



Testimony

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**MEDICAID PERSONAL
CARE SERVICES**

**More Harmonized
Program Requirements
and Better Data Are
Needed**

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GAO Highlights

Highlights of [GAO-17-598T](#), a testimony before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Medicaid, a joint federal-state health care program, provides long-term services and supports for disabled and aged individuals, increasingly in home and community settings. Federal and state Medicaid spending on home- and community-based services was about \$80 billion in 2014. Personal care services are a key component of this care. States can offer personal care services through many different types of programs, and each may be subject to different federal requirements established by statute, regulations, and guidance. The provision of personal care in beneficiaries' homes can pose safety risks, and these services have a high and growing rate of improper payments, including cases where services for which the state was billed were not provided. In recent years Congress has directed HHS to improve coordination of these programs which could harmonize requirements--that is, implement a more consistent administration of policies and procedures--and enhance oversight.

This statement highlights key issues regarding (1) the federal program requirements to protect beneficiaries' safety and ensure that billed services are provided, and (2) the usefulness of data collected by CMS for oversight. This testimony is based on reports GAO issued in 2016 and 2017. For these reports, GAO assessed CMS data on personal care services provided to beneficiaries and state spending. GAO also reviewed federal statutes, regulations, and guidance, and interviewed CMS officials.

View [GAO-17-598T](#). For more information, contact Katherine M. Iritani at (202) 512-7114 or iritanik@gao.gov.

May 2017

MEDICAID PERSONAL CARE SERVICES

More Harmonized Program Requirements and Better Data Are Needed

What GAO Found

In its November 2016 report, GAO found a patchwork of federal requirements related to how states must protect the safety of beneficiaries in their personal care services programs and to how states ensure that billed services are actually provided. Personal care services help beneficiaries with basic activities of daily living such as bathing and dressing, in a home- or community-based setting. For two types of programs under which personal care services can be offered, states must describe to the Centers for Medicare & Medicaid Services (CMS) how they will ensure the health and welfare of beneficiaries. Similar requirements were not in place for several other programs GAO examined. In addition, for some but not all personal care services programs that GAO reviewed, states must provide evidence to CMS that the state is paying claims for services that have actually been provided. These differing federal program requirements result in uneven beneficiary safeguards and levels of assurances regarding states' beneficiary protections and oversight of billed services. GAO recommended that CMS take steps to harmonize and achieve a more consistent application of federal requirements across programs. CMS agreed with GAO's recommendation and sought input on how to do so by publishing a request for information.

In its January 2017 report, GAO found limitations in the data that CMS collects to monitor the provision of personal care services and to monitor state spending on services. For example:

- **Data on personal care services provided were often not timely, complete or consistent.** The most recent data available during GAO's review (2016) were for 2012 and included data for only 35 states. Further, 15 percent of claims lacked provider identification numbers and 34 percent lacked information on the quantity of services provided. Data were also inconsistent as more than 400 different procedure codes were used by states to identify personal care services. Without timely, complete, and consistent data, CMS is unable to effectively oversee state programs and verify who is providing personal care services or the type, amount, and dates of services provided.
- **Data on states' spending on CMS's expenditure reports, the basis for states' receipt of federal matching funds, were not always accurate or complete.** From 2012 through 2015, 17 percent of expenditure lines were not reported correctly by states, according to GAO's analysis. Nearly two-thirds of these errors were due to states not separately identifying personal care services expenditures, as required by CMS, from other types of expenditures. Inaccurate and incomplete data limit CMS's ability to, among other oversight functions, ensure federal matching funds are appropriate.

GAO made several recommendations to improve the data CMS collects to monitor the provision of and expenditures on personal care services. CMS agreed with some but not all of these recommendations.

Chairman Murphy, Ranking Member DeGette, and Members of the Subcommittee:

I am pleased to be here today as you examine the personal care services benefit available under Medicaid, the federal-state health financing program for low-income and medically needy individuals. Medicaid is the nation's primary payer of long-term care services and supports for disabled and aged individuals who may need care for an extended period of time. Personal care services are a significant and important component of Medicaid's long-term care services and supports. Personal care services provide assistance to beneficiaries of all ages who have limited ability to care for themselves because of physical, developmental, or intellectual disabilities, helping them with activities of daily living such as bathing, dressing, and toileting. Such assistance can enable disabled and aged beneficiaries to remain in their homes, maintain their independence, and participate in community life to the fullest extent possible.

Medicaid spending on long-term care services and supports is significant, representing more than one-quarter of Medicaid spending annually. The federal cost of Medicaid long-term care spending is expected to increase from \$75 billion in 2015 to \$111 billion in 2026.¹ Historically, Medicaid spending for long-term care has been largely for services provided in institutional settings, such as nursing homes. In recent years, this trend has changed and the majority of federal and state spending has shifted towards home- and community-based services (HCBS)—that is, services and assistance provided to beneficiaries in their homes or other settings integrated with their communities.² As a result of the aging of the nation's population and increased opportunities for aged and disabled individuals to live in their homes instead of institutions, the demand for and spending on HCBS and personal care services is expected to increase.

Although personal care services are an important support for Medicaid beneficiaries, provision of these services is not without risk, both for beneficiary safety and for improper Medicaid payments. Beneficiaries receiving personal care services include aged individuals and individuals with physical, developmental, or intellectual disabilities, some of whom

¹Congressional Budget Office, Detail of Spending and Enrollment for Medicaid for CBO's March 2016 Baseline (Washington, D.C.: 2016).

²See Truven Health Analytics, *Medicaid Expenditures for Long-Term Services and Supports in FY 2013* (June 30, 2015).

can be vulnerable. Also, when personal care services are provided in a private home, other providers or community members may not be present to help discourage or report on questionable activities. These factors can result in some beneficiaries being at risk of unintentional harm and potential neglect and exploitation. A beneficiary's capacity to manage finances and secure possessions may decline with age, onset of dementia, or other cognitive disabilities, and put them at risk of theft or financial exploitation from unscrupulous attendants.³ Moreover, depending on the particular state and Medicaid program, personal care attendants who provide services may not be required to have a credential from an organization that trains workers for certain qualifications. The provision of personal care services is also at high risk for Medicaid improper payments, including instances where services for which the state was billed were not provided. The Centers for Medicare & Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services (HHS), estimated that about 12 percent of all states' payments for personal care services in 2015 were improper—twice the 6 percent error rate estimated for 2014—and that the projected dollar amount of payment errors was over \$3.6 billion, up from \$2 billion estimated for 2014.⁴

³GAO, *Elder Justice: National Strategy Needed to Effectively Combat Elder Financial Exploitation*, [GAO-13-110](#) (Washington, D.C.: Nov. 15, 2012). In addition, the HHS Office of Inspector General has issued reports that documented cases of beneficiary neglect. See U.S. Department of Health and Human Services Office of Inspector General, *Investigative Advisory on Medicaid Fraud and Patient Harm Involving Personal Care Services*, Memo to Vikki Wachino, Deputy Administrator and Director, Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services (Washington, D.C.: Oct. 3, 2016).

