Christi Grimm, Chief of Staff, Office of Inspector General, U.S. Department of Health and Human Services, response to questions for the record following "Combating Waste, Fraud, and Abuse in Medicaid's Personal Care Services Program"

The Honorable Tim Murphy: Questions for the Record from the May 2, 2017, hearing before the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations regarding Medicaid Personal Care Services.

1. **HHS OIG's 2012 portfolio states that the number of cases in which beneficiaries are committing fraud themselves are being charged as co-conspirators with their attendants is growing. Why do you think these cases are becoming more common?**

   OIG believes that these cases are becoming more common because of the lack of program integrity safeguards in the Medicaid Personal Care Services (PCS) program. Unfortunately, individuals intent on committing fraud recognize the many policy vulnerabilities in the program and exploit them for their benefit. Inadequate controls over items such as reporting and documentation of visits provide unscrupulous beneficiaries and their attendants the opportunity to either falsify documents to justify billings or not accurately report the services provided because they are not required to do so. A separate yet equally important reason for the increase in these types of cases is that beneficiaries often feel reliant on or indebted to their attendants for the services they provide, making them particularly vulnerable to pressure from ne'er-do-well attendants. This often makes beneficiaries reluctant to report any misconduct or fraudulent activity and, in more severe instances, causes them to join schemes with their attendants to defraud the PCS program.

   a. **While there are upsides of having relatives of beneficiaries be their PCS attendants, there are also potentially downsides, such as beneficiary-attendant fraud conspiracies. What are some ways in which we can prevent these fraud schemes between beneficiaries and attendants?**

      OIG understands the advantages and disadvantages of having friends or relatives serve as PCS attendants to beneficiaries and appreciates the Committee's question on ways to prevent these fraud schemes. While provisions in recent legislation offer necessary countermeasures, such as the Electronic Visit Verification Systems (EVVS), OIG believes the implementation of the following recommendations would help further mitigate the risk of beneficiary-attendant fraud conspiracies:

      - Establish minimum Federal qualifications and screening standards for PCS workers, including background checks.
      - Require States to enroll or register all PCS attendants and assign them unique numbers.
      - Require that PCS claims identify the dates of service and the PCS attendant who provided the service.

      These enhanced controls and oversight measures deter fraudulent individuals by limiting their opportunities to exploit program vulnerabilities. They provide more information on the services rendered and the attendants themselves, facilitate beneficiaries' ability to make sound decisions about their care, and enhance States' fraud-fighting efforts through the use of data analytics to prevent and detect fraudulent activity. States that have proactively instituted these safeguards have seen a dramatic decrease in their programmatic costs.

For example, Alaska now requires all PCS attendants to enroll in the State Medicaid agency. This allows the Alaska Medicaid Fraud Control Unit (MFCU) and the Alaska Program Integrity Unit to compare and match provider information against other data, such as Medicaid claims. Having that provider data available significantly improves their ability to detect fraud schemes and investigate bad actors. In a short span of 2 years, that type of data analysis helped support 108 criminal convictions and led to $5.6 million in restitution. It also had a sentinel effect that helped the State reduce its PCS costs from $125 million in 2013 to $85 million in 2015. This is a prime example of how program integrity safeguards can prevent fraud schemes and reduce program costs through deterrence.

b. To what degree can Medicaid Fraud Control Units' take action against beneficiaries who are complicit in defrauding Medicaid?

MFCUs do not generally pursue cases against Medicaid beneficiaries because of statutory limitations, except when there is a conspiracy involving a Medicaid provider. As a result, there are two ways in which a MFCU may pursue or can take action against PCS beneficiaries who are part of a conspiracy to commit fraud. First, if the beneficiary is allegedly responsible, whether in a formal conspiracy or in some other manner, for causing a PCS company, or PCS caregiver, to submit fraudulent claims to the program, the beneficiary may be included as a subject of the fraud investigation. Second, if the beneficiary is alleged to have improperly received PCS benefits, the MFCU could investigate the allegation of beneficiary fraud, if, again, there is an allegation of a conspiracy between the beneficiary and the caregiver or company as the "provider" of the services. Of course, for PCS services provided by a family member, fraud allegations may commonly involve some type of conspiracy or agreement between the family members.

c. Are there any statutory limitations to investigating or taking legal action with regards to beneficiary fraud?

