Duplicative billing during individual's institutional stays
- Coupled with MMIS edits, perform post payment reviews that compare dually eligible populations to determine if edits are being properly applied.

7. Differing Qualification & Monitoring Standards for PCS Attendants

How do these issues manifest?

- Missing supervision documentation of PCAs, if the State requires supervision of attendants.
- Missing PCA presence in all supervisory documentation, if the State requires PCA to be present during supervisory visits.

State Program Managers / Waiver Administrators' Actions

- Ensure that the providers are continuing to meet state certification or licensure requirements, where applicable.
- Specify what needs to be documented and performed during supervision.
- Require supervision and/or oversight (whether employed or contracted) and train the PCAs as part of the licensing requirement.
- Establish a monitoring process if the supervision is part of the PCS rate setting and not a separate billing component.
- Missing and abnormal supervision billings should be flagged for further review.

Educate the Public and the Provider Community

Possible Public Education Topics

- Understanding your Medicaid benefits
- How signing blank insurance claims forms enables fraud
- Techniques to ensure your Medicaid information is not stolen

Possible Provider Education Topics

- Requirements for provider documentation
- Fraud monitoring and how to address fraud allegations
- Billing & post payment review training

Program Regulations and Manuals Review

Example

A State requirement says:

“Agency must use a RN supervisor to perform a supervisory visit every 90 days and document the visit.”

This example statement will be used to examine what questions the providers might have when they read this regulation, then the state can address provider’s questions by updating the provider manual.

Note: This example uses RNs in PCS supervisory visits, however, it is at the discretion of the state to apply such rules. States can also choose to use case managers to perform these visits.

Program Regulations and Manuals Review Example

Provider Questions

- What is the specific documentation requirement? What needs to be documented? Is there a form?
- How often is documentation required— when does the 90 day period begin?
- What is the purpose of the supervisory visit?
- What is the method of the supervisory visit? Must this visit be an in-person visit? Should phone calls to the individual's home be allowed?
- Should the PCA be in presence every time a supervisory visit is performed? What about the individual and his/her family members?

Program Regulations and Manuals

Review Example

Policy/Procedures or Updated Regulation

- RN Supervisors are required to perform supervisory visits to participants' homes every 90 calendar days starting the date of the initial RN assessment visit.
 - During this in-person RN supervisory visit, the supervisor must assess the health and changes in condition of the participant.
 - Review and document major events that occurred for the participant during the 90-day period.
 - Observe and evaluate the PCA's services according to the Person-Centered Service Plan (PCSP), documenting any areas for improvement.
- The Supervisory visit and PCSP update assessments must be documented. The document must be signed and dated by both RN, PCA, and individual or representative in attendance on the day of the visit.

Note: This example uses RNs in PCS supervisory visits, however, it is at the discretion of the state to apply such rules. States can also choose to use case managers to perform these visits.

Program Regulations and Manuals Review Example

Provider Questions

- What should be the process for scheduling the visit?
- What if the individual refuses the RN supervisory visit? What should be the rescheduling rule?
- What if the individual was hospitalized for a short period when the supervisory visit was due?

Program Regulations and Manuals

Review Example

Policy/Procedures or Updated Regulation

- The RN supervisors must call and schedule the supervisory visit at least 2 calendar days in advance of the RN supervisory visit due date.
- If the individual or the representative refuses the visit, the reason for refusal must be documented. The visit must be rescheduled within 14 calendar days from the date of the refusal.
- Rescheduling attempts by the agency must be documented with the date of the call and the printed name and signature of the staff member who made the attempts.

Note: This example uses RNs in PCS supervisory visits, however, it is at the discretion of the state to apply such rules. States can also choose to use case managers to perform these visits.

Program Regulations and Manuals Review Example

Provider Questions

- Is the RN supervisory visit paid in this program?
 - Supervisory visit service could be part of the State's rate. This choice is up to the State. In this example, the State had a separate rate setting for RN supervisory visits.
- If the RN finds that the PCA lacks the required skill set, or hears a FWA allegation from the individual or the PCA, what should the RN do?
- What is the penalty of missing a RN supervisory visit?
- How long should visit documentation be kept?

Program Regulations and Manuals Review Example

Policy/Procedures or Updated Regulation

- When an allegation of fraud, abuse, or waste is reported during the supervisory visit, the RN supervisor must follow the FWA reporting procedures.
- RN supervisory visit is not part of the rate setting methodology for personal care service. RN supervisory visits have a separate calculated per visit rate and therefore penalties for non-performance will result in disallowance of the payment made for the supervisory visit.

