STATEMENT OF

TIM HILL,
DEPUTY DIRECTOR, CENTER FOR MEDICAID AND CHIP SERVICES

ON

COMBATING WASTE, FRAUD, AND ABUSE IN MEDICAID'S PERSONAL CARE SERVICES PROGRAM

BEFORE THE

U. S. HOUSE ENERGY AND COMMERCE COMMITTEE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

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U. S. House Energy and Commerce Committee,
Subcommittee on Oversight and Investigations
Combating Waste, Fraud, and Abuse in Medicaid's Personal Care Services Program
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Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee, thank you for the invitation and the opportunity to discuss personal care services (PCS) in Medicaid. We share this Subcommittee's commitment to protecting beneficiaries and ensuring taxpayer dollars are spent on legitimate items and services, both of which are at the forefront of our program integrity mission. Because Medicaid is jointly funded by States and the Federal government and is administered by States within Federal guidelines, both the Federal government and States have key roles as stewards of the program, and CMS and States work together closely to carry out these responsibilities. Under the Medicaid Federal-State partnership, the Federal government sets forth a policy framework for the program and States have significant flexibility to choose options that enable them to deliver high quality, cost-efficient care for their residents.

PCS are one example of Home- and Community-Based Services (HCBS), types of person-centered care delivered in the home and community and can include a variety of health and human services. HCBS, including PCS, can be a critical component in helping beneficiaries maintain as much independence as possible in their homes by providing assistance with basic Activities of Daily Living (ADL), such as bathing or dressing, and Instrumental Activities of Daily Living (IADL) such as meal preparation and money management. This allows beneficiaries to remain in the community rather than in a nursing facility or other institution. Creating and maintaining a Medicaid HCBS program benefits the community and the individuals served in many ways; these programs are usually less than half the cost of residential care, empower patients to have more control over their daily lives and management of their health, and provide essential and culturally appropriate support to patients and their families.[1]

CMS takes the oversight of State PCS programs seriously, and the health and well-being of Medicaid beneficiaries are a top CMS priority. Without PCS, many beneficiaries who are elderly and individuals with disabilities may have no practical alternative to institutionalization. Program

[1] https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/hcbs.html

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.

We appreciate the ongoing work done by the Department of Health and Human Services Office of Inspector General (OIG) and the Government Accountability Office (GAO) to highlight potential program integrity vulnerabilities and provide recommendations on strengthening safeguards. CMS relies on these recommendations to inform our program improvement activities across our programs, including PCS. We have taken action to address a number of the recommendations made by OIG and GAO, and we will continue to identify and take additional steps to enhance safety and quality of services provided to Medicaid beneficiaries while maintaining the flexibility States need to design Medicaid programs that best meet the unique needs of their residents.

Supporting Independence through Home- and Community-Based Services (HCBS) and Personal Care Services (PCS)

Home- and Community-Based Services (HCBS), including PCS, are types of person-centered care delivered in the home and community and can include a variety of health and human services. HCBS programs address the needs of people with functional limitations who need assistance with everyday activities, like getting dressed or bathing, and are designed to enable people to stay in their homes and community, rather than moving to a facility for care. HCBS programs are often funded by State-requested waivers. Waiver programs are part of a State's Medicaid program, but they provide a special group of services to certain populations. Waiver programs usually have medical and financial eligibility requirements, but eligibility for waiver services may not be exactly the same as the eligibility rules for other Medicaid eligibility groups. Coverage of PCS is optional for States, except when they are medically necessary for children under the age of 21 eligible for early and periodic screening, diagnostic, and treatment (EPSDT) services. When States include PCS, coverage can be established using several State Plan options, under one or more waivers approved by CMS, or both.