⁴Centers for Medicare & Medicaid Services (CMS), *Medicaid and CHIP 2015 Improper Payments Report*, (Washington, D.C.: 2016). These figures represent spending on a fee-for-service basis only and exclude claims paid as part of a managed care arrangement. An improper payment is defined by statute as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (2010) (codified at 31 U.S.C. § 3321 note). Additionally, Office of Management and Budget guidance instructs agencies to report as improper payments any payments for which insufficient or no documentation was found.

As the agency overseeing Medicaid at the federal level, CMS is responsible for overseeing state Medicaid programs, including protecting Medicaid fiscally from improper payments, ensuring that all beneficiaries are protected, and collecting data from states on Medicaid spending for services, and the types and volume of services provided, to carry out its oversight responsibilities. CMS also provides states with guidance on federal program requirements. Personal care services can be provided under many different authorities under Medicaid, and states have developed many different types of programs for delivering personal care and other home- and community-based services. In recent years, Congress has directed HHS to improve coordination of these programs, which could harmonize requirements—that is, implement a more consistent administration of policies and procedures. Specifically, in 2010 Congress required HHS to take steps to improve the coordination among, and regulation of all, providers of home- and community-based services to achieve a more consistent administration of policies and procedures across programs.⁵

We issued a report in each of 2016 and 2017 examining the federal oversight of Medicaid personal care services provided by state Medicaid programs.⁶ My remarks today are based primarily on these two reports and will focus on our assessment of:

1. federal program requirements to ensure the safety of Medicaid beneficiaries receiving personal care services and to ensure that billed services are actually provided; and
2. the extent CMS collects data that can be used to monitor the provision of and spending on personal care services by state Medicaid programs.

My remarks on the federal program requirements to ensure the safety of Medicaid beneficiaries and to ensure that billed services are provided are based on our 2016 report. For that report, we reviewed applicable federal laws, regulations, and guidance, including state reporting requirements specific to Medicaid personal care services programs. We also reviewed

⁵Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2402(a), 124 Stat. 119, 301-302 (2010).

⁶See GAO, *Medicaid Personal Care Services: CMS Could Do More to Harmonize Requirements across Programs*, [GAO-17-28](#) (Washington, D.C.: Nov. 23, 2016) and GAO, *Medicaid: CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services*, [GAO-17-169](#) (Washington, D.C.: Jan. 12, 2017).

personal care services programs in four states, selected to include variation in the types of such programs. In addition, we reviewed reports by CMS and HHS Office of the Inspector General relating to personal care services and interviewed CMS officials. My remarks on the data CMS collects on Medicaid personal care services are based on our 2017 report. For that report, we analyzed data collected by CMS on personal care services provided to beneficiaries and on state Medicaid spending on those services. For services provided, we analyzed Medicaid provider claims and managed care encounter data for calendar year 2012—the most recent and complete data available at the time of our 2016 analysis—for 35 states that had finalized 2012 data.⁷ For spending, we also analyzed Medicaid expenditure data for all 50 states and the District of Columbia for calendar years 2012 through 2015.⁸ Additional information on our scopes and methodologies are included in the 2016 and 2017 reports.

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicaid Program

Medicaid is jointly financed by the federal government and the states, with the federal government matching most state Medicaid expenditures using

⁷Each state transmits digital files with the claims and encounter data to CMS using the Medicaid Statistical Information System. This system is designed to provide CMS with a detailed, national database of Medicaid program information to support a broad range of program management functions, including health care research and evaluation, program utilization and spending forecasting, and analyses of policy alternatives. CMS developed a research-friendly data set called the Medicaid Analytic eXtract (MAX), which is a set of beneficiary-level data files derived from state-submitted MSIS claims data on Medicaid eligibility, service utilization, and payments. We used MAX data to analyze claims for personal care services because they are more reliable and consistent than states' quarterly MSIS reports. For purpose of this report we refer to MAX data as MSIS data because MAX is based on state MSIS data submissions.

⁸States must submit their Medicaid expenditures quarterly to CMS using the web-based Medicaid Budget and Expenditure System.

a statutory formula that determines a federal matching rate for each state. Medicaid is a significant component of federal and state budgets, with estimated total outlays of \$576 billion in fiscal year 2016, of which \$363 billion is expected to be financed by the federal government and \$213 billion by the states. Medicaid served about 72 million individuals, on average, during fiscal year 2016.⁹

As a federal-state partnership, both the federal government and the states play important roles in ensuring that Medicaid is fiscally sustainable over time and effective in meeting the needs of the populations it serves. States administer their Medicaid programs within broad federal rules and according to individual state plans approved by CMS, the federal agency that oversees Medicaid.

Federal matching funds are available to states for different types of payments that states make, including payments made directly to providers for services rendered under a fee-for-service model and payments made to managed care organizations:

- Under a fee-for-service delivery model, states make payments directly to providers; providers render services to beneficiaries and then submit claims to the state to receive payment. States review and process fee-for-service claims and pay providers based on state-established payment rates for the services provided.
- Under a managed care delivery model, states pay managed care organizations a set amount per beneficiary; providers render services to beneficiaries and then submit claims to the managed care organization to receive payment. Managed care plans are required to report to the states information on services utilized by Medicaid beneficiaries enrolled in their plans—information typically referred to as encounter data.

Most states use both fee-for-service and managed care delivery models, although the number of beneficiaries served through managed care has grown in recent years.

Federal law requires each state, under both fee-for-service and managed care delivery models, to operate a claims processing system to record

⁹Expenditure and enrollment data are from Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary, *2016 Actuarial Report on the Financial Outlook for Medicaid* (2017).

information about the services provided and report this information to CMS:

- Provider claims and managed care encounter data are required to include information about the service provided, including the general type of service; a procedure code that identifies the specific service provided; the location of the service; the date the service was provided; and information about the provider who rendered the service (e.g., provider identification number).
- Fee-for-service claims records must include the payment amount. Federal law requires states to collect managed care encounter data, but actual payment amounts to individual providers are not required.