Yes, there is a statutory rule that generally limits MFCU investigations to Medicaid provider fraud or patient abuse or neglect that occurs in Medicaid-funded facilities. This is the reason that MFCUs do not generally investigate beneficiary or recipient fraud matters, which are handled by other parts of the State or local government. The principal exception to this, as explained in the question above, is when there is conspiracy involving a Medicaid provider, such as a PCS company or caregiver.

Although not involving beneficiary fraud, there is a statutory limitation on the ability of MFCUs to investigate the abuse or neglect of patients that occur in a home or community-based setting, including the physical or financial abuse of an individual receiving personal care services in the home. This has been a longstanding concern for OIG as well as for the MFCU community, and we have proposed a legislative amendment to address this gap in MFCU authority. MFCUs commonly learn about these abuse allegations in the course of their fraud investigations and are forced to decline the cases or refer them to other law enforcement agencies.

The Honorable Frank Pallone: Questions for the Record from the May 2, 2017, hearing before the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations regarding Medicaid Personal Care Services.

1. **The Medicaid program is designed to give states flexibility to design their programs under broad federal guidelines. However, that flexibility can make it difficult to conduct effective oversight and ensure that these state programs are adequately serving beneficiaries.**

   a. **What steps should the Centers for Medicare & Medicaid (CMS) take to address the significant variations in State PCS program requirements?**

   Variations in State PCS programs exist because of a lack of Federal requirements for PCS and PCS attendants. OIG's November 2012 *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement*[1] (PCS Portfolio) summarized the findings of OIG's body of work on PCS and made recommendations to improve program vulnerabilities. Four recommendations from the report remain unimplemented and are basic safeguards that would begin to address variations across State PCS program requirements:

   - Establish minimum Federal qualifications and screening standards for PCS workers, including background checks.
   - Require States to enroll or register all PCS attendants and assign them unique numbers.
   - Require that PCS claims identify the dates of service and the PCS attendant who provided the service.
   - Consider whether additional controls are needed to ensure that personal care services are allowed under program rules and provided.

   This lack of consistency across and within States regarding the use of internal controls and qualifications puts beneficiaries at risk of harm and makes it difficult to effectively pursue fraud and abuse in the PCS program. Additionally, the 21st Century Cures Act requires that all States implement Electronic Visit Verification Systems (EVVS) for PCS by 2019. This requirement will improve States' ability to monitor billing and quality of care for PCS. As the EVVS is implemented, it will be important to ensure that the data gathered are complete, accurate, and timely.

[1] https://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf.

2. Your office recently noted that the Department of Health and Human Services, Office of Inspector General (HHS-OIG) has, on average, one full-time employee to oversee more than $680 million per year in federal health care spending.

a. How would budget cuts affect the HHS-OIG's ability to conduct vigorous oversight of the Medicaid PCS program and of the Medicaid program more broadly?

Whenever funding decreases for oversight activities, OIG must reassess the number and scope of audits, evaluations, and investigations it can conduct. OIG is a people-driven organization, and our largest investments are in employees with the skills necessary for effective oversight of more than 100 highly complex health and human services programs. Any decrease in OIG's oversight activities reduces program oversight. Reductions in oversight funding make it more difficult to ensure program integrity and increase the potential for harm to patients and recipients of social services. OIG is charged with overseeing the Department's more than $1 trillion investment in health and human services programs that touch the lives of virtually all Americans. Medicaid and CHIP specifically serve more than 74 million enrolled individuals, more than any other Federal health care program, and costs are projected to increase by nearly 6 percent annually beginning in FY 2018 through FY 2025 due to the aging population. Given the current size and projected growth of Medicaid, effective oversight would become more challenging with fewer resources. We are assessing the impact of a reduced budget on our work and will continue to make hard choices to prioritize the most critical oversight needs. We are also continuing to review our operations and infrastructure to ensure that we operate as efficiently as possible.