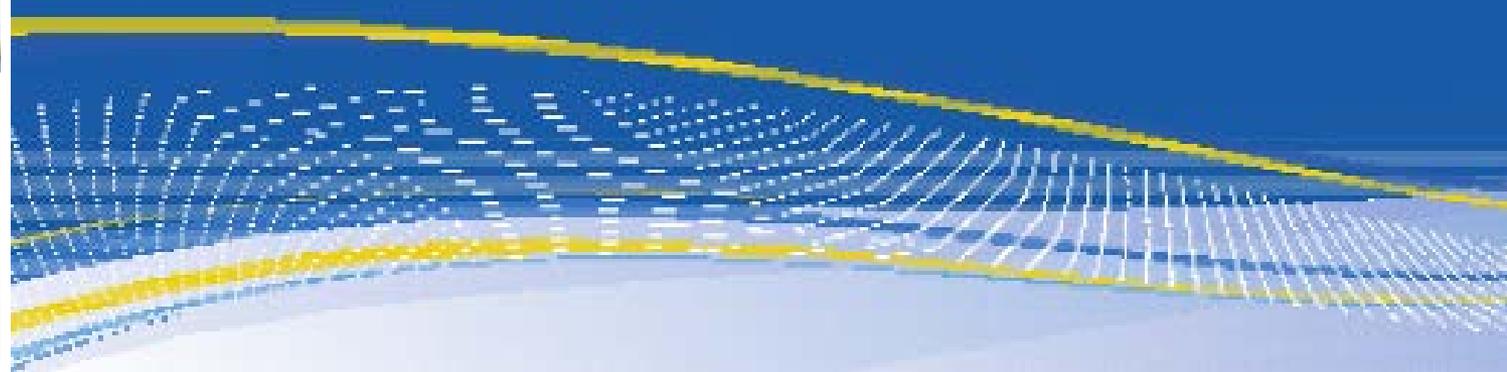




Increasing Fiscal Protections for Personal Care Services



Division of Long Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services



Training Objectives

- Understanding the basic concepts of Fraud, Waste and Abuse (FWA).
- Understanding the basic concepts of Personal Care Services (PCS).
- Understanding how to complete Appendix I-1, relating to post-payment review process of PCS.
- Outlining recommendations for detecting and addressing PCS related FWA.

Major Lessons Learned from PCS Fraud Cases

- PCS fraud is an area of concern in Medicaid due to the high rate of utilization and high vulnerability of the population.
- 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 without authorization for retention payments are some of the more common instances of fraud.
- Educating providers, beneficiaries, and the general public is an essential measure to address FWA in PCS.

Personal Care Services Definition

Definition of Personal Care Services¹

➤ 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**
 - Agency directed model.
 - A qualified PCS agency hires, fires, pays and trains Personal Care Attendants (PCAs) to provide services to individuals.
- **Self-directed²**
 - Alternative to the agency directed 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 some or 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.

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.³
- Example: Knowingly submitting claims for services that were not rendered.

Waste

- Overutilization, underutilization, or misuse of resources. Waste typically is not an intentional act.⁴
- 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.⁴
- 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 unless retention payments have been authorized.

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?

- Service costs and utilization continue to increase:⁵
 - 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 Office of Inspector General (OIG) report:⁶
 - Audit of two states recommended to refund more than \$61.1 million to the 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 because of improper Personal Care Service claims.

Importance of Fiscal Protections in PCS

- Fiscal integrity protections are important for all services and programs:
 - Essential to prevent improper payments.
 - Vital to the continuation of all services and programs.
 - Reduces and prevents fraud, waste, and abuse.
 - Allows for States to continue to support PCS programs.

Trends for FWA

Per the OIG report *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement (November 2012)*, the OIG found a common trend in improper payments:

- Services were not provided in compliance with State requirements.*
- Services were not supported by documentation.*
- Services were provided during periods in which the beneficiaries were in Medicaid-reimbursed institutional stays and retention payments had not been authorized.
- Services were provided by PCS attendants who did not meet State qualification requirements.