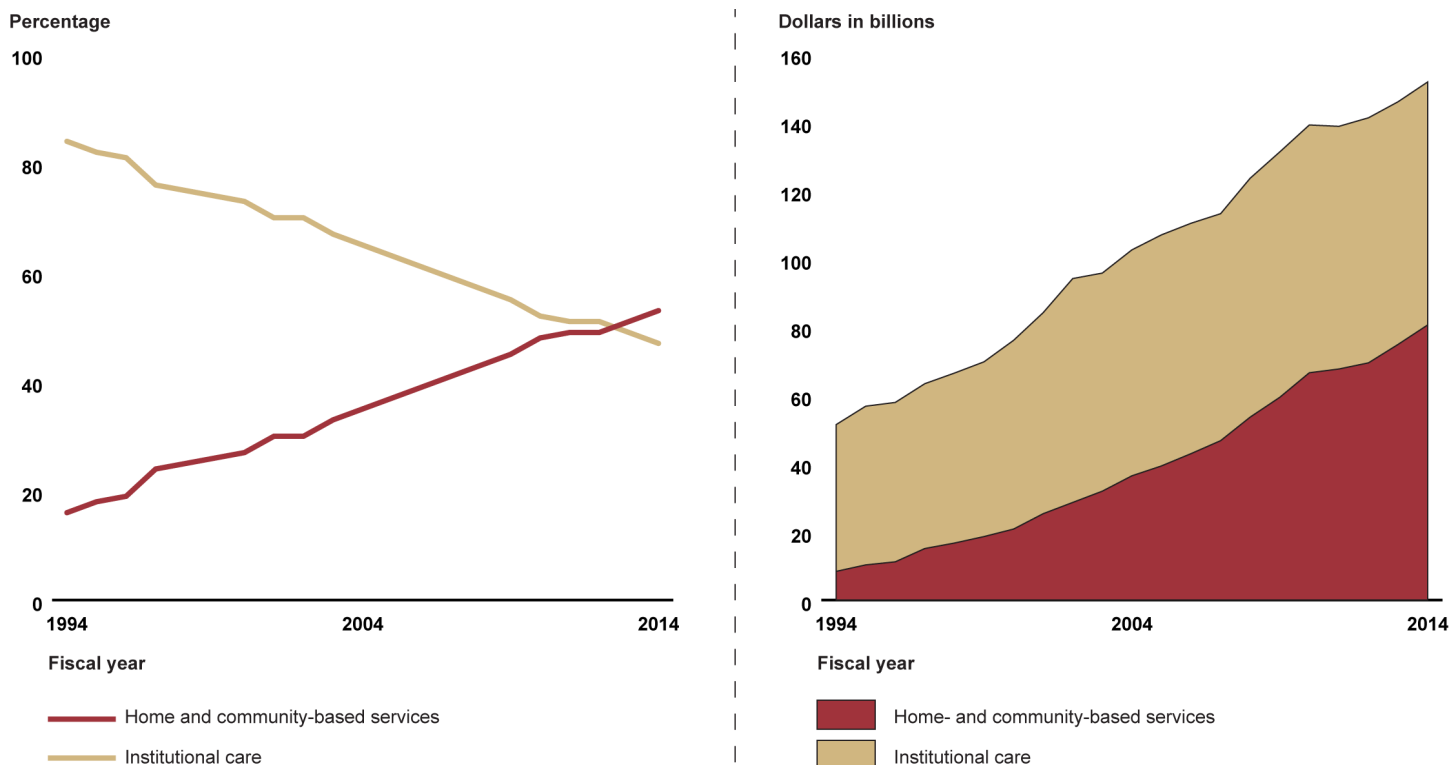
Long-Term Services and Supports, Home and Community Based Services, and Personal Care Services

Long-term services and supports financed by Medicaid are generally provided in two settings: institutional facilities, such as nursing homes and intermediate-care facilities for individuals with intellectual disabilities; and home and community settings, such as individuals' homes or assisted living facilities. Under Medicaid requirements governing the provision of services, states generally must provide institutional care to Medicaid beneficiaries, while HCBS coverage is generally an optional service. Medicaid spending on long-term services and supports provided in home and community settings has increased dramatically over time—to about \$80 billion in federal and state expenditures in 2014—while the share of spending for care in institutions has declined, and HCBS spending now exceeds long-term care spending for individuals in institutions (see fig. 1).¹⁰ All 50 states and the District of Columbia provide long-term care

¹⁰Medicaid HCBS and institutional long-term care spending is roughly equal for services provided on a fee-for-service basis. However, when long-term care services provided under a managed care arrangement are included, HCBS spending exceeds institutional spending. Truven Health Analytics, under contract with CMS, reported that 2013 was the first instance of expenditures for HCBS exceeding institutional services as a percentage of all long-term care services—51 percent for HCBS compared to 49 percent for institutional services. See Truven Health Analytics, *Medicaid Expenditures for Long-Term Services and Supports*.

services to some Medicaid beneficiaries in home and community settings.¹¹

Figure 1: Percentage of Spending and Total Spending on Medicaid Long-Term Services and Supports for Institutional Care and Home- and Community-Based Services, Fiscal Years 1994 through 2014



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) and state data collected and published by Truven Health Analytics, under contract with CMS. | GAO-17-598T

Personal care services, a key type of HCBS, are typically nonmedical services provided by personal care attendants—home-care workers who may or may not have specialized training. The demand for personal care services is expected to increase as is the number of attendants providing

¹¹Changes to federal Medicaid law in the last 35 years have expanded states' options for providing long-term care services and supports, including personal care services, in home and community settings. Factors driving these changes may include the desire and increased ability of beneficiaries who are aged and disabled to live in their homes and communities and the Supreme Court's 1999 *Olmstead* decision, which held that states must serve individuals with disabilities in community-based settings under certain circumstances. *Olmstead v. L.C.*, 527 U.S. 581 (1999).

these services in coming years.¹² The number of Medicaid beneficiaries receiving personal care services at this time is not known, but likely in the millions. In calendar year 2012, the most recent and complete available data, an estimated 1.5 million beneficiaries in the 35 states reporting at the time received personal care services at least once.¹³ Total Medicaid spending for personal care services is also not known, as spending in managed care delivery systems is not reported by service. Total Medicaid spending for personal care services in fee-for-service delivery systems was about \$15 billion in FY 2015.

