



CMCS Informational Bulletin

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SUBJECT: Strengthening Program Integrity in Medicaid Personal Care Services

Introduction

The Centers for Medicare & Medicaid Service (CMS) and states are taking important steps to support increased access by Medicaid beneficiaries who are aged or have a disability to high-quality home and community-based services (HCBS).¹ These efforts are yielding concrete results: in FY 2014, the majority (53%) of the \$152 billion in federal and state Medicaid spending on long-term care services and supports (LTSS) was spent on community-based supports, reversing a long-standing imbalance weighted toward spending on nursing facility and other institutional care.² To continue this progress, CMS and states have moved forward with implementing recent regulations requiring greater community integration³ and adopting key improvements to managed LTSS⁴.

Like other HCBS services, personal care services (PCS) are intended to enable Medicaid beneficiaries who are aged and those with disabilities to live with as much independence as possible in their homes or other community settings rather than in a nursing facility or other institution. Recently the Office of Inspector General (OIG) issued an Investigative Advisory identifying a number of program integrity vulnerabilities in the delivery of PCS and

¹ CMCS Informational Bulletin, "Suggested Approaches for Strengthening and Stabilizing the Medicaid Home Care Workforce," August 3, 2016, <https://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html>

² Truven Health Analytics, "Improving the Balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FY 1981-2014" (June 3, 2016), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/long-term-services-and-supports.html>

³ 79 Federal Register 2947 (January 16, 2014), <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>

⁴ "Medicaid and CHIP Managed Care Final Rule (CMS 2390-F): Strengthening the Delivery of Managed Long Term Services and Supports (April 25, 2016), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-final-rule.html>

recommending corrective actions by CMS.⁵ Earlier this year, CMS published guidance for PCS agencies and attendants describing the steps they should take to avoid improper payments.⁶ This Informational Bulletin is addressed to states, PCS agencies and attendants and other stakeholders. It describes PCS, summarizes the program integrity vulnerabilities, and highlights safeguards state Medicaid agencies can put in place to strengthen program integrity in PCS without undermining beneficiary access to PCS, especially self-directed services.

Personal Care Services (PCS)

Coverage of PCS is optional for states, except when they are medically necessary for children eligible for early and periodic screening, diagnostic, and treatment (EPSDT) services. PCS can be covered as a State Plan option,⁷ under one or more waivers approved by CMS,⁸ or both. The definition of PCS is not uniform across these authorities, but in general, PCS consists of non-medical services supporting Activities of Daily Living (ADL), such as movement, bathing, dressing, toileting, and personal hygiene. PCS can also offer support for Instrumental Activities of Daily Living (IADL), such as meal preparation, money management, shopping, telephone use, etc. Typically, an attendant provides PCS and rules for attendant qualifications are set by states. Certain Medicaid authorities allow states to offer family members or legal guardians the option to become an attendant.

There are generally two models of PCS service delivery that states can choose to make available: agency-directed or self-directed. Agency-directed is the traditional delivery model for PCS. Under this approach, a qualified PCS agency hires, fires, pays and trains PCAs to provide services to eligible individuals. A variation of the agency model is the “agency with choice”, in which an agency is co-employer with the beneficiary of PCS attendants. Self-directed PCS is an alternative to the traditional delivery model. Under self-directed models, beneficiaries or their representatives have decision-making authority over PCS and take direct responsibility to manage their services with the assistance of a system of available supports. 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” which includes recruiting, hiring, training and/or supervising providers and “Budget Authority”, pursuant to which the individual directs how state-authorized Medicaid funds in a participant budget are spent. Beneficiary decision-making and autonomy are hallmarks of self-directed models of service provision, and CMS strongly encourages use of self-directed models with necessary supports using a person centered planning process.

⁵ OIG, Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement, November 2012, www.oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf

⁶ “Preventing Medicaid Improper Payments for Personal Care Services” (July 2016), <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/pcs-booklet.pdf>

⁷ Section 1905(a)(24) of the Social Security Act, 42 CFR 440.167; section 1915(i), 42 CFR 440.182; section 1915(j), 42 CFR Part 441, Subpart J; and 1915(k), 42 CFR Part 441, Subpart K.

⁸ Section 1915(c) of the Social Security Act, 42 CFR 440.180; section 1915(d), and section 1115.

