U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

April 28, 2017

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled "Combating Waste, Fraud, and Abuse in Medicaid's Personal Care Services Program"

On May 2, 2017, at 10:15 a.m. in 2322 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled "Combating Waste, Fraud, and Abuse in Medicaid's Personal Care Services Program."

Personal Care Services (PCS) is a Medicaid benefit that all 50 states provide to beneficiaries. PCS provides important non-medical assistance to people with disabilities, individuals with chronic or temporary conditions, and the elderly, and these services are available in the beneficiaries' homes. Data suggests that the utilization of PCS services is growing rapidly, and Medicaid fee-for-service spending for PCS increased from $12.7 billion in 2012 to $15 billion in 2015.[1]

In recent months, the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) and the Government Accountability Office (GAO) have released reports indicating fraud, abuse, and mismanagement within Medicaid's PCS program. The findings in these reports raise questions about the Centers for Medicare and Medicaid Services' (CMS) effectiveness in administering the PCS program, and suggest changes that may be necessary to safeguard vulnerable beneficiaries. This hearing will examine three areas of concern identified by the OIG and GAO reports: (1) PCS fraud and abuse that directly harms beneficiaries, (2) the lack of uniformity in beneficiary safeguards, and (3) poor data collection that hampers effective administration and accountability within PCS.

I. WITNESSES

- Timothy Hill, Deputy Director, Medicaid and CHIP Services, Centers for Medicare and Medicaid Services;
- Christi Grimm, Chief of Staff, Office of Inspector General, Department of Health and Human Services; and
- Katherine Iritani, Director, Health Care, Government Accountability Office.

[1] GOV'T ACCOUNTABILITY OFFICE, GAO-17-169, CMS NEEDS BETTER DATA TO MONITOR THE PROVISION OF AND SPENDING ON PERSONAL CARE SERVICES (2017).

II. BACKGROUND

This hearing will examine the recent work by the HHS OIG and the GAO that highlights serious deficiencies in the PCS program. The Committee will also discuss ways to solve the problems identified so that CMS can safeguard vulnerable beneficiaries and protect taxpayer dollars.

1. HHS OIG Fraud and Abuse Investigations

On October 3, 2016, the OIG issued an Investigative Advisory to CMS.[2] The Advisory summarized Medicaid fraud schemes involving PCS identified by the OIG between November 2012 and August 2016. The fraud schemes identified by the Advisory built upon those included in a 2012 Portfolio on PCS fraud issues that HHS OIG issued to CMS. As the program has grown, OIG reports that the increasing volume of fraud involving PCS has become a top concern.[3] OIG further stated that "CMS would help to prevent and quickly detect instances of fraud and patient harm and neglect" if it implemented the basic recommendations included in the 2012 Portfolio.[4]

In 2012, the OIG published a PCS Portfolio that presented findings collected from two dozen previous OIG audits and hundreds of investigations.[5] The Portfolio included five recommendations for CMS to improve vulnerabilities detected through the OIG's work. These recommendations range from requiring states to collect and report PCS data, to requiring minimum standards and background checks for those who work as PCS attendants.[6] One recommendation called for CMS to address six additional unimplemented recommendations from previous OIG reports regarding PCS.[7] CMS did not implement many of OIG's important recommendations in the intervening years between their release in 2012 and the Advisory issued in 2016.

In the last four years, the OIG has opened over 200 investigations involving PCS fraud and associated patient harm across the United States. The October 3, 2016, Advisory describing these schemes found "significant vulnerabilities in the PCS program, including a lack of internal controls, and that PCS fraud continues to be a persistent problem."[8] OIG described several of the fraud schemes identified through its investigations, such as:

- Two PCS attendants in Washington State persuaded a beneficiary to sign blank time sheets and submitted claims for periods when the beneficiary was out of the country.

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[2] INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERV., INVESTIGATIVE ADVISORY ON MEDICAID FRAUD AND PATIENT HARM INVOLVING PERSONAL CARE SERVICES (2016). [hereinafter *Investigative Advisory*]
[3] *Id.*
[4] *Id.*
[5] INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERV., PERSONAL CARE SERVICES: TRENDS, VULNERABILITIES, AND RECOMMENDATIONS FOR IMPROVEMENT (2012).
[6] *Id.*
[7] *Id.*
[8] *Investigative Advisory*, *supra* note 2.

- A PCS agency in Alaska knowingly authorized PCS attendants to submit false time sheets, and billed Alaska's Medicaid program for services provided by employees who were not legally authorized to bill Alaska Medicaid.

- A PCS attendant in Illinois submitted claims seeking more than $34,000 for services she did not provide. The same attendant received payments for over a year, even though she was excluded from all federal health care programs because her nursing license was suspended for allegedly diverting controlled substances from her employer.