Types of Personal Care Services Programs

With approval from CMS, states can choose to provide personal care services under one or more types of authorities (referred to in this statement as programs) put in place over the past 41 years under different sections of the Social Security Act. The various types of programs provide states with options for permitting participant direction and choices about how to limit services, among other things (see table 1).

Table 1: Types of Programs under Which States Can Provide Medicaid Personal Care Services

Program name (Year)	Number of states administering personal care services through program	Authorizing statute and program description
State Plan Personal Care Services (Implemented in 1975)	25	Starting in 1975, states have had the option of offering personal care services as a Medicaid State plan benefit. In its present form, section 1905(a)(24) of the Social Security Act, enacted in 1993, authorizes states to provide personal care services as a covered service in their state Medicaid plans. State Plan personal care services can serve beneficiaries who need an institutional level of care or those who do not need an institutional level of care. States must provide services to all eligible beneficiaries and cannot limit the number covered or use waiting lists.

¹²Overall, the number of personal care attendants employed is projected to increase by 26 percent from 2014 to 2024, growing from 1,768,400 in 2014 to 2,226,500 in 2024. The 26 percent rate of growth is much faster than the projected national average for all occupations of 7 percent. See U.S. Department of Labor, Bureau of Labor Statistics, *Occupational Outlook Handbook, 2016-17 Edition* (2016).

¹³See [GAO-17-169](#).

Program name (Year)	Number of states administering personal care services through program	Authorizing statute and program description
Home- and Community- Based Services (HCBS) Waiver (Enacted in 1981)	48	Section 1915(c) of the Social Security Act authorizes states to seek waivers of certain traditional Medicaid requirements in order to provide HCBS, including personal care services. For example, the Secretary of HHS can waive the requirement that the state provide services statewide to eligible beneficiaries. States can choose to provide any of a specified range of services to eligible beneficiaries including personal care services, case management, habilitation, and respite care. ^a Only beneficiaries who need an institutional level of care are eligible. CMS can waive certain federal requirements, allowing states to target services to specific groups and limit the number of beneficiaries served.
State Plan HCBS (Enacted in 2006)	4	Section 1915(i) of the Social Security Act authorizes states to provide any of the same range of services as available under HCBS Waivers, including personal care services. Unlike HCBS Waiver programs, states have the option to cover beneficiaries who need an institutional level of care, but must provide services to beneficiaries who do not require an institutional level of care. States can target services to specific groups of beneficiaries but may not limit access to services based upon the cost of services or the income or location of eligible beneficiaries.
Participant-Directed Option (Enacted in 2006)	9	Section 1915(j) of the Social Security Act gives states additional options for the delivery of personal care services and other services. The Participant-Directed Option is not a stand-alone program but, instead, must be offered in conjunction with either State Plan personal care services or HCBS Waiver. States can offer beneficiaries the option to receive individual budgets to pay for personal care services and other services. Beneficiaries may also be permitted to compensate a legally liable relative, such as a spouse or a parent, for personal care services. States are permitted to limit the number of beneficiaries served and to target services to specific groups. Beneficiaries can be eligible for an institutional level of care or not.
Community First Choice (Enacted in 2010)	8 ^b	Section 1915(k) of the Social Security Act authorizes states to provide personal care services and a range of services. States must provide services to all beneficiaries who are eligible. Only beneficiaries who would otherwise need an institutional level of care are eligible. States receive a 6 percentage point enhanced federal match for all services provided under Community First Choice programs.

Source: Social Security Act, Title XIX and CMS. | GAO-17-598T

^aCase management is a service that assists Medicaid recipients in gaining access to needed medical, social, educational, and other services. Habilitation services help beneficiaries to acquire or improve skills to become more independent. Respite care provides a range of services to beneficiaries when unpaid caregivers are absent or need relief.

^bThe number of states with a Community First Choice program is current as of September 2016.

CMS has implemented the different statutory requirements associated with these various program types by issuing regulations, as well as guidance to help states implement their Medicaid programs in accordance with applicable statutory and regulatory requirements. Guidance can include letters to state Medicaid directors, program manuals, and templates to help states apply for CMS approval to provide certain services like personal care. Together with federal statutes, the regulations

and guidance issued by CMS establish a broad federal framework for the provision of personal care services. States are responsible for establishing and administering specific policies and programs within the federal parameters laid out in this framework.

Federal Program Requirements for Maintaining Beneficiary Safety and Ensuring That Billed Services Are Provided Differ Significantly

In our 2016 report examining the federal program requirements for the multiple programs under which personal care services are provided, we found significant differences in federal requirements related to beneficiary safety and ensuring that billed services are provided.¹⁴ These differences may translate to differences in beneficiary protections across program types. Program requirements can include general safeguards for ensuring beneficiary health and welfare, quality assurance measures, critical incident monitoring, and attendant screening. For example, states implementing an HCBS Waiver program or a State Plan HCBS program must:

- Describe to CMS how the state Medicaid agency will determine that it is assuring the health and welfare of beneficiaries. To do so, states must describe: the activities or processes related to assessing or evaluating the program; which entity will conduct the activities; the entity responsible for reviewing the results of critical incident investigations; and the frequency at which activities are conducted.
- Demonstrate to CMS, by providing specific details that an incident management system is in place, including incident reporting requirements that establish the type of incidents that must be reported, who must report incidents, and the timeframe for reporting.

In contrast, states implementing a State Plan personal care services program or a Community First Choice program have fewer requirements for beneficiary safeguards. For example, for these programs, states are not required to do the following:

- Provide CMS with detailed information describing the activities they are taking to assure the health and welfare of beneficiaries.

¹⁴For purposes of this analysis, we reviewed regulations specific to personal care services, which appear at 42 C.F.R. Parts G, J, K, and M, as well as any personal care service-specific guidance issued by CMS. We did not review regulations or guidance of general applicability, such as program integrity requirements set forth in 42 C.F.R. part 455, because changes to these requirements would affect services beyond those provided under personal care services programs.

- Demonstrate to CMS specific details about their critical incident management process and incident reporting system; instead they are required to describe more generally their “process for the mandatory reporting, investigating and resolution of allegations of neglect, abuse, or exploitation.”¹⁵

Table 2 below illustrates more broadly the differences in federal program requirements that establish beneficiary safeguards and protections that we identified in our 2016 report.