**One of the most common findings in fraudulent PCS schemes*

Fiscal Integrity Concerns Specific to Self-Directed PCS

In addition to the FWA trends outlined, Self-Directed PCS services have specific fiscal integrity concerns, such as:

- The need for controls to address the potential related party (i.e., family and legally responsible caregivers) fraud schemes, specifically pertaining to programs which allow individuals to select families and legally responsible caregivers as their PCS attendant.

To address these concerns, multiple parties should perform oversight of the self-directed PCS program:

- Fiscal Management Services (FMS) should oversee self-direction programs.
- Support brokers should oversee self-direction program participants.
- State Medicaid Agencies are still responsible for the oversight of FMS agencies and support brokers.

Fiscal Integrity Documentation in a 1915(c) Waiver Applications

Technical Guide Requirements

- Appendix I-1 – Fiscal integrity systems
- Technical guide, pg. 249 requires the states to describe:

*“The state’s own financial audit program to ensure the integrity of provider billings for Medicaid payment of waiver services, including the **methods, scope and frequency of audits conducted by the State.**”*

Recommendations for FWA Prevention

How to increase fiscal protections in PCS:

- Based on reviews of personal care programs in 1915(c) waiver applications and a review of the OIG reports, the following are recommendations related to preventing FWA opportunities and documenting fiscal integrity related to PCS in Appendix I-1.
 - Recommendation 1: Establish adequate post payment review processes and provide detailed descriptions under Appendix I-1.
 - Recommendation 2: Implement adequate post payment review processes specific to self-direction PCS and provide detailed descriptions under Appendix I-1 or other applicable appendices (e.g. Appendix E, Participant Direction of Services).

Recommendation 1: Establish Adequate Post Payment Review Processes and Provide Detailed Descriptions in Appendix I-1

- To address OIG's concerns from its 2012 report, CMS is currently conducting research with contractors.
- Recent review of the 1915(c) waiver applications revealed that states lack clarity and/or are missing descriptions for areas in Appendix I-1.
 - Process and steps involved in the post-payment review include method, scope and frequency of the following:
 - Sampling process involved in selecting claims, providers, or individuals for review.
 - Specific elements and documents reviewed during the post-payment review process.
 - How the results of the post-payment reviews are communicated to the providers and other organizations, and how they are used for systemic corrections and/or improvements.

Recommendation 1: Establish Adequate Post Payment Review Processes and Provide Detailed Descriptions in Appendix I-1

States must include the following **three** requirements when discussing their post-payment review process:

- **Scope:** How is data selected for review?
 - Describe the data source from which the sample is derived.
 - Examples: MMIS paid claims, a list of service providers and/or participants in the waiver program.
 - Describe the time period from which the sample was selected.
 - Examples: Samples can be selected for a particular month, or split into time periods such as a quarter or an entire fiscal year.
- **Frequency:** How often are reviews performed?
- **Method:** What method is used to ensure the integrity of payments?
 - Describe process for assuring the integrity of payments.
 - See next slides for review methods recommendations.

Recommendation 1: Establish Adequate Post Payment Review Processes and Provide Detailed Descriptions in Appendix I-1

Post-Payment Review Method Considerations

- Post-payment reviews should verify services are in compliance with state standards, as specified in the waiver.
- States should consider including the following elements in their post-payment review and describe the process in detail on Appendix I-1:
 - How 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 aligns with the PCSP.
 - Whether claims data and service documentation confirms services billed were rendered.

Recommendation 1: Establish Adequate Post Payment Review Processes and Provide Detailed Descriptions in Appendix I-1

Service Documentation Review Considerations before the post-payment review:

- If the State uses a single standardized form for the PCA service record, ensure that the records reflect the amount/scope/duration of services specified in the PCSP, regardless of whether the records are in electronic or paper format.
- During the creation of a standardized PCA service record/form, consider including comment boxes on forms that require employees to fill in their daily observations.
- This method could allow for some level of confidence that the worker was on-site and that services were rendered if the comments are reviewed to ensure that they are not identical or substantively identical in nature.