Generally, PCS consists of services supporting ADL, such as movement, bathing, dressing, toileting, and personal hygiene, or IADL, such as meal preparation, money management,

shopping, and telephone use. Typically, an attendant provides PCS and rules for attendant qualifications are set by States. Given the nature of the services provided, personal care provider qualifications have tended to be less formal than those for providers of nursing or licensed therapies. Many States have adopted personal care provider qualifications such as minimum age requirements, possession of a valid driver's license, criminal background checks, and completion of training required by the State and specific training required by the beneficiary. Certain Medicaid authorities allow States to offer family members or legal guardians the option to become a paid 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 personal care attendants (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 States to collaborate with stakeholders in considering use of self-directed models with necessary supports and a person-centered planning process. By allowing beneficiaries to choose trusted friends and family as PCS attendants, the use of self-directed programs has assisted in increasing the pool of providers available.

As a result of receiving HCBS, including PCS, many beneficiaries have been able to achieve greater independence and community integration and have been able to exercise self-direction,

personal choice, and control over services and providers.[2] Maintaining this State flexibility is a critical component in CMS's overall efforts to encourage innovation and facilitate States' abilities to address the specific needs of their residents. Studies suggest the HCBS delivery system is more cost effective than an institutional placement[3], and a 1915(c) HCBS waiver can only be approved as long as, on an annual basis, the State can verify that the cost of services in the community does not exceed the cost of services in the associated institutional settings.

CMS Support for State Program Integrity Efforts

While PCS programs vary greatly by State and within States, States must request and receive approval from CMS to operate the programs and specify the services to be delivered, and CMS works in concert with the State through the review process to ensure that the State oversight system is sufficient and that individuals have appeal rights. In addition, in the newer PCS coverage authorities and in the 1915(c) waiver program, States are required to report, track, and evaluate data, including allegations of abuse, neglect, exploitation, and unexplained death. Their reviews of this data are reported to CMS on a regular basis, and we take action as permitted through regulation to address any concerns identified. In an effort to continuously improve the quality of care provided, and in response to GAO and OIG recommendations, CMS has taken a number of steps to improve program coordination by issuing additional guidance, providing technical assistance to States, and modernizing Federal databases.

In January 2014, CMS promulgated a final rule[4] that harmonized many requirements for HCBS, including PCS. These regulations addressed beneficiary assessments and plan of care provisions for certain programs that provide PCS. The final rule also provided States with the option to combine coverage for multiple target populations into one waiver to facilitate streamlined administration of HCBS waivers, and allowed States to use a five-year renewal cycle to align concurrent waivers that serve individuals eligible for both Medicaid and Medicare. The rule also requires that States safeguard against the provision of unnecessary or inappropriate services and

[2] https://kaiserfamilyfoundation.files.wordpress.com/2014/03/8568-medicaid-beneficiaries-who-need-home-and-community-based-servcies.pdf
[3] https://aspe.hhs.gov/basic-report/cost-effectiveness-home-and-community-based-long-term-care-services
[4] 79 FR 2948, January 16, 2014

supports, relying on principles of person-centered planning to describe the services needed to address issues identified in an assessment of the individual's healthcare status.

More recently, CMS published guidance for providers summarizing some of the key PCS and PCA requirements, a brief explanation of differences between PCS and home health services, an overview of common causes of improper payments, and guidance on how to avoid them.[5] In February 2016, CMS provided training[6] to State officials on monitoring fraud, waste, and abuse in home and community-based settings for PCS. The training included information on OIG's recent PCS findings and possible actions States can take to help to identify and prevent PCS waste, fraud and abuse.

CMS has also recently issued Informational Bulletins to States providing suggested approaches for strengthening and stabilizing the Medicaid home care workforce[7] and other options to strengthen program integrity in Medicaid PCS.[8] For strengthening and stabilizing the Medicaid home care workforce, suggestions included the implementation of a registry to reflect individuals meeting the State's provider qualifications, if applicable, and the option for States to require basic training to workers without usurping beneficiary decisions on what skills are most appropriate for their homecare workers. To address vulnerabilities regarding improper payments for PCS services, we recommended that States establish adequate post-payment review processes, incorporate prepayment edits that automatically deny unusual activity, such as duplicative billings for the same service and duplicative billing during an individual's institutional stay, and perform ongoing audits. Other options identified to address program integrity within PCS programs included developing and implementing procedures for ensuring compliance with requirements for provider qualifications and screening, and verification of beneficiary need for services.