Table 2: Federal Medicaid Personal Care Services Program Requirements on Safeguarding Beneficiaries, by Program Type, as of November 2016

Requirements for states ^b	Personal Care Services Program Type ^a			
	State Plan personal care services	State Plan Home- and Community-Based Services (HCBS)	HCBS Waivers	Community First Choice
General health and welfare				
Assure necessary safeguards have been taken to protect the health and welfare of beneficiaries	○	●	●	●
Describe health and welfare safeguards	○	●	●	●
Measure and improve performance in meeting assurances	○	●	●	○ ^c
Submit performance measurement evidence to determine whether or not an assurance has been met	○	○	●	○ ^c
Annually report on the impact of the program on the health and welfare of recipients	○	○	●	● ^d
Assure that interventions and supports will cause no harm to the individual	○	●	●	● ^e
The beneficiaries’ plan of care must reflect risk factors and measures in place to minimize these factors, including back-up plans when needed.	○	●	●	●
Quality assurance related to health and welfare				
Quality assurance (general)	●	●	●	●
Quality assurance system that continuously monitors health and well-being	○	●	●	●
Quality improvement strategy to measure individual outcomes	○	●	●	●
Critical incidents				

¹⁵See, for example, 42 C.F.R. § 441.585(a)(2) (2016).

Personal Care Services Program Type ^a				
Requirements for states ^b	State Plan personal care services	State Plan Home- and Community-Based Services (HCBS)	HCBS Waivers	Community First Choice
Quality assurance and improvement plan must identify critical incidents	○	●	●	●
Quality assurance system must include a process for the mandatory reporting, investigation, and resolution of allegations of critical incidents	○	○	○	●
Demonstrate that on an ongoing basis, the state identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death	○	●	●	○ ^f
Demonstrate that an incident management system is in place	○	●	●	○
Attendant Qualifications, Training, Screening, and Monitoring				
Set standards for training	○	○	○	●
Develop provider qualifications or standards	●	●	●	● ^g
Monitor uncredentialed providers	○	●	●	○

Legend: ● = Required ○ = Not required

Source: GAO analysis of Section XIX of the Social Security Act; Personal Care Services Regulations; CMS guidance | GAO-17-598T

^aOne other type of personal care services program is called the Participant-Directed Option. It is not a standalone program; instead, states pair it with either State Plan personal care services or HCBS Waivers. The requirements of the underlying paired authority apply to programs offering the Participant-Directed Option.

^bFor purposes of this analysis, we reviewed regulations specific to personal care services, which appear at 42 C.F.R. Parts G, J, K, and M, as well as any personal care services-specific guidance issued by CMS. We did not review regulations or guidance of general applicability, such as Medicaid program integrity requirements set forth in 42 C.F.R. part 455, because changes to these requirements would affect services beyond those provided under personal care services programs.

^cFor the Community First Choice program, states describe how they measure individual outcomes in their state plan amendments, but there is no requirement to measure and improve program performance and submit evidence of such.

^dStates must report on beneficiaries' "physical and emotional health."

^eFor Community First Choice, states must assure that interventions and supports will cause no harm when they are provided in a setting that is owned or controlled by the provider. For HCBS Waivers and State Plan HCBS, states must provide this assurance regardless of the setting.

^fFor Community First Choice, states must have quality assurance plans that include a process for reporting critical incidents, but are not required to have prevention programs.

^gThis requirement applies to attendants who work for a provider agency that is approved by the state to provide personal care services to beneficiaries.

Differences in federal program requirements may also result in significant differences in the level of assurance that billed services are actually provided to beneficiaries. States implementing HCBS Waiver programs and State Plan HCBS programs, for example, are required by CMS to provide evidence that the state is only paying claims when services are

actually rendered, while the State Plan personal care services and Community First Choice programs are not required to do so.

Table 3 below highlights the federal Medicaid personal care services program requirements that we identified in our 2016 report to ensure that billed services are provided for each of the different type of HCBS program states may administer.

Table 3: Federal Medicaid Personal Care Services Program Requirements on Ensuring Billed Services Are Provided, by Program Type, as of November 2016

Requirements for states on ensuring that billed services are provided ^b	Personal Care Services Program Type ^a			
	State Plan personal care services	State Plan Home- and Community-Based Services (HCBS)	HCBS Waivers	Community First Choice
Assure financial accountability and submit to an independent financial audit	○	●	●	○
Provide evidence that claims are only for services rendered	○	●	●	○
Describe the processes to validate provider billings to help ensure that services were provided	○	●	●	○
Monitor service delivery for participant-directed services	●	●	●	○

Legend: ● = Required ○ = Not required

Source: GAO analysis of Section XIX of the Social Security Act; Personal Care Services Regulations; CMS guidance | GAO-17-598T

^aOne other type of personal care services program is called the Participant-Directed Option. It is not a standalone program; instead, states pair it with either State Plan personal care services or HCBS Waivers. The requirements of the underlying paired authority apply to programs offering the Participant-Directed Option.

^bFor purposes of this analysis, we reviewed regulations specific to personal care services, which appear at 42 C.F.R. Parts G, J, K, and M, as well as any personal care service-specific guidance issued by CMS. We did not review regulations or guidance of general applicability, such as Medicaid program integrity requirements set forth in 42 C.F.R. part 455, because changes to these requirements would affect services beyond those provided under personal care services programs.

The four selected states we examined as part of our 2016 report used different methods to ensure attendants provided billed services to beneficiaries, according to state officials. For example, for at least some personal care services programs, two states required beneficiaries to sign timesheets, and two states used electronic visit verification timekeeping

systems.¹⁶ All four states performed quality assurance reviews for some personal care services programs to ensure billed services are received.¹⁷

The differing federal program requirements can create complexities for states and others in understanding federal requirements governing different types of HCBS programs, including personal care services. These different requirements may also result in significant differences in beneficiary safeguards and fiscal oversight, as illustrated in the following examples:

- Beneficiaries may experience different health and welfare safeguards depending on the program in which they are enrolled. For example, in one state we reviewed in 2016, the state required quarterly or biannual monitoring of beneficiaries for most of its personal care services programs. In contrast, for another program, the state required only annual monitoring contacts, in part, officials told us, due to the differing program requirements.¹⁸ Depending on the program type, CMS may have fewer assurances that beneficiaries' with similar levels of need are in programs with similar protections. For example, three of the four states we reviewed—Maryland, Oregon, and Texas—have in recent years transitioned coverage of personal care services

¹⁶Electronic visit verification timekeeping systems are newer, technology-based systems that electronically record when attendants begin and end providing services to a beneficiary. Such systems may include features to verify the attendant's location and make sure the attendant is in the beneficiary's home.