An Adequate Post-Payment Review Process

Service Documentation Review Considerations (Continued)

- Sampling the service records for review:
 - Describe how the individuals' records are selected for the post-payment review.
 - If the State uses family and legal guardian PCAs, then include how Appendix C-2-d provisions described in the waiver applications are met.
 - Describe on I-1 and/or reference where such provisions are described, such as Appendix C-2-d.

An Adequate Post-Payment Review Process

Service Documentation Review Considerations (Continued)

- Selection/Sampling Process for Post Payment Review:
 - Unusual billing patterns captured during claims data analysis:
 - Think outside the box – highest billed entities are often selected by the State and other organizations for review. What about other options?
 - Identify any violations in the sample and expand the review to determine the extent of these violations. If the state has already identified violators, the state should do an analysis to determine how broad based the violation is.
 - If claims show that payments were made during periods of institutional stays and retention payments were not permitted, check to see if other violations are present.

An Adequate Post-Payment Review Process

Service Documentation Review Considerations (Continued)

- During post-payment review:
 - Compare service documentation to billed claims to ensure that there is available documentation for each billed claim.
 - Confirm that documentation is not being completed in a pro-forma fashion.
 - Review the “quality” of service documentation.
 - Are service records being photocopied with only the dates being changed and content remaining the same?
 - Is the content of the service record virtually the same on a daily basis?
 - Check for the visit verification methods. Who should be verifying the PCS visit? How is it verified?
 - Use MMIS (if applicable) to review claims. This process can detect billings for individuals who have been *institutionalized with retention payments*.

An Adequate Post-Payment Review Process

Service Documentation Review Considerations (Continued)

- During post-payment review:
 - Compare the records for any overlap with other services, such as overlap between PCS services and Home Health Aide visits.
 - How is the State assuring by policy (procedure prohibition) / procedure (MMIS edits) or by audit process that there is no overlap in services provided?

An Adequate Post-Payment Review Process

Service Documentation Review Considerations (Continued)

- During post-payment review:
 - Fraud is difficult to detect by documentation alone. Other approaches include:
 - Verify with the families and individual(s) whether they are receiving the services and whether they are satisfied with the services that they receive.
 - Can be accomplished by a telephone call, mailing, electronic questionnaire, or an in-person visit. If a visit occurs, observations of the individual(s) and environment may be a critical component.

An Adequate Post-Payment Review Process

Service Documentation Review Considerations (Continued)

- During post-payment review:
 - Compare the service address against the service payment check delivery address and determine if the PCA is cashing the check for the services delivered.
 - Part of the detailed review could include reviewing check copies to ensure that the same signature is present on all checks cashed.

Example of Appendix I-1 Post-Payment Review Description

Example of Appendix I-1 for Post-Payment Review:

- **Scope:** How is data selected for review?
 - The State selects five providers annually for post payment reviews. The State ensures that the same providers will not be selected twice during the five year waiver period. Among the providers selected annually for review, the State decides whether to perform an on-site or desk review based on a risk analysis of paid claims from the previous fiscal year. All paid claims data from the previous state fiscal year are selected and reviewed. A risk analysis will be conducted using the following criteria: highest utilization of services and highest number of duplicate claims reported. The two providers with the most frequent occurrences of risk analysis criteria will be selected for onsite reviews. Three remaining providers will be selected for desk reviews.*

**Sampling methods and frequencies used in this slide are for demonstration purposes only. States should determine a valid sampling approach for their waiver programs.*

Examples outlined above are demonstrative examples. States can determine their own review methods.

Example of Appendix I-1 Post-Payment Review Description

Example of Appendix I-1 Post-Payment Review (continued):

➤ **Frequency:** How often reviews are performed?

➤ Post payment reviews are performed annually.*

**Sampling methods and frequencies used in this slide are for demonstration purposes only. States should determine a valid sampling approach for their waiver programs.*

Examples outlined above are demonstrative examples. States can determine their own review methods.

Example of Appendix I-1 Post-Payment Review Description (Cont.)