Spending on PCS, like spending on HCBS services generally, is an increasing portion of Medicaid spending, reflecting the need for such services among the large and growing number of beneficiaries who are elderly or have disabilities. In FY 2014, federal and state spending on PCS totaled \$14.5 billion, or about 18 percent of Medicaid HCBS spending and 10 percent of total Medicaid spending on long-term services and supports that year.⁹ In addition to the approximately 950,000 beneficiaries receiving PCS under the Medicaid state plan in 2012, many of the 1.4 million beneficiaries receiving 1915(c) waiver services also received PCS.¹⁰ PCS, like other types of home and community-based care, is largely paid for on a fee-for-service basis. However, there is increasing state interest in delivering these services through managed care (MLTSS).¹¹

Program Integrity Vulnerabilities

The OIG has identified a number of issues related to improper payments for PCS services and other compliance, payment and fraud vulnerabilities.¹² Findings from the OIG regarding services include services not provided in compliance with state requirements, not supported by documentation, provided during periods in which the beneficiaries were in Medicaid-reimbursed institutional stays and payments for retaining the attendants during the institutional stay had not been authorized, and provided by PCS attendants who did not meet state qualification requirements. Findings related to billing practices include billing for services not rendered, furnished to ineligible beneficiaries, and furnished by unauthorized caregivers. Finally, in terms of abuse and neglect, the OIG highlighted instances of abuse and neglect of beneficiaries by PCS attendants, resulting in beneficiary harm.

In response to OIG findings, CMS has recommended that states establish adequate post-payment review processes for PCS, including implementing post-payment review processes specific to self-directed PCS.¹³ CMS also issued guidance to PCS agencies and attendants explaining how to avoid improper billing and describing the sanctions that apply to fraud,

⁹Truven Health Analytics, “Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014.” April 15, 2016. Table A. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/long-term-services-and-supports.html>

¹⁰ <http://kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2012-data-update/>

¹¹ Managed LTSS reached 15 percent of LTSS spending in FY 2014, Truven Health Analytics, “Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014.”

¹² OIG, Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement, November 2012, www.oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf and Office of Inspector General, “Investigative Advisory on Medicaid Fraud and Patient Harm Involving Personal Care Services,” p. 2, <https://oig.hhs.gov/reports-and-publications/portfolio/ia-mpcs2016.pdf>

¹³ CMCS, Increasing Fiscal Protections for Personal Care Services. April 2016. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/hcbs-training.html>

including civil monetary penalties, criminal fines, imprisonment, and exclusion from participation in Medicaid, Medicare, and other Federal health care programs.¹⁴

Assuring both Program Integrity and Beneficiary Autonomy in Self-Directed PCS

When establishing safeguards to ensure program integrity in PCS, states should take into account the special circumstances of the self-direction model. Unlike PCS agencies, which enroll in the Medicaid program and sign provider agreements holding them accountable for properly claiming and meeting program standards, individual beneficiaries who direct their own services based on their needs and preferences are attempting to maximize their independence and ability to live in their homes and communities. The program integrity safeguards that make policy and operational sense in the case of a PCS agency with many clients may not be suitable to an individual beneficiary directing his or her own PCS services. This is particularly true in the case of the qualifications of workers that are most relevant to individual needs and preferences. (For example, a beneficiary requiring his or her worker to be able to communicate in a particular language, including sign language, or have experience in dealing with particular mobility issues.) States are again encouraged to collaborate with their stakeholders, including beneficiary advocates, to determine the methods of PCS delivery and the resulting program integrity protections that will prevent fraud and abuse while still maintaining beneficiary autonomy in self-directed models.

Program Integrity Safeguards

The PCS benefit is a key component of Medicaid home and community-based care. Without PCS, many elderly beneficiaries and individuals with disabilities have no practical alternative to institutionalization as they face a loss of their independence. Thus, program integrity weaknesses in PCS put vulnerable beneficiaries at risk of substandard or harmful care and put program funds at risk for fraud, waste, and abuse. CMS is committed to working with states and OIG to strengthen program integrity in PCS. The following are safeguards states could, and in some instances should already have, put in place to protect the PCS benefit and program beneficiaries.

