Personal Care Services

Preventing Medicaid Improper Payments for Personal Care Services

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Content Summary

Medicaid personal care services (PCS) are valuable, and the need for them is growing.[1] When States offer PCS to Medicaid beneficiaries, States facilitate beneficiaries staying in their homes and communities, which helps control Medicaid spending for long-term services and supports. PCS are typically provided as an optional benefit under individual State Medicaid programs, and PCS coverage and payment rules can vary greatly among Medicaid programs.

Such variation can be confusing for PCS providers. PCS providers must adhere to the rules of each Medicaid program, and providers that submit improper claims for payment can face serious consequences, including civil, monetary, and criminal penalties. This booklet gives PCS providers a summary of PCS and personal care attendant (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. PCS providers can avoid improper payments by thoroughly learning and applying State Medicaid rules in their everyday practices. PCS providers should also become familiar with recent changes in the regulations governing home and community-based services, including PCS.[2] These changes generally allow States more flexibility to deliver services. For more information about these changes, refer to https://www.medicaid.gov/medicaid/hcbs/index.html on the Medicaid website.[3]

PCS improper payments continue to draw the attention of the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) and Congress.[4, 5] Common PCS improper payments are the result of claims submitted without supporting documentation; services provided and billed that are not eligible for

payment according to State Medicaid programs; services provided without required supervision; services provided by unqualified PCAs or PCAs without verification and documentation of required qualifications; services provided while a beneficiary is in an institution, such as a hospital; services not provided; and other types of fraud, waste, and abuse.

Medicaid improper payments are a major fiscal and policy concern.[6, 7] Improper payments include any payments "made for treatments or services that were not covered by program rules, that were not medically necessary, or that were billed for but never provided,"[8] and the law mandates their recoupment.[9, 10] Improper payments can be the result of mistakes or fraud, waste, and abuse.

Based on a 2010 report of an examination of a sample of paid 2006 and 2007 PCS claims, HHS-OIG found $724 million in improper payments for undocumented PCA qualifications.[11] According to the Payment Error Rate Measurement three-year summary report (2014–2016), approximately 90 percent of the instances of improper payments found in Medicaid personal support services were due to problems with provider enrollment or information (e.g., providers not screened using required risk-based criteria) or missing documentation to support the medical record. The claim category of personal support services includes PCS, and was the fifth category overall in projected dollars in error among all service types.[12]

In a portfolio released in 2012, HHS-OIG summarized earlier findings that PCS were often not provided in compliance with State requirements, were unsupported by documentation, or were provided during periods when beneficiaries were in institutional stays (and the payments were not otherwise authorized).[13, 14, 15] To understand the reasons PCS improper payments occur, it is important to have a broad understanding of PCS and the problems that can arise when providing and billing these services.

Personal Care Services

Purpose

Medicaid PCS are services provided to eligible beneficiaries that help them to stay in their own homes and communities rather than live in institutional settings, such as nursing facilities. These services may be provided by an independent or agency-based PCA. PCS are optional Medicaid services, except when they are medically necessary for children eligible for early and periodic screening, diagnostic, and treatment (EPSDT) services.[16]

Authorization

States can choose to provide PCS through their State plan,[17] a Medicaid demonstration,[18] or a waiver program.[19] Because PCS are typically an optional benefit, they can vary greatly by State and within States, depending on the Medicaid authority used.[20, 21] To see a current list of demonstration and waiver programs available in any State, visit https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html on the Medicaid website and select the State and demonstration or waiver authorities you want to see. Each State that wants to provide Medicaid PCS develops a State Medicaid plan amendment, waiver application, or demonstration application and submits it to the Federal government for review and approval.

Setting

PCS may be provided in the beneficiary's home or at other locations.[22] Other locations can include any setting outside the home such as a worksite or grocery store. However, PCS may not be provided under the State plan for hospitalized beneficiaries or beneficiaries in nursing facilities, or intermediate care facilities for individuals with intellectual disabilities.[23, 24] Under waiver authority, States can pay for PCS during temporary inpatient stays, similar to institutional bed holds.[25] States have great flexibility in how they develop and implement their PCS Medicaid programs, and wide variation can exist both within and between State programs. If PCS providers have concerns or questions about program benefits, they can contact their State Medicaid agency (SMA) for guidance.

