



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Protecting Personal Care Services from Fraud and Abuse: OIG's Concerns Regarding Vulnerabilities in Medicaid Personal Care Services

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Personal Care and Related Services are Growing Programs in Medicaid

- In 2011, Medicaid costs for PCS totaled at least \$12.7 billion, which represents a 35 percent increase since 2005.
- Waiver PCS and programs such as Community First Choice etc mean that care provided in home setting by unskilled workers will have significant role in the future of Medicaid care.





PCS' Unique Characteristics

- PCS is the rare Medicaid service most people would love to “need”.
- Unskilled, non-professional, (normally) non-licensed caregivers
- PCS occur in an unregulated setting

As a result, potential for fraud and abuse is high





OIG Body of Work on PCS

- 8 Statewide (including NYC) and 10 provider Audits
- 4 Studies
- Numerous criminal and civil investigations, most worked jointly with State Medicaid Fraud Control Units (MFCUs).





OIG Statewide PCS Audits

- Audits of 8 States PCS claims have found vulnerabilities such as-
 - Insufficient resources to adequately monitor their PCS program, especially once it began to experience substantial growth
 - Inadequate controls in the States' prior authorization process
 - Ineffectiveness of accrediting organizations to which the State delegated authority to ensure compliance with applicable State regulations
 - Failure to conduct monitoring site visits of PCS agencies that employed attendants, leaving the role of oversight largely to beneficiaries
 - Inadequate controls to prevent paying improper PCS claims, including instances where PCS was claimed while the beneficiary received institutional care
- Error rates for States have been as high as 40% (and as low as 0%)





OIG Audits of PCS Providers

Most Significant Findings From Audits of Individual PCS Agency Providers Include-

- No documentation that services were provided
 - Plan of care not followed
 - No documentation of supervisory visits
 - Training requirements not met
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- Review of New Mexico Medicaid Personal Care Services Provided by Heritage Home Healthcare ([A-06-09-00063](#)), May 2012
 - Review of Louisiana Medicaid Personal Care Services Provided by American Pride Caregivers, LLC ([A-06-09-00107](#)), June 2012
 - Review of Medicaid Personal Care Service Claims Submitted by Dane County Department of Human Services and Claimed by Wisconsin From July 1, 2006, Through June 30, 2008 ([A-05-10-00018](#))
 - Review of Medicaid Personal Care Service Claims Submitted by Clarity Care, Inc., and Claimed by Wisconsin From July 1, 2006, Through June 30, 2008 ([A-05-10-00019](#))
 - Review of Personal Care Services Provided by Tri-State Home Health and Equipment Services, Inc., in the District of Columbia ([A-03-08-00207](#))
 - Review of Federal Reimbursement Claimed by North Carolina for Medicaid Personal Care Services Claims Submitted by Shipman Family Home Care, Inc. ([A-04-09-04041](#))
 - Review of New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health ([A-06-09-00062](#))
 - Review of New Mexico Medicaid Personal Care Services Provided by Clovis Homecare, Inc. ([A-06-09-00117](#)) June 2012
 - Partnership Review of Medicaid Claims Processed by Cerebral Palsy and Stavros for Personal Care Attendant Services Provided to Beneficiaries during Inpatient Stays ([A-01-08-00001](#)), November 2008
 - Review of Medicaid Personal Care Service Claims Submitted by Independence First, Inc. and Claimed by Wisconsin From July 1, 2006, Through June 30, 2008 ([A-05-09-00093](#)), April, 2010





OEI Study on Requirements for PCS Attendants

Objective: To determine the requirements that States have established for PCS attendants (PCAs).

Key Findings:

- *States had established 301 sets of attendant requirements nationwide.*
- The six most common requirements were background checks, training, age, supervision, health, and education/literacy. Wide variations exist for these requirements.
- In 48 States, the responsibility for ensuring that attendants met established requirements was delegated to some entity other than the State Medicaid agency. 47 States conducted some type of direct oversight usually in the form of an audit or review.

States' Requirements for Medicaid-Funded Personal Care Service Attendants

Published – December 2006 ([OEI-07-05-00250](#))





OEI Study on Inappropriate Claims for PCS

Objective: To determine whether the attendant who provided the PCS met all required qualifications in 10 States.

Key Findings:

- Attendant qualifications were undocumented for 18% of Medicaid PCS claims, resulting in \$724 million in inappropriate payments.
- The qualifications that were the most undocumented were background checks, age, and education; and 2% of Medicaid PCS claims, respondents had no record of serving the beneficiaries.