[5] https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/pcs-improperpayment-factsheet-082914.pdf
[6] https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-3a-fwa-in-pcs-training.pdf
[7] https://www.medicaid.gov/federal-policy-guidance/downloads/cib080316.pdf
[8] https://www.medicaid.gov/federal-policy-guidance/downloads/cib121316.pdf

Last November, to better ensure the successful delivery of HCBS, including PCS, CMS released a Request for Information[9] to solicit feedback on the following:

- The benefits and consequences of implementing standard Federal requirements for personal care workers in agency-directed and/or self-directed models of care;
- The criteria of what standardized qualifications would include, in terms of educational, minimum age, and screening requirements;
- Circumstances in which standardization would not apply or would require different standards;
- The role of State-administered home care worker and/or PCS attendant registries;
- The role of criminal background checks;
- The role of home care worker organizations in providing training to support implementation of Federal qualification standards;
- The feasibility for State Medicaid programs of including home care worker identity on claims submitted for reimbursement;
- Program integrity safeguards that could be used instead of or in addition to OIG's recommended controls for both agency-directed and self-directed PCS; and
- Program integrity safeguard development

CMS received over 500 comments in response, and we are in the process of analyzing this feedback and will incorporate suggestions as appropriate. As we move forward with program improvement efforts, CMS is committed to maintaining State flexibility for PCS, in terms of provider qualifications and oversight.

In February 2017, CMS focused a Medicaid Integrity Institute (MII)[10] course on PCS. The MII is a CMS-funded program that provides training to State Medicaid and program integrity staff. CMS developed the "Emerging Trends in HCBS/PCS" course to bring together State and Federal stakeholders to discuss vulnerabilities, mitigation strategies, and challenges and barriers related to PCS administration. Federal participants included CMS, OIG, and the Department of

[9] https://www.federalregister.gov/documents/2016/11/09/2016-27040/medicaid-program-request-for-information-rfi-federal-government-interventions-to-ensure-the
[10] For more info, see MII "About" page: https://www.justice.gov/mii/about

Justice (DOJ). State participants brought clinical, program integrity, policy, operations, social work, law enforcement, and programmatic expertise to the course. This diverse structure allowed participants to articulate and develop a holistic approach to PCS program integrity. As a result, the class participants reached consensus on potential program considerations that support the safe delivery of services to vulnerable populations of beneficiaries eligible for HCBS and PCS and more effective stewardship of program funds.

CMS has also developed focused Program Integrity Reviews related to PCS. The reviews assess State program integrity effectiveness related to PCS, and provide States with feedback in terms of vulnerabilities that may exist as well as resources to correct the vulnerabilities and identify best practices which can be shared with other States. CMS will conduct this type of focused review in five States in 2017 (IA, MS, NY, SD, and TX).

Finally, as part of the 21st Century Cures Act (P.L. 114-255) enacted last December, starting in 2019, States must require PCS provided under Medicaid to use an electronic visit verification (EVV) system in order to receive the full Federal medical assistance percentage. EVV systems electronically record the date, time, and, in some cases, location of a PCS provider's visit to a beneficiary by utilizing technology such as cell phone GPS, digital signatures with time and date stamping, or biometric recognition. Already, many States have either mandated or encouraged the use of EVV systems. We look forward to continuing to work with States as they move forward in their design and implementation processes of these systems.

Conclusion

CMS and States have worked for decades to support increased availability and provision of quality HCBS for Medicaid beneficiaries, which is not only a more cost-effective method of service delivery, but is also often the option preferred by individuals receiving services. CMS greatly appreciates the work of OIG and GAO regarding the potential vulnerabilities in the provision of Medicaid PCS, and we look forward to continuing our partnership with these agencies as well as the States. As we continue to improve program integrity for PCS, we must also work to ensure that any additional oversight requirements do not create administrative burden, increase costs and impact beneficiary choice and control. We will continue to assess the

operational feasibility for States of these recommendations and the implications for beneficiary access and quality of services. The successful delivery of PCS to Medicaid beneficiaries must ensure that both individual needs and preferences are met and that the program has adequate safeguards in place, and we look forward to continuing to improve our efforts in these areas.