Description

PCS are categorized as a range of human assistance provided to persons with disabilities and chronic conditions to enable them to accomplish activities of daily living (ADLs) or instrumental activities of daily living (IADLs). ADLs are activities a beneficiary engages in to meet fundamental needs on a daily basis, such as eating, bathing, dressing, ambulation, and transfers from one position to another. IADLs are day-to-day tasks that allow an individual to live independently but are not considered necessary for fundamental daily functioning. Tasks can include meal preparation, hygiene, light housework, and shopping for food and clothing.[26]

Under State waivers, PCS may be broader and more flexible, including, for example, services that address behavioral issues.[27] PCS providers should contact their SMA for additional information defining PCS. When States cover these services, they can help limit Medicaid spending for institutional long-term care by reducing the number of Medicaid beneficiaries residing in institutions.

Medicaid PCS must be distinguished from home health aide services provided through either the Medicare or Medicaid home health benefit. The next section explains the difference between the two types of services and how they are billed.[28, 29, 30]

Providers

PCAs are not subject to Federal training requirements. They can provide basic ADL and IADL support, but they are typically not authorized to provide skilled nursing services. However, to crack down on fraud and abuse many States have established minimum qualifications for PCS providers. The qualifications are not uniform nationally. PCAs in 7 States require the same training as home health aides, while 11 States still have no training requirements. For those States that do have training requirements, the requirements range from being uniform across all programs in a State to only certain programs having training requirements that may or may not be uniform.[31]

However, Medicaid home health agencies and the aides they employ are required to meet Federal Medicare standards because they are authorized to provide skilled nursing services, other therapeutic services, or health aide services to beneficiaries.[32, 33] Home health aides may provide ADL and IADL support in the course of their other duties, but they must use higher-paying codes than PCAs.[34, 35, 36] PCS should never be billed as Medicaid or Medicare home health services when home health services are not authorized in the plan of care (POC).[37, 38]

Need

PCS are important, and the need for such services is likely to continue to rise.[39] The number of PCA and home health aide jobs is expected to grow by nearly 50 percent by 2022.[40] Section 5102 of the Affordable Care Act authorizes grants for States "to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels," and PCAs are among the targeted professions for these training strategies. Section 5507(a) of the Affordable Care Act authorized a demonstration project to train low-income individuals for health care professions. Six States participated.[41, 42]

Over the next several years the average lifespan will increase in the United States, and, with it, chronic diseases, injuries, and disabilities will also rise. Between 2000 and 2030, the estimated number of people in the United States age 65 or older is expected to increase by approximately 36 million.[43] Since 2006, the need for PCS has steadily increased.[44] Combining as many as 71 million people over the age of 65 with the number of individuals with chronic or temporary conditions and people with disabilities, it is likely that many of them will need assistance to remain in their homes.

What Constitutes a Personal Care Services Improper Payment?

An improper payment is any payment that should not have been made according to Federal or State rules. Through audits of State Medicaid programs, HHS-OIG has identified the following five common types of improper PCS payments:

- Claims paid without supporting documentation;
- Services provided and billed that are not eligible for reimbursement according to State Medicaid plans, demonstrations, or waivers;
- Services provided without required supervision;
- Services provided by unqualified PCAs or PCAs without verification and documentation of their required qualifications;[45] and
- Payments made for care provided while a beneficiary was in an institution, such as a hospital[46] (not including payments to a PCA to retain services or during a period in which the individual is receiving covered respite care).[47]

HHS-OIG is encouraging the Centers for Medicare & Medicaid Services (CMS) to publish new Federal rules for PCS and PCA certification to make State rules more consistent. HHS-OIG sees this as one of the main factors in questionable or missing documentation of PCA credentials and the services PCAs provide.[48] In a recent statement to Congress, HHS-OIG's Director of Medicaid Audits, John Hagg, summarized recent recommendations to CMS and the States to address deficiencies responsible for a large portion of PCS improper payments:

- Make qualification standards for care attendants more consistent;
- Require care attendant enrollment or registration with the State and require attendant identities, dates, and times on Medicaid claims;
- Expand Federal requirements and guidance to reduce claims variation requirements for documentation, beneficiary assessments, plans of care, and supervision of attendants across States;
- Issue adequate prepayment controls guidance to States;
- Assess whether additional controls are needed to ensure PCS are allowed under program rules and are provided; and
- Provide States with the data to identify overpayments when beneficiaries are receiving institutionalized care.[49]

Services Without Supporting Documentation

Medicaid providers must keep records ensuring that claims paid by Federal funds satisfy applicable requirements, including, but not limited to, disclosing the extent of services provided.[50] At a minimum, HHS-OIG suggests that documentation should include the identity of the PCA providing the service and the dates and hours of service.[51] Many States require this.[52, 53, 54, 55, 56, 57] The PCA must become familiar with the documentation practices of his or her employer and the Medicaid documentation requirements in the State the services are provided.