Inappropriate Claims for Medicaid Personal Care Services

Published – December 2010 ([OEI-07-08-00430](#))





OEI Study on Payments for PCS During Institutional Stays

Objective: To determine the extent to which five State Medicaid programs made payments in error for PCS during periods of beneficiary institutionalization.

Key Findings:

- In the first quarter of fiscal year 2006, the five States reviewed paid nearly \$500,000 in error for PCS provided during periods of institutionalization.
- Billing practices in three States create vulnerabilities that could mean that up to \$11 million in one quarter may have been paid in error.
- Although all five States reported having controls to prevent Medicaid payments for personal care services provided during institutional stays, the controls did not prevent all erroneous payments.

Payments Made in Error for Personal Care Services During Institutional Stays

Published – August 2008 ([OEI-07-06-00620](#))





OEI Study on PCS in Excess of 24 Hours per Day

Objective: To further examine the extent to which PCS claims may be vulnerable to payment errors based on findings identified in a institutional payments report. Study examined PCS claims in 5 States during Oct-Dec, 2005.

Key Findings:

- Medicaid paid 871 PCS claims that billed in excess of 24 hours of services per day, for a total of \$873,132.
- States' billing practices create vulnerabilities. States programs allowed providers to bill for PCS in date ranges that included days on which no services were provided, making data analysis difficult, if not impossible.

Medicaid-Funded Personal Care Services in Excess of 24 Hours per Day

Published – October 2008 ([OEI-07-06-00621](#))





Takeaways on OEI Work

- More consistent attendant requirements, less fragmentation in program administration, or some level of standardization within States may make monitoring attendant requirements less cumbersome, enhance quality assurance and minimize risk of overpayments caused by services by unqualified attendants.
- States' billing practices that may result in undetected overpayments for PCS are not consistent with requirements and represent a potential source of vulnerability for payment errors.
- Given the continuing increase in PCS utilization and expenditures, the integrity of the providers of any payments for these services is vital to ensuring the health and welfare of Medicaid beneficiaries.





Billing Policies That Impair Program Integrity Efforts

- **PCAs Typically Not Identified On Claims**
 - Most States do not enroll PCAs, and therefore the identity of the PCA does not appear on the claims form
 - As a result, it is impossible for States to conduct basic data analysis for PCA hrs of service/day, excluded PCAs, etc; or to see claims of previously identified high risk PCAs
- **Dates Of Services Not Identified On Claims**
 - Studies found number of States allow “span billing”
 - Span billing hinders prosecution of PCS fraud





Fraud Trends in PCS

MFCUs have more open PCS cases than cases of any other program type- over 1,000 in Sept. 2012

- Schemes
 - Services not rendered
 - Often detected via services to institutionalized bene
 - Bene and PCA split PCS payments and no/limited services given
 - Medically unnecessary services- bene capable of independent living, but lies to assessor about abilities
 - Large-scale fraud by PCS agencies
 - Staffing agency fraud (false credentials)





Fraud in Self-Directed PCS Programs is a Significant Concern Nationwide

- **Illinois:** OIG project focusing on PCS fraud initiated after complaints alleging wide-scale fraud by beneficiaries and PCAs. To date, investigators have obtained 12 convictions (including five benes) and indicted 10 more people earlier this month (one involving a bene death). This press release summarizes a number of these cases:
http://www.justice.gov/usao/ils/News/2013/July/07112013_Medicad%20Press%20Release.html
- **Massachusetts/Vermont:** OI opened a project after reviewing data showing a significant percentage of the highest paid PCAs in MA had criminal records. Project expanded to VT due to backlog of complaints regarding its self-directed PCS. More than 12 convictions so far of benes and PCAs, and investigations continue. See for example
<http://www.mass.gov/ago/news-and-updates/press-releases/2013/2013-06-28-costa-esteves-indictment.html>
- **Ohio:** Numerous cases against both PCAs and benes in self-directed PCS program. An example of their cases is at <http://statecasefiles.justia.com/documents/ohio/tenth-district-court-of-appeals/2010-ohio-4440.pdf>
- Cases are routinely being prosecuted around the country. For site that provides new case press releases nationwide, see <http://oig.hhs.gov/fraud/enforcement/state/index.asp>





PCS Assessment Processes May Be Vulnerable to Fraud

- Data analysis in one State shows that beneficiaries receiving highest volume of PCS hours lacked expected types of diagnosis codes
 - CMS ran lists of various diagnoses that could justify large numbers of PCS hours, and those diagnoses accounted for less than .01% of the high volume services (>1040 hrs/yr or >8 hrs/day)
 - **Instead, the most common diagnoses for those receiving high volume services were Type II diabetes and hypertension**