¹⁷State quality assurance procedures help assure state Medicaid personal care services programs are meeting quality standards and are to be implemented in compliance with federal and state program requirements. States design their own quality assurance procedures in accordance with federal Medicaid personal care service requirements, which vary by Medicaid personal care services program and are subject to approval by CMS. In general, quality assurance procedures across the four states we reviewed include monitoring such as case file or record reviews and in-home visits to make sure required procedures were followed.

¹⁸Federal internal control standards state that agencies should establish control activities that appropriately cover the objectives and risks of an entity's operations. See GAO, *Standards for Internal Controls in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. In the case of personal care services, a risk-based internal control process would suggest that programs protecting Medicaid beneficiaries from harm and ensuring that payments are made only made when services are actually provided are comparable across programs serving like beneficiaries. A consistent process and comprehensive framework for managing risk can help ensure risks are managed effectively, efficiently, and coherently.

for beneficiaries who need an institutional level of care from personal care services programs with relatively more stringent federal beneficiary safety requirements to programs with relatively less stringent requirements. Although they were not required to do so, state officials in the three states reported that the states chose to continue using the same quality assurance measures in the new programs as the best way to ensure safety for beneficiaries. Without more harmonized requirements, we concluded that CMS has no assurance that states that transition personal care services from HCBS Waivers to Community First Choice in the future will make the same decisions.

- States can use different processes for each personal care services program to ensure that billed services are actually provided, and some programs may not be subject to federal personal care services requirements explicitly in this regard. For example, in one state we reviewed in 2016, steps taken to ensure billed services are provided under some types of personal care services programs were not required in another of the state's programs.¹⁹

A report we issued in 2012 reviewing states' implementation of different HCBS programs also suggested that states could benefit from more harmonization of program requirements. Officials in selected states we reviewed in 2012 noted the complexity of operating multiple programs.²⁰ For example, officials from one state reported that the complexity resulted in a siloed approach, with different enrollment, oversight, and reporting requirements for each program. The administration and understanding of the programs available to beneficiaries was difficult for state staff and beneficiaries, according to officials in another state. The officials indicated that they would prefer CMS issue guidance on how states could operate different HCBS program types together, rather than issuing guidance on each program separately.

In our 2016 report, we acknowledged certain efforts CMS had taken to harmonize requirements and improve oversight of personal care services programs. However, despite these efforts, we found that significant

¹⁹The state reported that in one personal care services program, a supervisor must visit the beneficiary and document whether the attendant is delivering the authorized personal care services tasks. The state did not apply the same process to another of its personal care services programs for which there was no specific requirement in this regard.

²⁰GAO, *Medicaid: States' Plans to Pursue New and Revised Options for Home- and Community-Based Services*, [GAO-12-649](#) (Washington, D.C.: June 13, 2012).

differences in program requirements existed. We recommended that CMS take additional steps to better harmonize and achieve a more consistent application of program requirements, as appropriate, across the different personal care services programs in a way that accounts for common risks faced by beneficiaries and to better ensure billed services were provided. CMS agreed with these recommendations, and has sought input by publishing a request for information on numerous topics related to Medicaid home and community-based services, including input on how to ensure beneficiary health and safety and program integrity across different types of personal care services programs.

Data on Personal Care Services Collected by CMS were Often Not Timely, Complete, Consistent, or Accurate

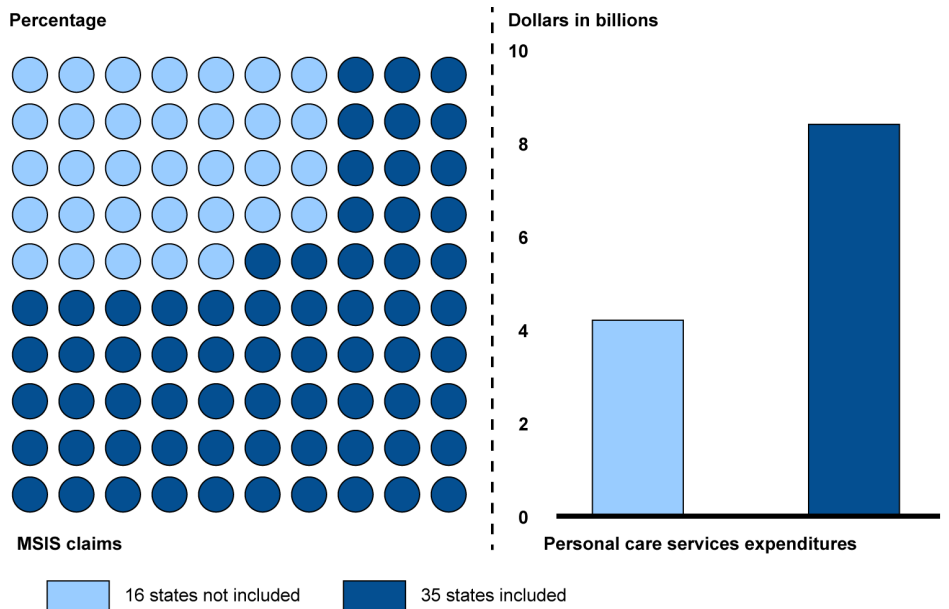
Claims and Encounter Data Were Not Timely, Complete, or Consistent

In our 2017 report examining the data CMS uses to monitor the provision of personal care services, we found that claims and encounter data collected by CMS were not timely. Data are typically not available for analysis and reporting by CMS or others for several years after services are provided. We found that this happens for two reasons. First, although states have 6 weeks following the completion of a quarter to report their claims data, their reporting could be delayed as a result of providers and managed care plans not submitting data in a timely manner, according to the CMS contractor responsible for compiling data files of Medicaid claims and encounters. For example, providers may submit claims for fee-for-service payments to the state late and providers may need to resubmit claims to make adjustments or corrections before they can be paid by the state. Second, once complete MSIS data are submitted by the states, the data must be compiled into annual person-level claims files that are in an accessible format, checked to identify and correct data errors, and consolidated for any claims with multiple records. This process, for one year of data, can take several years and, as a result, when information from claims and encounters becomes available for use

by CMS for purposes of program management and oversight it could be several years old.