- A PCS attendant in Missouri submitted claims for providing care to four different beneficiaries while working another full-time job. The attendant was paid for services, even though her time sheets for more than 130 days indicated she was in two places at the same time.

Most OIG fraud investigations are the result of a referral from an individual who has personal knowledge of the fraud.[9] Currently, states and the federal government do not collect enough PCS data, so it is not possible for the OIG to analyze data and detect fraud schemes such as suspicious billing patterns. To help curb fraud in PCS and protect vulnerable beneficiaries, Congress acted in the Helping Families in Mental Health Crisis Act of 2016 (H.R. 2646) to direct states to require the use of an electronic visit verification system for Medicaid-provided personal care services and home health services.[10] Such a system would ensure that services are verified regarding the type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends. This provision of H.R. 2646 became law as part of the 21st Century Cures legislation.

In addition to fraud, the OIG Advisory found troubling incidents of patient abuse or neglect:

- One beneficiary in Pennsylvania died of exposure to the cold while under the care of a PCS attendant, who inexplicably took the beneficiary shopping in downtown Philadelphia even though that beneficiary had a developmental disorder and a history of running away.

- A beneficiary in Idaho was hospitalized for severe dehydration and malnourishment and was hospitalized after her PCS attendant – her son – neglected her care. Investigators found the home filthy with drug paraphernalia, trash, and dog feces in the home.

- A PCS attendant in Vermont allegedly arranged to split payments for services with the beneficiary's wife, and submitted claims for 456 hours of services that were not

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[9] *Id*.
[10] H.R. 2646, 114th Cong. (2016).

> provided. The PCS attendant was also allegedly compensated by using the patient's prescription opioid painkillers.[11]

The OIG notes that beneficiaries—often disabled individuals or the elderly poor—are unable to report abuse and harm because of beneficiaries feel beholden to their attendants or have physical or cognitive impairments. This makes beneficiary safeguards and strong oversight even more important to protect these vulnerable populations.

2. Uniformity in Beneficiary Safeguards

In November 2016, the GAO released a report finding a lack of standardized requirements for state PCS programs. GAO noted that harmonizing program requirements can "improve coordination of program services" and facilitate better oversight on the state and federal levels.[12] Of the four states audited, GAO found that each state had a different standard for beneficiary safeguards, such as attendant screening and training, and beneficiary monitoring. For example, while all four states required background checks, the rigor of the background differed depending on the state. In California, beneficiaries can hire an attendant even if that attendant was convicted of a felony related to social service fraud. In Oregon, some beneficiaries are responsible for screening attendants against HHS OIG's list of excluded providers, where the rest of the states require that step in addition to a background check. GAO attributed these varying standards to a "patchwork of federal requirements" and stated that HHS could act within limits of existing law to harmonize these requirements.[13]

3. Insufficient Data on PCS Expenditures

In January 2017, the GAO released a report finding significant deficiencies in the data systems that collect information about the administration of the PCS program.[14] CMS utilizes two data systems—MSIS and MBES—to collect data about PCS.[15] According to GAO, the MSIS data was "not timely, complete or consistent," and only included data for 35 states.[16] Further, the most recent data at the time of GAO's audit was from 2012. The MBES data was "not always accurate or complete;" for example, 17 percent of expenditure lines were not reported correctly between 2012 and 2015.[17] GAO warned that, "without good data, CMS is unable to effectively monitor who is providing personal care services or the type, amount, and dates of services."[18]

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[11] *Investigative Advisory*, *supra* note 2.
[12] GOV'T ACCOUNTABILITY OFFICE, GAO-17-28, CMS COULD DO MORE TO HARMONIZE REQUIREMENTS ACROSS PROGRAMS (2016).
[13] *Id.*
[14] GOV'T ACCOUNTABILITY OFFICE, GAO-17-169, CMS NEEDS BETTER DATA TO MONITOR THE PROVISION OF AND SPENDING ON PERSONAL CARE SERVICES (2017).
[15] The MSIS is the Medicaid Statistical Information System, which collects detailed information from provider claims on services rendered to individual Medicaid beneficiaries and state payments for these services. The MBES is the Medicaid Budget Expenditure System and collects states' total aggregate Medicaid expenditures across 80 broad service categories.
[16] GOV'T ACCOUNTABILITY OFFICE, GAO-17-169, CMS NEEDS BETTER DATA TO MONITOR THE PROVISION OF AND SPENDING ON PERSONAL CARE SERVICES (2017) at 36.
[17] *Id*. at 37.
[18] *Id*.

III. ISSUES

The following issues may be examined at the hearing:

- How does the growth of PCS increase the risk of fraud?
- How does coordination in program requirements facilitate better oversight on the state and federal levels?
- What role do states play in ensuring the integrity of the PCS program?
- What problems can CMS address administratively?
- How can better data curb waste, fraud and abuse in the Personal Care Services program?

IV. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Emily Felder of the Committee staff at (202) 225-2927.