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ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States
House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

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MEMORANDUM

April 28, 2017

To: Democratic Members of the Subcommittee on Oversight and Investigations

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Combating Waste, Fraud, and Abuse in Medicaid's Personal Care Services Program"

On **Tuesday, May 2, 2017, at 10:15 a.m. in 2322 Rayburn House Office Building**, the Subcommittee on Oversight and Investigations will hold a hearing titled "Combating Waste, Fraud, and Abuse in Medicaid's Personal Care Services Program." The hearing will examine Medicaid personal care services and recommendations to prevent fraud and patient harm and neglect within the program.

I. PERSONAL CARE SERVICES UNDER MEDICAID

The Personal Care Services (PCS) program is an optional benefit through which states may elect to provide nonmedical assistance to the elderly, people with disabilities, and individuals with chronic or temporary conditions so that they may remain in their homes and communities.[1] Examples of PCS include assistance with bathing and dressing. PCS services are often provided by an attendant, who typically works for a personal care agency that enrolls in Medicaid and bills for services on the attendants' behalf.[2] States are required to develop standards for attendants to ensure quality of care.[3]

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[1] U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG), *Investigative Advisory on Medicaid Fraud and Patient Harm Involving Personal Care Services* (Oct. 3, 2016) (www.oig.hhs.gov/reports-and-publications/portfolio/ia-mpcs2016.pdf).

[2] U.S. Government Accountability Office (GAO), *Medicaid Personal Care Services: CMS Could Do More to Harmonize Requirements across Programs* (Nov. 2016) (GAO-17-28).

[3] *See* note 1.

II. PROGRAM INTEGRITY IN MEDICAID AND PROVISIONS UNDER THE AFFORDABLE CARE ACT

States are the first line of defense against Medicaid fraud and improper payments. States bear the initial responsibility for compliance with federal requirements, detection of improper payments, recovery of overpayments, and referral of suspected fraud and abuse cases to law enforcement.[4] The Centers for Medicare & Medicaid Services (CMS) works closely with states to ensure compliance with federal Medicaid rules. Medicaid Fraud Control Units, located in the offices of state attorneys general, work in conjunction with the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) and the Department of Justice to investigate and prosecute Medicaid fraud.

The Affordable Care Act (ACA) contains numerous provisions to improve prevention, detection, and enforcement actions against Medicaid fraud, including $350 million over ten years (FY 2011-FY 2020) to combat fraud.[5] In 2011, HHS announced new rules under the ACA to move CMS anti-fraud efforts away from "pay and chase" and toward a "prevention and detection" model, including enhanced screening and more robust sharing of claims data. The ACA also provided new authority for CMS to temporarily halt enrollment and payment to providers suspected of fraud, authority for the HHS-OIG to impose stronger penalties for fraud, and increased Federal sentencing guidelines for health care fraud.[6]

III. HHS-OIG AND GAO AUDITS HAVE UNCOVERED VULNERABILITIES WITHIN THE PCS PROGRAM

HHS-OIG and the Government Accountability Office (GAO) have conducted a number of reviews of Medicaid PCS over the years and have flagged various program vulnerabilities. For example, a 2012 HHS-OIG assessment found improper payments for PCS, including documentation problems and noncompliance with state requirements. The assessment also determined that some PCS payments or services were provided during periods in which beneficiaries were in institutional stays that were being reimbursed by Medicare or Medicaid, or were provided by PCS attendants who failed to meet state qualification requirements.[7]

In a more recent investigative advisory on Medicaid PCS fraud, HHS-OIG noted cases in which PCS attendants fraudulently billed for services that were unnecessary or not provided, as well as instances in which PCS attendants caused patient harm or death. In this advisory, HHS-OIG noted outstanding recommendations to CMS that had been in HHS-OIG's 2012 report.

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[4] GAO, *Medicaid Program Integrity: Expanded Federal Role Presents Challenges to and Opportunities for Assisting States* (Dec. 7, 2011) (GAO-12-288T).

[5] Department of Justice, *Departments of Justice and Health and Human Services Team Up to Crack Down on Health Care Fraud* (Nov. 5, 2010) (press release).

[6] Centers for Medicare & Medicaid Services, *CMS Fraud Prevention Initiative: New Tools to Fight Fraud and Protect Taxpayer Dollars* (July 2011) (www.cms.gov/outreach-and-education/outreach/partnerships/downloads/backgrounderfraudpreventioninitiative.pdf).

[7] HHS-OIG, *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement* (Nov. 2012) (OIG-12-12-01).

Those recommendations included establishing minimum Federal qualifications and screening standards (including background checks) for PCS workers, revising enrollment and registration requirements for PCS attendants, and requiring that PCS claims data include dates of service and the identity of the PCS attendant who provided the service.

Similarly, GAO has also raised concerns about PCS vulnerabilities. For example, a November 2016 report identified variation in state requirements for beneficiary safety and billing of services, which complicates oversight efforts. GAO recommended that CMS collect and analyze required state reports on PCS and take further steps to harmonize federal requirements across state programs providing these services.[8] In a January 2017 report, GAO found gaps and errors in CMS's PCS claims data, which limit the data's usefulness for conducting oversight. This report made recommendations to CMS to enhance PCS data, including ensuring state compliance with data reporting requirements and developing plans to better use this data for program oversight.[9]

The Energy and Commerce Committee considered Medicaid PCS program integrity extensively during the 114th Congress. In a legislative hearing on September 11, 2015, the Committee considered H.R. 2446, which would have required electronic visit verification for PCS under Medicaid. This legislation was marked up on November 4, 2015, and a version of the bill was signed into law along with the 21st Century Cures Act on December 13, 2016.[10] This new law will help address past HHS-OIG concerns that state Medicaid programs lack appropriate documentation to demonstrate that services have been rendered and that PCS attendants meet state and federal requirements.

IV. WITNESSES

The following witnesses have been invited to testify:

Timothy Hill
Deputy Director, Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Service

Katherine Iritani
Director, Health Care
U.S. Government Accountability Office

Christi Grimm
Chief of Staff
Office of Inspector General
U.S. Department of Health and Human Services

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[8] *See* note 2.

[9] GAO, *CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services* (Jan. 2017) (GAO-17-169).

[10] P.L. 114-255.