Without proper documentation, PCS may not be reimbursable even if they were provided. PCS providers also need to remember that Federal law requires the retention of health care records for at least 6 years from the date of creation.[58] If no supporting documentation is provided for claims billed, any improperly paid claims are considered overpayments, and repayment is required. If there is a pattern of no supporting documentation for services billed, this pattern can trigger an audit or investigation.

Services Not Eligible for Reimbursement

PCS providers may only submit Medicaid claims for services covered under a State's Medicaid plan or through an approved waiver or demonstration. It is improper to bill or for the State to pay for PCS services if a State does not allow the provision of that PCS service.

Common examples of PCS typically not covered under Medicaid include services:

- Provided to a beneficiary not eligible for Medicaid;
- Not documented in the beneficiary's POC;
- Provided exclusively for other members of the household besides the beneficiary, such as laundry for other family members; and
- Provided by a PCA without verified qualifications.

In addition, under the PCS State plan benefit authorized under section 1905(a)(24) of the Social Security Act, Medicaid programs generally do not allow billing for PCS provided by a legally responsible relative.[59] This would include spouses or parents of a minor child. However, if a State has an approved waiver under the Social Security Act Section 1915(i) or (k) State plan benefit, Section 1115 demonstration, or Section 1915(c) waiver, billing for care provided by a legally responsible relative is permissible. For example, Arizona applied for and received a waiver from CMS in 2007 allowing payment to a family member for transporting the beneficiary outside of their area to receive authorized health care services through that State's long-term care system.[60] Because States have great flexibility in developing and implementing Medicaid programs, PCS providers should make sure they understand the Medicaid waivers and programs that cover PCS in the States where they practice, as well as the rules that apply for each.

It is important for PCS providers to remember that even covered services may be subject to limitations. Services outside the limitations are not eligible for payment. Each State may define the number of hours that an individual is eligible for PCS within a given time span. For example, while one State limits PCS to 40 hours per week,[61] another State limits services to 16 hours per week.[62] If the time required to render services exceeds what the State plan or waiver allows, it is not reimbursable. However, some States may allow for an increase in the number of hours upon request if additional services are necessary. Note that the number of hours of PCS provided to children under EPSDT cannot be limited to an amount less than the amount of time that is medically necessary.[63, 64] PCS providers should check with their SMA regarding the number of hours of PCS permitted.

Services Provided Without Required Supervision

States determine what, if any, supervision is required for PCS. State supervision requirements vary as to who is responsible for supervising PCAs, how supervision is accomplished, and how often supervision occurs. Approved supervising entities may include nurses (both Registered Nurses and Licensed Practical Nurses), PCS agency staff, case managers, other agency staff deemed qualified, and in some cases the beneficiary.[65] Without the appropriate PCS supervision completed and documented in accordance with State regulations or policies, any payments made for services provided may be repayable by the provider under those State regulations and policies. This is the case even if a PCA arrives at the beneficiary's home when scheduled, provides all the services required by the POC, and provides appropriate assistance to the beneficiary.

Services Provided Without State Verification of Attendant Qualifications

An HHS-OIG report on PCS emphasized, "States are required to institute provider safeguards to protect the health, welfare, and safety of Medicaid beneficiaries receiving PCS." States can institute such safeguards by establishing qualifications for PCAs, or "establishing requirements for reviews of beneficiaries' plans of care and supervision of services provided."[66] States that provide PCS according to a State plan are required by Social Security Act Section 1905(a)(24) to assure that PCS are "provided by an individual who is qualified to provide such services."[67, 68]

The most commonly mandated State PCA qualifications the HHS-OIG found are "passing criminal background checks and minimum levels of age, health status, education, and training."[69, 70] Among these common State PCA qualifications, there is significant variation in how the qualifications are defined. For example,

HHS-OIG noted that while one State may define a background check to include a nationwide criminal background check, checking abuse and neglect registries, and checking Federal or State exclusion lists, another State may only require reference checks. HHS-OIG found that background checks were one of the qualifications most often undocumented.[71]

Due to the considerable variation of State-required PCA qualifications,[72] PCS providers must know and follow the PCA qualification requirements for the States where they practice and must verify and document those qualifications before they provide and bill Medicaid for PCS.