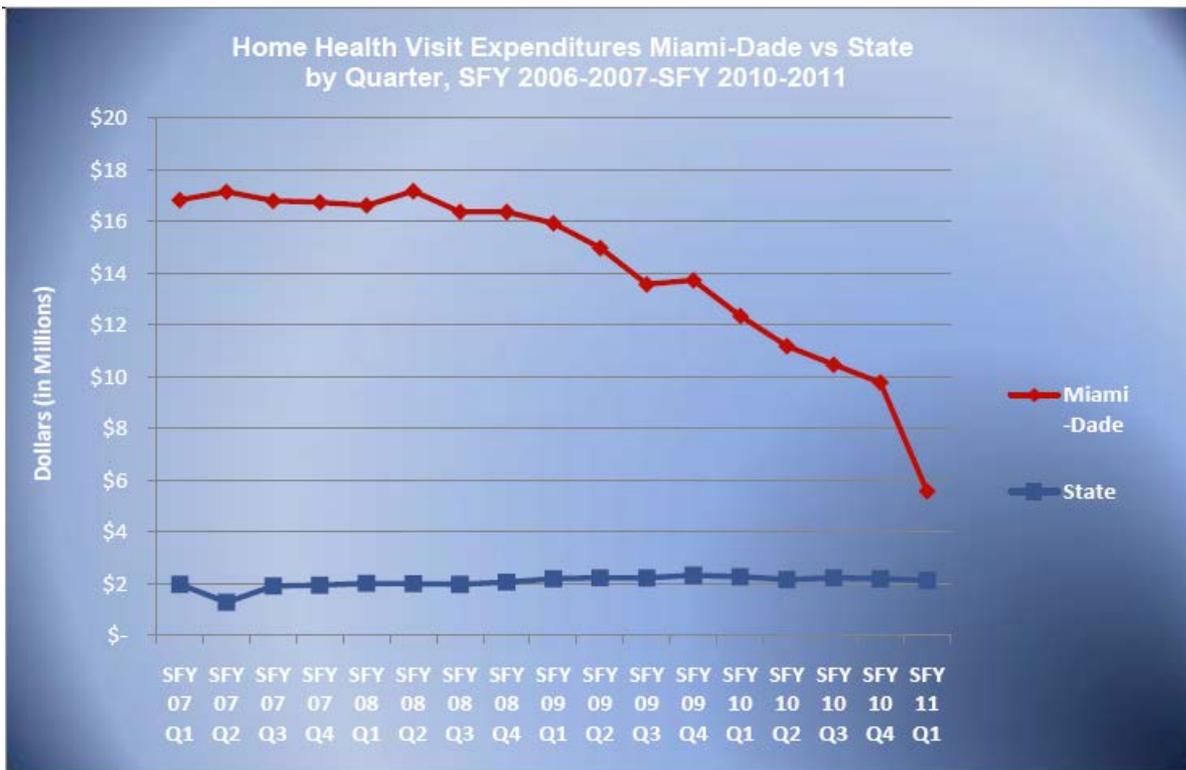




Florida Electronic Verification Results

From AHCA's February 2, 2011 evaluation report to the Governor and Legislature:

Figure 1: Miami-Dade home health visit expenditures are dropping steadily



MEDICAID & PUBLIC ASSISTANCE FRAUD
STRIKE FORCE



From annual report released October 1, 2011:

“After one full year of piloting this strategy, AHCA reports a decrease of 50% in claims paid for home health visits in SFY 2010-2011 when compared to the prior year. This program also resulted in a reduction in home health care visits by 51% during the same time period.”





OIG Portfolio on Vulnerabilities in Medicaid PCS

- Released December, 2012
- Synthesizes OIG's PCS audit, evaluation, and investigative work
- Includes recommendations to CMS in light of OIG's findings





Recommendations For CMS Contained in the OIG PCS Portfolio

1. CMS should promulgate regulations to:
 - Require States to enroll all PCS attendants as providers or assign all PCS each attendant a unique identifier; and require that PCS claims include the specific date(s) when services were performed and the identity of the rendering PCS attendants.
 - Establish minimum Federal qualification standards applicable to all PCS reimbursed by Medicaid.
 - Create and/or expand Federal requirements and issue operational guidance for claims documentation, beneficiary assessments, plans of care, and supervision of attendants.
2. CMS should issue guidance to States regarding adequate prepayment controls regarding issues such as a core list of the necessary claims edits to prevent inappropriate PCS payments during periods when beneficiaries are receiving institutional care.
3. CMS should consider whether additional controls are needed to ensure that PCS are allowed under program rules and are provided.
4. CMS should take action to provide States with data suitable for identifying overpayments for PCS claims during periods when beneficiaries are receiving institutional care paid for by Medicare or Medicaid.





Questions/Comments

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