Provider Qualifications and Basic Training

HCBS services differ from medically-focused services. Recognizing the importance of balancing program integrity and self-direction, states frequently establish broad provider qualifications for HCBS services, although the qualifications can vary depending on the specific service being provided. For services provided primarily in the home, such as PCS, qualifications can include possession of a valid driver's license, a minimum age threshold, and the receipt of any training

¹⁴ “Preventing Medicaid Improper Payments for Personal Care Services” (July 2016), <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/pcs-booklet.pdf>

required by the state. Some states require basic competency-based training such as first aid and CPR certification, etc. However, such minimum qualification requirements should not restrict the ability of beneficiaries to require individualized training on the specific ways to provide care based on their own needs and preferences. Training can be provided by professional home care associations, training organizations, public Workforce Investment Act programs, or unions. In many consumer-directed personal care programs, much of the training can also be provided directly by the beneficiary. One example of basic training provided to PCS attendants that resulted in positive attendant and beneficiary outcomes was recently publicized in California’s In-Home Supportive Services program.¹⁵ PCS attendants were trained in CPR and first aid, infection control, medications, chronic diseases and other areas, which was linked to reduced use of the emergency by PCS recipients.

PCS services covered under 1905(a)(24) of the Social Security Act and 42 CFR 440.167 must be provided by an individual who is “qualified to provide such services and who is not a member of the individual’s family.”¹⁶ In the case of HCBS waiver services, the state Medicaid agency must assure that there are “adequate standards for all types of providers that provide services under the waiver,” including PCS.¹⁷ States have discretion in determining who is “qualified” to furnish State Plan PCS services and what safeguards are “adequate” for HCBS waiver service providers. Whatever provider qualifications a state chooses to establish for PCS attendants, the state should have in place procedures for ensuring that PCS attendants comply with the qualifications, including specifying how PCS agencies or attendants are to document their compliance.

Registry of PCS Attendants

States should consider establishing a centralized data bank for PCS that would be accessible to PCS agencies as well as to beneficiaries. The data bank could include: a registry of qualified PCS attendants, registration of the PCS agency with the Medicaid agency, excluded PCS agency data (In & out-of-state information, OIG’s Exclusions Database (LEIE), etc.), and comprehensive rules for minimum age and qualification requirements for each provider type. Per CMS guidance issued in 2016¹⁸, use of registries can help strengthen the identity of the workforce and provide beneficiary access to information about qualified home care workers. In the case of self-directed PCS models where beneficiaries can hire family members or friends, a state will need to ensure there are no significant barriers for beneficiaries to add family members or friends to a registry.

Screening of PCS Providers

¹⁵ Newcomer, Bob, UCSF, 2016. Evaluation of California’s In-Home Supportive Services Pilot Program Training In-Home Workers.

¹⁶ 42 CFR 440.167(a)(2).

¹⁷ 42 CFR 441.302(a)(1).

¹⁸ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib080316.pdf>

Federal regulations require that all providers furnishing services to Medicaid beneficiaries on a fee-for-service basis be screened and enrolled in the Medicaid program.¹⁹ (CMS will require compliance with this requirement by states and managed care plans with managed care contracts beginning on or after July 1, 2018).²⁰ A fee-for-service provider is defined as “any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency.”²¹ The level of screening to which a provider is subject varies with the risk of fraud, waste, or abuse the provider presents to the Medicaid program;²² in the case of provider types like PCS agencies that participate only in Medicaid, the determination of risk is at the discretion of the state.²³ The purpose of the screening and enrollment requirements is to identify bad actors before they enroll in the Medicaid program in order to prevent them from harming beneficiaries and / or diverting Medicaid funds.

In the case of agency-directed PCS, agencies are considered to be providers for purposes of screening and enrollment because they have signed provider agreements with the state Medicaid agency and are legally responsible for the truthfulness, accuracy, and completeness of the claims they submit for payment.²⁴ In contrast, the attendants that PCS agencies employ or with whom they subcontract are not considered to be providers for this purpose, and states are not required to screen them or to enroll them in their Medicaid programs. At a minimum, however, PCS agencies must ensure that they do not employ or subcontract with any individual or entity who has been excluded from Medicaid or other federal health care programs.²⁵ State Medicaid agencies should review the risk levels to which they have assigned PCS agencies and ensure that the appropriate level of screening, including a review of all ownership and control disclosures, is being applied at initial enrollment and at revalidation of enrollment. In agency-directed models, the PCS agency is the employer and handles all employer functions for the employees, such as payroll services, training, tax services, verification of timesheets, hiring, including performing background checks on potential candidates.