Services Provided to Beneficiaries During an Institutional Stay

Under Federal and State regulations, PCS are typically not covered if services are provided when a Medicaid beneficiary is an inpatient in the hospital, a nursing facility, or an intermediate care facility for individuals with intellectual disabilities (except that payment may be made during a period of covered respite care).[73] Services provided during such a stay are generally not reimbursable, although payments to retain the services of a PCA during such a stay may be reimbursable in some States under a waiver.[74] Such "retainer payments" may be reimbursable if made "to enable a state to hold PCS for a short period of time while a person is hospitalized or absent from his or her home."[75]

Accurate billing by a PCS provider or agency for periods coinciding with institutional stays is an important part of providing and promoting PCS and containing Medicaid spending. HHS-OIG conducted an audit of five States regarding such periods and completed data analysis for one quarter of fiscal year (FY) 2006. The analysis revealed all five States erroneously paid for PCS when beneficiaries were receiving care in institutions. Medicaid agencies from these States paid nearly $500,000 in error during the quarter.[76]

A major billing vulnerability the HHS-OIG audit revealed was PCS claims paid that overlapped with institutional care claims due to date-range billing. Date-range billing is billing for a period of time, such as a week or a month, without specifying the dates when PCS were provided. For example, a PCS provider might bill 20 days within a 1-month range without specifying which days PCS were provided. If the beneficiary was in an institution for any days during the month, the provider may not be able to show that he or she provided care and billed for PCS only on days when the beneficiary was at home rather than in the institution.[77]

State Medicaid plans may allow date-range billing for PCS, but to avoid this vulnerability, providers should address date-range billing in their policies. One option is not to use date-range billing when PCS were not provided on each day within

the date range. Under this approach, PCS providers would also retain documentation that verifies which days services were provided and submit an itemized bill for those periods. For example, if a PCA provided services daily, the services could be billed for a date range specified by the State plan. If a State allows monthly date ranges, a PCA could bill for the entire month: for example, September 1–September 30. However, if the beneficiary was institutionalized for any reason during the date range or the PCA does not see the beneficiary daily, the specific dates billed would be documented and would account for breaks in service (for example, September 1–September 8, and September 15–September 30).

Fraud, Waste, and Abuse

The major reason for improper payments in State Medicaid programs involves fraud, waste, and abuse. Simple, infrequent billing mistakes may not necessarily constitute fraud, waste, or abuse; they may more than likely be human errors. When billing errors occur, PCS providers, like all providers, are required to disclose the errors and return any payments received for them. Some PCS providers are offering medically unnecessary services or more services than necessary—such as more hours than authorized to meet beneficiary needs—thereby wasting resources. It is important that PCS providers only offer necessary and authorized services.

Some PCS providers deliberately defraud government health care programs. Fraud is defined as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."[78] Fraudulent PCS might include deliberately billing undocumented, ineligible, unsupervised, or unauthorized PCS; billing PCS provided when a beneficiary was in an institutional setting (except that payment may be made during a period of covered respite care or as authorized through an approved retainer payment); billing for PCS never provided; or billing for PCS provided to ineligible or fictional beneficiaries. The following are examples of fraudulent behavior in connection with PCS:

- **Services provided by uncertified individuals:** An audit of an Ohio health care services provider revealed that several of the caregivers did not have the required certification or training, resulting in the rejection of 75 percent of the provider's claims. The State Auditor found the provider owed the State over $2.1 million;[79]
- **Services delivered to ineligible recipients:** A New York company operating a managed long-term care plan was ordered to pay a $46.7 million settlement to Medicaid for using improper marketing techniques to recruit over 1,200

ineligible beneficiaries to its adult day care programs to provide PCS. They received approximately $3,800 per member per month. The members they recruited did not meet the minimum criteria to qualify for PCS;[80]

- **Services provided under forged credentials:** A Louisiana couple who owned and operated a PCS business, along with the wife's cousin, were convicted of forging Red Cross cardiopulmonary resuscitation credentials for 19 personal care workers they employed. The workers never attended the required training, and were therefore not qualified to provide the Medicaid services they provided. The owners received over $7 million in fraudulent Medicaid payments for services provided by the unqualified individuals;[81]
- **Services never rendered:** On January 8, 2015, a Virginia couple was convicted of several counts relating to health care fraud, false statements, alteration of records, and identity theft. They submitted approximately 7,800 claims to Virginia Medicaid for PCS never delivered to 78 Medicaid beneficiaries. The husband and wife were sentenced to 63 months and 25 months in prison, respectively, and must pay nearly $1.5 million in restitution;[82] and
- **False claims submitted by an excluded individual:** A Washington, D.C., woman who had been excluded from Federal health care programs in 2000 by HHS-OIG concealed her identity, hid her lifetime exclusion, opened a health care business for which she obtained a Medicaid number, and purportedly provided home health and PCS to clients. In fact, many of the services were never provided. She and her husband recruited family members and others to participate in the scheme, and they created fraudulent documentation to hide the illegal activity. In all, the couple and several other conspirators defrauded Washington, D.C., Medicaid of over $80 million. The scheme was discovered as part of a larger crackdown on Medicaid fraud in D.C. and the surrounding region.[83]

What Are the Consequences of Improper Payments?