We also found that Medicaid personal care services claims and encounter data that CMS collects were incomplete in two ways. First, specific data on beneficiaries' personal care services were not included in the calendar year 2012 MSIS data for 16 states, as of 2016, when we conducted our analysis. Nevertheless, these 16 states received federal matching funds for the \$4.2 billion in total fee-for-service payments for personal care services that year—about 33 percent of total expenditures for personal care services reported by all states (see figure 2).²¹

Figure 2: Percentage of Calendar Year 2012 Personal Care Services Fee-For-Service Expenditures for States That Were and Were Not Included in the Medicaid Statistical Information System Data

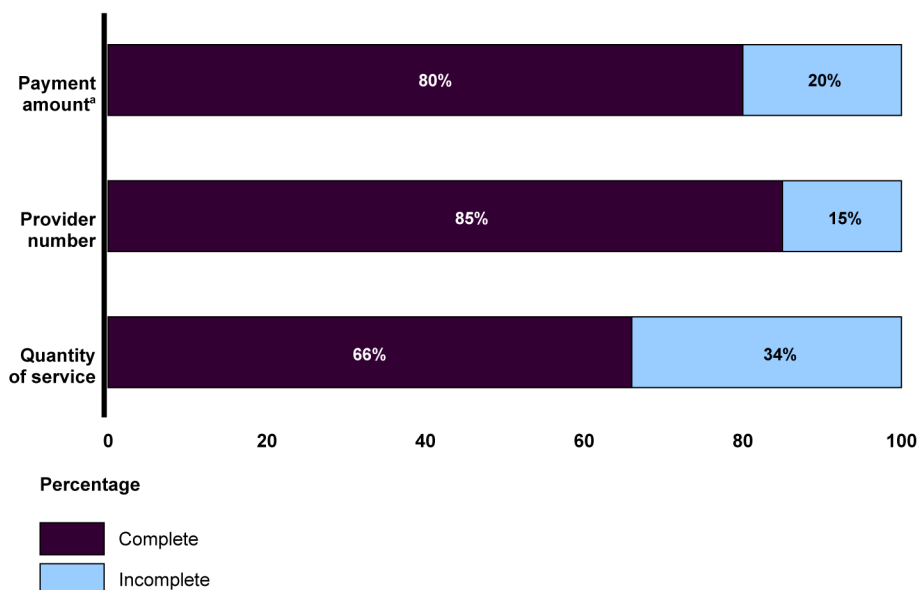


Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-598T

²¹To estimate the Medicaid personal care services expenditures associated with the 16 missing states, we analyzed aggregate fee-for-service expenditures for these services as reported by these states through the Medicaid Budget and Expenditure System.

Second, even for the 35 states for which 2012 MSIS claims and encounter data were available, certain data elements collected by CMS were incomplete. For example, for the records we analyzed, 20 percent included no payment information, 15 percent included no provider identification number to identify the provider of service, and 34 percent did not identify the quantity of services provided (see figure 3).²²

Figure 3: Percentage of 2012 Medicaid Claims and Encounters for Personal Care Services in 35 States That Had Complete Information on Payment, Provider Information, and the Quantity of Services Provided



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-598T

^aPayment amounts are available for claims made under a fee-for-service deliver model; payments made to providers under managed care are not included in the data.

²²We previously reported that managed care encounter data submitted by states to CMS have been relatively incomplete and unreliable. See GAO, *Medicaid: Service Utilization Patterns for Beneficiaries in Managed Care*. [GAO-15-481](#) (Washington, D.C.: May 29, 2016).

Incomplete data limit CMS's ability to track spending changes and corroborate spending with reported expenditures because the agency lacked important information on a significant amount of Medicaid payments for personal care services. For example, among the 2012 claims we reviewed for personal care services under a fee-for-service delivery model, claims without a provider identification number accounted for about \$4.9 billion in total payments. Similarly, payments for fee-for-service claims with missing information on the quantity of personal care services provided totaled about \$5.1 billion. These data gaps represented a significant share of total personal care services spending, which totaled about \$15 billion in fee-for-service expenditures in 2015.

Even when states' claims and encounter data collected by CMS was complete, we found that it was often inconsistent, which limits the effectiveness of the data to identify questionable claims and encounters. For purposes of oversight, a complete record (claims or encounters) should include data for each visit with a provider or caregiver, with dates of when services were provided, the amount of services provided using a clearly specified unit of service (e.g., 15 minutes), and the type of services provided using a standard definition. Such a complete record would allow CMS and states to analyze claims to identify potential fraud and abuse. The following examples illustrate inconsistencies in data regarding when services were provided and the types of services that were provided from the 35 states whose data we reviewed:

- **When services were provided.** State-reported dates of service were overly broad. In the 35 states, some claims for personal care services had dates of services (i.e., start and end dates) that spanned multiple days, weeks, and in some cases months. For 12 of the 35 states, 95 percent of their claims were billed for a single day of service. However, in other states, a number of claims were billed over longer time periods. For example, for 10 of the states, 5 percent of claims covered a period of at least 1 month, and 9 states submitted claims that covered 100 or more days. When states report dates of service that are imprecise, it is difficult to determine the specific date for which services were provided and identify whether services were claimed during a period when the beneficiary is not eligible to receive personal care services—for example, when hospitalized for acute care services.
- **Type of services provided.** States used hundreds of different procedure codes for personal care services. Procedure codes on submitted claims and encounters were inconsistent in three ways: the number of codes used by states; the use of both national and state-

specific codes; and the varying definitions of different codes across states. More than 400 unique procedure codes were used by the 35 states. CMS does not require that states use standard procedure codes for personal care services; instead, states have the discretion to use state-based procedure codes of their own choosing or national procedure codes. As a result, the procedure codes used for similar services differed from state to state, which limits CMS's ability to use this data as a tool to compare and track changes in the use of specific personal care services provided to beneficiaries because CMS cannot easily compare similar procedures by comparing service procedure codes.