Example of Appendix I-1 Post-Payment Review (continued):

➤ **Methods used to review integrity of payments*:**

➤ **During post payment reviews, the State:**

- Requests service records from the provider selected for review.
- Compares sampled claims against selected records to determine if documentation supports services billed were actually rendered and to determine whether documentation meets State requirements.
- Reviews the PCSP to verify that it is valid and renewed within the last 12 months.
- Conducts quality assurance phone interviews with the selected sample individuals to gauge service satisfaction.

**Examples outlined above are demonstrative examples. States can determine their own review methods.*

Example of Appendix I-1 Post-Payment Review Description (Cont.)

Example of Appendix I-1 Post-Payment Review (continued)

- **Post-Review Activity:** The providers are notified of review results.*
 - If there are concerns generated related to either the desk review or on-site review, a corrective action plan could be required.*
 - The State may require the provider to conform to a corrective action plan and/or submit a remittance for services that the provider cannot substantiate were rendered.*
 - Providers have the opportunity to appeal the State's decision.*

**Examples outlined above are demonstrative examples. States can determine their own review methods.*

Recommendation 2: Implement Adequate Post Payment Review Processes Specific to Self-Direction PCS

- Self-directed providers are typically paid differently than an Agency. Often this is accomplished through the use of a FMS entity. The FMS entity may take several different forms:
 - Example 1: An independent private entity that performs employer functions. The level of involvement can vary between individual FMS entities. Services offered can include payroll services, training, tax services, verification of timesheets, and assistance with hiring.
 - Example 2: Operated by the State, performs the same functions as the aforementioned FMS.

What is Financial Management Service?

Role of the FMS

- §1915(c) waiver authority does not permit payments for services provided directly 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.
- FMS also provides protections and safeguards for participants who direct their own waiver services, such as performing background checks on potential PCAs or verifying time sheets.
- FMS may act as employer of the PCA.*

** This training reflects Medicaid policy and procedure for self-direction. States and individuals are urged to review the FLSA page of the Department of Labor website (<http://www.dol.gov/whd/flsa/>) as FLSA's changes to regulations may impact the delivery of self-directed services.*

What is Financial Management Service?

- Supports and facilitates self-direction services for two purposes.
- Role of the FMS per Technical Guide pgs. 201-202:
 - *Important safeguard for participants and workers alike ensuring that participants are in compliance with Federal and state tax, labor, workers' compensation insurance and Medicaid regulations:*
 - Ensures payroll is implemented in an accurate and timely manner.
 - Ensures that invoices for services and supports included in the PCSP are paid appropriately and in a timely manner.

Employer Authority and Budget Authority

- FMS functions may vary by whether the individual in the State has employer authority and/or budget authority.
- In self-direction, individuals are responsible for managing some or all aspects of service delivery in a person-centered planning process which may include:
 - **Employer Authority** – Recruiting, hiring, training, and supervising providers.
 - **Budget Authority** – Managing the participant directed budget and potentially determining the rates for services (within parameters set by State).
- Examples of FMS entities' basic functions based on employer vs. budget authority.
 - **Employer Authority:** Verify PCA immigration status, perform background checks for PCAs, and operate a payroll service for PCAs.
 - **Budget Authority:** Track and report budget funds, prepare and distribute budget and expense reports to individuals and families.
 - For **both** employer and budget authority: Process and pay invoices for services and supports, verify timesheets, and ensure that services are paid in accordance with PCSP.

Significance of Self-Direction Payment Monitoring

Why is Self-Direction Post-Payment Monitoring Significant?

- OIG's Personal Care Portfolio issued in November 2012 noted that self-directed Medicaid service models with certain individual decision-making processes may be particularly vulnerable to fraud schemes involving services not being rendered. Examples of these processes are:
 - Individuals can become an employer who can hire, fire, and select shift times without typically having a system of checks and balances such as is present in the agency-directed model. Without a system of checks and balances, self-direction programs may be vulnerable to FWA. State should ensure that FMS and support brokers are providing checks and balances.
 - Individuals may or may not have the pool of staffing necessary to make critical decisions – such as firing a PCA without experiencing a loss of services.
 - Individuals may agree to authorize more hours than received in order to continue receiving the service.