Improper payments affect State Medicaid programs, taxpayers, providers, and beneficiaries. Since 2006, HHS-OIG has conducted several PCS audits identifying large sums of recoupable dollars. According to a recent HHS-OIG report, audits of seven States' PCS claims identified over $582 million in questioned costs based on deficiencies.[84] The 2015 annual report of the Health Care Fraud and Abuse Control Program, jointly released by the U.S. Department of Health and Human Services and the U.S. Department of Justice, shows that the government recovered over $304 million in Federal Medicaid funds for all services, along with an undisclosed amount of State Medicaid funds, in FY 2015.[85] When the Federal government recovers Medicaid overpayments from States, it may affect State funds paid by the

taxpayers, the identified PCS providers who received the payments, and the benefit options available for beneficiaries.

The consequences for improper payments vary depending on what caused the PCS provider to receive an improper payment. Most PCS providers are honest, want to do the right thing, and disclose and return improper payments when identified. Self-disclosure[86, 87] is available to all providers and is always the best policy. Improper payments are overpayments and must be reported and returned as required by law.[88] If a provider or a provider's employee has made a consistent mistake for an extended period, it should be disclosed as soon as it is identified, and the underlying problem should be rectified. This shows a good faith effort on the provider's part, though it does not release the provider from returning the improper payments. Nor does it absolve or release the PCS provider from other possible consequences.

An audit or investigation may be triggered by many things, such as a PCS provider's billing practices that indicate a consistent pattern of unusual billings, random audits, or whistleblowers. PCS fraud may subject a provider to State and Federal civil,[89] monetary,[90] and criminal penalties,[91] and exclusion[92] from participation in Federal health care programs like Medicaid.

How Can Improper Personal Care Services Payments Be Prevented?

Enrolled Medicaid providers become State partners in providing PCS to beneficiaries. The consequences of overpayments can be avoided through preventive strategies implemented by both PCAs and PCS agencies. These strategies include:

- Learning and understanding agency and applicable State Medicaid plan and waiver rules;
- Requiring mandatory attendance at State-offered trainings, including refresher courses every 2 to 5 years, and reading State-provided educational materials; and
- Contacting the State for guidance when Federal and State rules are not well understood.

Additional strategies for PCS agencies include:

- Developing, implementing, and disseminating policies and procedures in compliance with State Medicaid programs;
- Developing and implementing regular effective applicable staff education;

- Conducting self-audits to ensure staff follow all internal policies and procedures, thereby identifying problems early; and
- Implementing immediate corrective actions for any identified problems.

Medicaid State programs and PCS providers can take steps to ensure correct billing and documentation practices that promote accuracy and aid in the prevention of improper payments. PCS providers should learn and understand all State Medicaid plan and waiver rules that relate to providing PCS. Improper payments result in State and provider recoupment. Suspected fraud prompts audits and investigations. A fraud conviction usually results in a variety of civil and criminal penalties. All parties involved in providing, authorizing, supervising, and providing PCS are responsible for protecting the quality and the integrity of the Medicaid program.

Reporting Fraud, Waste, and Abuse

If fraud is suspected, contact the SMA, Medicaid Fraud Control Unit (MFCU), or HHS-OIG:

- SMA and MFCU at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforConsumers/Report_Fraud_and_Suspected_Fraud.html on the CMS website. Click the State By State Fraud and Abuse Reporting Contacts link.
- HHS-OIG at https://oig.hhs.gov/fraud/report-fraud/index.asp on the HHS-OIG website.
- To contact HHS-OIG by mail, phone, fax, or email:

  Office of Inspector General

  U.S. Department of Health and Human Services

  ATTN: OIG HOTLINE OPERATIONS

  P.O. Box 23489

  Washington, DC 20026

  Phone: 1-800-HHS-TIPS (1-800-447-8477)

  TTY: 1-800-377-4950

  Fax: 1-800-223-8164

  Email: HHSTips@oig.hhs.gov

To see the electronic version of this booklet and the other products included in the "Personal Care Services" Toolkit posted to the Medicaid Program Integrity Education page, visit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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