In the case of self-directed PCS, providers are typically paid differently than the agency-directed model. Often this is accomplished through the use of a Financial Management Service (FMS) entity.²⁶ The FMS entity, which may be an independent private entity or operated by the state, performs the employer functions such as those identified in the agency-directed models. When the FMS entity submits fee-for-service claims for self-directed PCS services furnished by

¹⁹ 42 CFR 455.410, 455.450

²⁰ 42 CFR 438.608(b)

²¹ FF

²² 42 CFR 455.434(b); 42 CFR 455.450.

²³ “Medicaid Provider Enrollment Compendium (MPEC),” March 2016, section 1.3.E.
<https://www.medicaid.gov/affordablecareact/provisions/downloads/mpec-032116.pdf>

²⁴ 42 CFR 455.18

²⁵ 42 CFR 1001.1901(b)(1)

²⁶ §1915(c) waiver authority does not permit direct payments to a waiver participant, either to reimburse the participant for expenses incurred or to enable the participant to directly pay a service provider. FMS works as an intermediary organization that performs financial transactions on behalf of the participant.

attendants that it employs at the direction of the beneficiary, the FMS entity is considered the provider for purposes of screening and enrollment.

Under federal regulations, Medicaid providers determined by state Medicaid agencies to be “high” risk are required to undergo fingerprint-based criminal background checks.²⁷ However, states have discretion to conduct or require criminal background checks for individual PCS attendants who are not considered providers but who are employed by or subcontract with providers and furnish the PCS services for the provider that submits the claims. A number of states, including Iowa, Minnesota, Ohio, and Virginia, conduct criminal background checks of PCS attendants.

The CMS National Background Check Program (NBCP) enables long-term care providers, including PCS agencies, to conduct a fingerprint-based search of the state and federal criminal history of individuals having direct access to, and one-on-one contact with, Medicaid beneficiaries.²⁸ While NBCP is not a mandatory program, OIG has recommended criminal background checks for all PCS attendants. The role of background checks in identifying criminal histories of individuals applying for PCS attendant status is not disputed and states should consider requiring such checks. However, states are also encouraged to collaborate with stakeholders, including beneficiary advocates, to develop enrollment policies that support consumer-directed programs that allow friends and family members to be recognized as PCS attendants. The Equal Employment Opportunity Commission has issued guidance on how criminal history can be viewed in the context of prospective employment.²⁹ Federal Financial Participation (FFP) is available to support states’ efforts in obtaining criminal background checks for individuals applying for PCS attendant status. As part of administering consumer-directed PCS, a state may incur costs applicable to either performing criminal background checks or contracting with an entity to perform criminal background checks. In either situation, Medicaid’s allocable portion of the incurred cost can be claimed as a state program administrative expenditure and reimbursed at the 50 percent administrative claiming rate. With regard to agency-directed PCS, costs applicable to criminal background checks can be considered by the state in developing the PCS rate which should be paid on a per service basis and claimed at the applicable Federal Medical Assistance Percentage (FMAP).

Verification of Need for Services

²⁷ 42 CFR 455.450(c).

²⁸ <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/BackgroundCheck.html>

²⁹ https://www.eeoc.gov/laws/guidance/arrest_conviction.cfm

PCS covered under the state Plan option must be authorized by a physician or authorized in accordance with a service plan approved by the state.³⁰ The state has discretion to determine the functional eligibility criteria that qualify a beneficiary for PCS. PCS covered through an HCBS waiver or Community First Choice benefit must be furnished only to beneficiaries who are determined to need an institutional level of care based on an initial evaluation (and annual reevaluation).³¹ Whatever the functional eligibility criteria, states should verify that the individual's eligibility for the PCS benefit is documented before the services are furnished.