Significance of Self-Direction Payment Monitoring

Why is Self-Direction Post-Payment Monitoring Significant?

- Unlike an agency which may have a more robust pool of individuals, decisions can be more complicated with self directed services when there is no back-up care. With self-directed services, individuals may suffer from lack of service if the PCA cannot provide service and no backup plan is in place.
 - *According to the Technical Guide pg. 184: “When individuals are supported in their own private residence or other settings where staff might not be continuously available, the service plan should include a backup plan to address contingencies such as emergencies, including the failure of a support worker to appear when scheduled to provide necessary services when the absence of the service presents a risk to the participant’s health and welfare. An effective back-up plan is one that is crafted to meet the unique needs and circumstances of each waiver participant. The response to this item should also describe the types of back-up arrangements that are employed. Such arrangements may include arranging for designated provider agencies to furnish staff support on an on-call basis as necessary.”*
- FMS agencies’ role of providing safeguards to the individuals participating in self-direction services is significant in preventing all of the examples listed above.

Significance of Self-Direction Payment Monitoring

Issues Identified in Current Self-Direction Options 1915(c) Waiver Review:

- Self-directed PCS needs further descriptions when discussing fiscal integrity controls in Appendix I-1.

Prevalent issues noted from the Appendix I-1 reviews include:

- Lacking detail of the self-direction specific post-payment reviews and/or not referencing the relevant sections that discuss self-direction specific post-payment reviews.
- Insufficient or missing information about the frequency of FMS audits and the entity responsible for performing FMS audits.
- These issues might be addressed elsewhere in the application; however, in Appendix I-1, the States should indicate which other sections of the application the relevant information is discussed.

Self-Direction Monitoring and Payments: Recommendations

Specify in Appendix I-1, the different post-payment review procedures used for self-directed services:

- The FMS audit process, which confirms the service documentation matches paid claims data, must specify the entity performing the audit, as well as specify the scope, methods, and frequency of these audits. The State must oversee the FMS and confirm the post payment activity.
- If the FMS audit process is discussed elsewhere in the application, we recommend that the State indicate the location of that information in Appendix I-1.

Self-Direction Monitoring and Payments: Recommendations

If the State uses a limited fiscal agent, the following must be specified in Appendix I-3:

- The State is using a limited fiscal agent.
 - Per the Technical Guide pg. 206: “A limited fiscal agent is an entity that processes billings, receives payment from the Medicaid agency for approved claims and disburses funds to providers.”
- The entity or entities that serve as a limited fiscal agent.
- The payment functions performed by the limited fiscal agent.
- How the Medicaid Agency exercises appropriate oversight of the limited fiscal agent, e.g., recommend that an audit be conducted specifically for the FMS to ensure claims are billed appropriately.

Self-Direction Monitoring and Payments: Recommendations

When establishing self-direction post-payment review process, consider:

- Post-payment review for self-direction services and FMS agencies should **not** differ from the post-payment review process discussed in previous slides.
- The case manager should play a significant role in checking the health and welfare of the individual.
- The same possibilities of FWA from the earlier discussion exist in self-direction services.
 - *How is the State ensuring the same protections from agency directed apply to the FMS?*
- Share the review results with the community, possibly through education programs for individuals, families, FMS, support brokers, and/or PCAs providing service.

Current Efforts by CMS to Combat FWA in PCS Programs

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 to Combat FWA in PCS Programs

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.
- Requires participating States to include fingerprint based search of State and Federal criminal history.
- While NBCP is not a mandatory program, OIG has recommended criminal background checks for all PCS programs.

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. Appendix I should be used to ensure the integrity of payments, including but not limited to PCS.
- An adequate post-payment review process is the primary deterrent and identifier of FWA in PCS.
- States are required to indicate rate methodology and post payment review methods in Appendix I-1, and meet all accompanying requirements.
- CMS is making efforts to combat and/or address FWA in PCS. Report suspected fraud by using the OIG hotline or by contacting the State.

Additional Resources

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

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Questions & Answers

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**Thank you for
attending our session!**