Medicaid Expenditure Data Collected by CMS Were Not Always Accurate or Complete

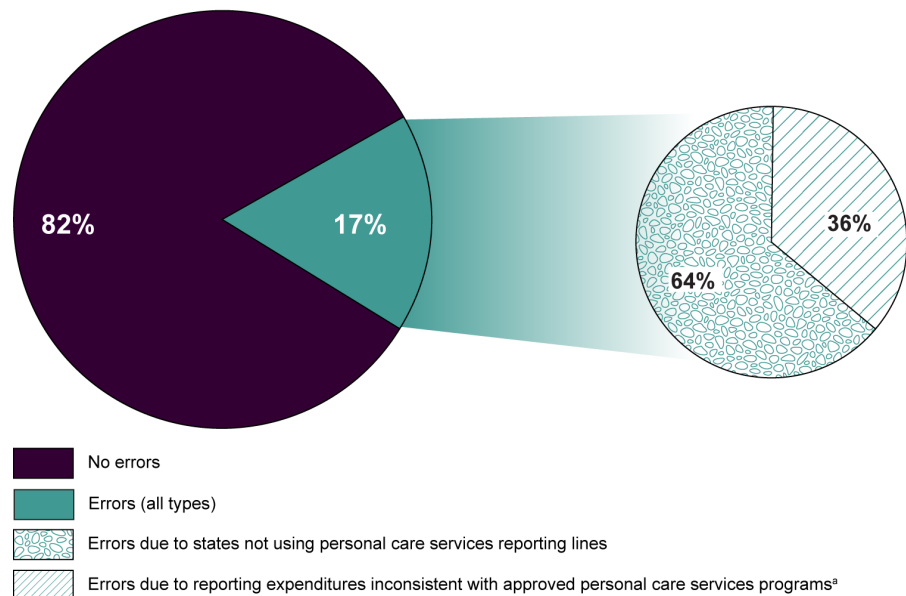
In our 2017 report we found that Medicaid personal care services expenditure data collected were not always accurate or complete, according to our analysis of expenditure data collected by CMS from states for calendar years 2012 through 2015. When submitting expenditure data, CMS requires states to report expenditures for personal care services on specific reporting lines. These reporting lines correspond with the specific types of programs under which states have received authority to cover personal care services, and can affect the federal matching payment amounts states receive when seeking federal reimbursement. For example, a 6 percent increase in federal matching is available for services provided through the Community First Choice program.²³ For three other types of HCBS programs, CMS also requires states to report their expenditures for personal care services separately from other types of services provided under each program on what CMS refers to as feeder forms—that is, individual expenditure lines for different types of services that feed into the total HCBS spending amount for each program.

We found that not all states were reporting their personal care services expenditures accurately, and, as result, personal care services expenditures may have been underreported or reported in an incorrect category. We compared personal care services expenditures for all states for calendar years 2012 through 2015 with each state's approved programs during this time period and found that about 17 percent of personal care services expenditure lines were not reported correctly. As

²³In addition to the 6 percent enhanced federal matching rate, states operating a Community First Choice program are subject to a maintenance of expenditures requirement—that is, states operating such a program are required in their first year to maintain or exceed the level of spending from the prior year.

illustrated in figure 4, nearly two-thirds of the reporting errors were a result of states not separately identifying and reporting personal care services expenditures using the correct reporting lines, as required by CMS. Without separate reporting of personal care expenditures as required, CMS is unable to ensure appropriate federal payment, monitor how spending changes over time across the different program types and have an accurate estimate of the magnitude of potential improper payments for personal care services. The other types of errors involved states erroneously reporting expenditures that did not correspond with approved programs. As a result, CMS is not able to efficiently and effectively identify and prevent states from receiving federal matching funds inappropriately, in part because it does not have accurate fee-for-service claims data that track payments by personal care program type that is linked with expenditures reported for purpose of federal reimbursement.

Figure 4: Percentage of Personal Care Services Expenditure Lines in 2012 to 2015 with State Reporting Errors



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-598T

^aErrors include states reporting personal care services expenditures for programs that they did not administer and states not reporting personal care services expenditures for programs that they did administer.

These errors demonstrated that CMS was not effectively ensuring its reporting requirements for personal care expenditures were met. We concluded that by not ensuring that states are accurately reporting expenditures for personal care services, CMS is unable to accurately identify total expenditures for personal care services, expenditures by program, and changes over time. According to CMS, expenditures that states reported through MBES are subject to a variance analysis, which identifies significant changes in reported expenditures from year to year. However, CMS's variance analysis did not identify any of the reporting errors that we found. CMS officials told us that they would continue to review states' quarterly expenditure reports for significant variances and follow up on such variances.

In our 2017 report, we acknowledged certain efforts CMS had taken to improve the data it collects. However, these efforts had not addressed data issues we identified that limited the usefulness of the data for oversight. We recommended that CMS take steps to improve the collection of complete and consistent personal care services data and better monitor the states' provision of and spending on Medicaid personal care services. Specifically, CMS agreed with recommendations to better ensure states comply with data reporting requirements and to develop plans for analyzing and using the data. The agency neither agreed nor disagreed with recommendations to issue guidance to ensure key data regarding claims and encounter data are complete and consistent, or with a recommendation to ensure claims data can be accurately linked with aggregate expenditure data. In light of our findings of inconsistent and incomplete reporting of claims and encounters, errors in reporting expenditures, and the high-risk of improper payments, we believe action in response to these recommendations is needed.

In conclusion, Medicaid personal care services are an important benefit for a significant number of Medicaid beneficiaries and amount to billions of dollars in spending to the federal government and states. The demand and spending for personal care services continues to grow. However, the services are not without risk. Personal care services are at high risk for improper payments and beneficiaries may be vulnerable and at risk of unintentional harm and potential neglect and exploitation. Over the years, federal laws have given states a number of different options to provide home- and community- based services. Having various options for providing personal care services provides flexibilities for states in how they administer their programs and provide services to different groups of beneficiaries. At the same time, our work has also found a patchwork of

federal requirements, resulting in varying levels of beneficiary safeguards and requirements to ensure that billed services are actually provided. As a result, beneficiaries with similar needs could be receiving services in programs with significantly different safeguards in place, depending on the program. Similarly, the level of assurance that billed services are actually provided could vary based on the type of program. Further, our work showed that the data CMS collects for oversight of these programs is not always timely, complete, accurate, and consistent. Without better data, CMS is hindered in effectively performing key management functions related to personal care services, such as ensuring state claims for enhanced federal matching funds are accurate. CMS has taken steps to improve the data it collects from states, and to establish more consistent administration of policies and procedures across the programs under which personal care services are provided. However, we found additional steps are warranted.

Chairman Murphy, Ranking Member DeGette, and Members of the Subcommittee this concludes my prepared statement. I would be pleased to respond to any question that you might have at this time.

GAO Contact and Staff Acknowledgments

If you or your staffs have any questions about this testimony, please contact Katherine M. Iritani at (202) 512-7114. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals making key contributions to this testimony include Tim Bushfield, Assistant Director; Anna Bonelli; Christine Davis; Barbara Hansen; Laurie Pachter; Perry Parsons; and Jennifer Whitworth.

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