Documentation of Claims

PCS providers, like providers of any other Medicaid services, must be able to document the provision of services for which they have submitted a claim for payment.³² Section 11600 of the State Medicaid Manual indicates that claims for any Medicaid service must be reviewed to ensure the following: it contains all the required information (which includes the date(s) of service, who provided the service, where the service was provided, length of time required for the service, if relevant, and third party billing information); the information is internally consistent; the individual who received the service and the provider who submitted the claim were certified as eligible to participate in the program on the date(s) of service; the service provided is covered under the program; the service does not exceed frequency limitations; and any required prior authorizations or certifications were obtained.

Improper payments for PCS occur when, among other things, claims are not supported by sufficient documentation. States and PCS providers should review the common documentation and billing errors relating to PCS and promising practices for correcting them.³³ PCS providers should check to avoid billing errors prior to submitting claims.³⁴ States' monthly submission of Transformed Medicaid Statistical Information System (T-MSIS) data will give CMS and other stakeholders the ability to more closely monitor the trends in states' PCS claims over time.

If a state uses a single standardized form for the PCS service record, the state should ensure that the records reflect the amount/scope/duration of services specified in the PCS plan. It should also consider including comment boxes on forms that require employees to fill in their daily observation. In the alternative, states could require PCS attendants to document the provision of services with some kind of verification mechanism. There are no standard

³⁰ 42 CFR 440.167(a)(1)

³¹ 42 CFR 441.302(c) 441.510(c)

³² Section 1902(a)(27) of the Social Security Act, 42 CFR 431.107(b)(1), (2).

³³ CMS, Common Errors That Lead to Improper Payments for Personal Support Services. October 2015. <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/hcbs-tk1-common-errors-PersSupServ-factsheet.pdf>

³⁴ CMS, Quality Checklist for Billing Home and Community-Based Services. October 2015. <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/hcbs-tk1-qual-check-billing-factsheet.pdf>

requirements for verification of PCS provision. CMS encourages states to implement some form of verification to ensure that PCS being billed were actually provided.

Prepayment Edits

To avoid making payments on improper PCS provider claims, states should ensure that all claims for PCS services are processed with specific edits that automatically deny unusual activity, such as duplicative billings for the same service and duplicative billing during an individual's institutional stay (unless they are billings for retention payments authorized as part of the state's approved PCS program). The cost of system development of these special edits in the state's Medicaid Management Information System (MMIS) claims processing subsystem is eligible for the ninety percent enhanced match because the edits are applicable to MMIS development. In addition, states should ensure that their requirements for record retention are clearly communicated to providers, along with language on penalties to be imposed for non-compliance. Claims submission policies require that PCS claims include all relevant data elements identified above, and states are encouraged to review PCS claims when they span a wide range of service dates (i.e., larger than 30 days).

Post-payment Review

States should conduct post-payment reviews to verify that services are in compliance with state standards for PCS services. In conducting post-payment review, states should consider including the following elements: how an individual's level of care was certified and re-certified; whether the Person-Centered Service Plan (PCSP) is current at the time of Medicaid eligibility and billing; whether the scope/amount/duration of services provided aligns with the PCSP; and whether claims data and service documentation confirms services billed were rendered. States should be utilizing billing system edits to prohibit payment for services provided beyond the scope of services authorized. In instances in which a post-payment review reveals a lack of supporting documentation to validate the service claim, or reveals that services were provided outside of the service authorization parameters, states should recoup impacted payments from providers.

Audits

States should perform ongoing audits and provider quality reviews of PCS agencies to ensure that services for which claims are paid are:

- Covered services under the State Plan;
- Delivered in accordance with an approved plan of care;
- Properly documented;
- Delivered by appropriately certified staff; and

- Not inappropriately billed while the beneficiary was in a hospital or nursing home.

For Further Information

CMS recently issued a Request for Information on strengthening the provision of home and community-based services, including PCS. Additional discussion is reflected in this document on the need to ensure the availability of high-quality and safe PCS to assist individuals to remain in their communities, while also ensuring services are delivered according to program integrity standards. Public input is solicited on actions CMS may consider in achieving both of those goals.

CMS hopes the content of this bulletin is helpful to states in strengthening integrity in Medicaid PCS. States interested in learning more on these topics and to request technical assistance may contact Melissa Harris in CMCS at melissa.harris@cms.hhs.gov, and Clint Eisenhower in CPI at clint.eisenhower@cms.hhs.gov.