Note: This example uses RNs in PCS supervisory visits, however, it is at the discretion of the state to apply such rules. States can also choose to use case managers to perform these visits.

Program Regulations and Manuals Review Conflict Check

Differing guidelines within programs and across waivers

- “... 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.”
– per page 4 of the OIG Personal Care Portfolio, Nov. 2012

Program Regulations and Manuals Review Conflict Check

Differing guidelines within programs and across waivers (cont.)

- States should consider the following:
 - If there are differences in rules for the same service, are they warranted based on the population?
 - How are updated rules and regulations communicated to providers?
 - How often do state program managers meet with program integrity or Managed Care Organization (MCO) to reinforce and/or review regulations?
 - How do state program managers work to prevent instances of discrimination, such as refusing services to individuals with high levels of utilization or risk?

State Oversight – Other Considerations

Program Considerations

- If either national or state-wide criminal background checks are required, how does this apply to sole-proprietors if the state manual does not mention the specifics of background checks, such as:
 - Who is responsible for performing checks?
 - Who pays for the background check service?
 - Who reviews the results?
 - What is the required frequency of background checks?

State Oversight – Other Considerations

Impact of Rate Setting on Service Administration

- In tiered rates based on acuity, where individuals with a higher acuity level are compensated more generously:
 - What stops providers from assessing individuals as higher-acuity to obtain a bigger payout?
 - Providers should not be allowed to perform assessments per conflict of interest guidance (42 CFR 441.301(c)(vi)).
 - How are assessment results validated to ensure providers are not assessing individuals at a higher acuity level?

Current Efforts by CMS

Current Efforts for 1915(c) Waiver Application Review

- Multi-step review process that measures the integrity of the waiver programs as described in the waiver application, including but not limited to:
 - Review the Quality Improvement System (QIS) evidentiary report on the discovery and remediation of issues identified.
 - Review the QIS strategy in the waiver application.
 - Ensure that the waiver application addresses the issues identified in the evidentiary report when reviewing the renewal application.

Current Efforts by CMS

National Background Check Program (NBCP)

- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/BackgroundCheck.html>
- Awarded \$50 million to 26 states.
- Designed comprehensive national background check programs for direct patient access employees.
- Required States to include fingerprint based search of State and Federal criminal history.

How to Report Suspected FWA Issues

Office of Inspector General (OIG) National Fraud Hotline:

- 1-800-HHS-TIPS
- (1-800-447-8477)
- Visit their website: <http://oig.hhs.gov/fraud/report-fraud/index.asp>

How to Report Suspected FWA issues to your State Medicaid Agency or Medicaid Fraud Control Units (MFCU):

- Locate your State's contact information using either the CMS State Contacts Database (<https://www.cms.gov/apps/contacts/>) or the State's Medicaid website.
- Locate your State's MFCU office by using the National Association of MFCU's list of contacts (<http://www.namfcu.net/states>). 49 states (all except North Dakota) have a MFCU office.

How to Report Suspected FWA Issues

How to Report Suspected FWA issues to your State Medicaid Agency or Medicaid Fraud Control Units (MFCU):

- In addition, States may have an Office of Attorney General (AG) who is responsible for investigating FWA. Check your State's website for additional information pertaining to the State's AG office.
- You can identify yourself or report FWA anonymously. If you are reporting anonymously, be sure to report enough information so that a proper investigation can ensue.

Summary

- FWA in PCS is a significant concern. State Program Managers, Waiver Administrators, Fiscal Agents, and Federal Staff can work to prevent FWA by considering multiple options at various stages of regulatory rule making and service delivery.
- Common vulnerabilities include minimal requirements for PCS programs and for the providers delivering services through such programs.
- It is important to educate both individuals receiving services and PCS providers about ways to prevent or combat FWA.

Additional Resources

- Direct link to the site with the webinar is:
<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>

References

1. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Self-Directed-Services.html>
2. <http://www.acfe.com/fraud-101.aspx>
3. <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/fwa-overview-booklet.pdf>
4. <http://oig.hhs.gov/newsroom/spotlight/2012/portfolio01.asp>
5. http://oig.hhs.gov/newsroom/news-releases/2011/personal_care_services.asp
6. <https://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf>

Questions & Answers

For Further Information

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**Thank you for
attending our session!**