

**COMBATING WASTE, FRAUD, AND ABUSE IN
MEDICAID'S PERSONAL CARE SERVICES PROGRAM**

HEARING
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED FIFTEENTH CONGRESS

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COMBATING WASTE, FRAUD, AND ABUSE IN MEDICAID'S PERSONAL CARE SERVICES PROGRAM

TUESDAY, MAY 2, 2017

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:16 a.m., in Room 2322, Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Members present: Representatives Murphy, Griffith, Brooks, Collins, Walberg, Walters, Costello, Carter, Walden (ex officio), DeGette, Schakowsky, Tonko, Clarke, Ruiz, and Pallone (ex officio).

Staff present: Jennifer Barblan, Chief Counsel, Oversight and Investigations; Ray Baum, Staff Director; Elena Brennan, Legislative Clerk, Oversight and Investigations; Lamar Echols, Counsel, Oversight and Investigations; Blair Ellis, Press Secretary/Digital Coordinator; Emily Felder, Counsel, Oversight and Investigations; Jennifer Sherman, Press Secretary; Julie Babayan, Minority Counsel; Jeff Carroll, Minority Staff Director; Christopher Knauer, Minority Oversight Staff Director; Miles Lichtman, Minority Policy Analyst; Kevin McAloon, Minority Professional Staff Member; Jon Monger, Minority Counsel; Dino Papanastasiou, Minority GAO Detailee; and C.J. Young, Minority Press Secretary.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Good morning. The subcommittee convenes this hearing today to examine Medicaid Personal Care Services, a critical lifeline for our Nation's most vulnerable populations.

Medicaid is the largest provider of long-term care services for disabled and elderly individuals. Lately, long-term care has shifted from nursing homes and institutional settings to services provided to beneficiaries in their homes.

Personal care services, or PCS, provides essential services to Medicaid beneficiaries with significant needs so that they can stay in their homes. As they enter this ever more vulnerable stage of life, most elderly persons prefer to live in familiar surroundings.

These are not health services, but rather they assist beneficiaries with daily activities they can no longer do without assistance such

as meal preparation, laundry, and transportation so that they can continue to live in their communities.

PCS now makes up a large component of home- and community-based care and continues to grow rapidly. In 2015, Federal and State expenditures for PCS amounted to \$15 billion, up from \$12.7 billion in 2011. The actual figure is probably significantly higher because this number only reflects fee-for-service claims, and does not include managed care.

The U.S. Department of Labor projected that employment of personal and home health aides will grow by 46 percent between 2008 and 2018, which far exceeds the average growth of 10 percent for all occupations.

While the move toward home care has undoubtedly improved the lives of Medicaid beneficiaries by allowing them to stay at home and saves money for taxpayers, we cannot turn a blind eye to waste, fraud, and abuse in the Personal Care Services program.

More than 29 reports by the HHS Office of Inspector General have uncovered systemic fraud in PCS. The OIG has uncovered schemes between PCS attendants and Medicaid beneficiaries to submit claims for services that were not provided. This type of fraud is difficult to detect because attendants can often be a beneficiary's spouse, child or friend.

Even more troubling is the abuse that HHS OIG's investigations found. Stories like that of a beneficiary in my home State of Pennsylvania dying of exposure to the cold while under the care of a PCS attendant. This beneficiary had autism and a history of running away, but the attendant left her alone in a crowded shopping mall and waited an hour to call authorities.

In Maryland, a disabled woman was left alone in a locked car on a hot and sunny day, while her attendant went shopping with a friend. This woman was unable to open the car door. A concerned citizen noticed her in distress and called the police.

In Vermont, an attendant stole the opioid painkillers prescribed for the beneficiary, even though the beneficiary was in significant discomfort and pain. This same attendant was on probation for drug possession at the time.

These are just some of the many stories of abuse uncovered by the OIG and other authorities. We will discuss them more today.

We talk about program integrity and high improper payments a lot on this subcommittee. We are used to getting into the weeds on error rates, methodology, and data collection.

To help curb fraud in PCS and protect vulnerable beneficiaries, Congress acted in the Helping Families in Mental Health Crisis Act of 2016 to require the use of an electronic visit verification system for Medicaid-provided PCS and home health services. This became law as part of 21st Century Cures, and when implemented, will help ensure that information regarding the services provided are verified.

Having verified data that will help identify waste, fraud, and abuse is important because there are real people at risk. Those who use the PCS program include our friends and neighbors, who may not have the resources or ability to speak up when they encounter abuse. This subcommittee and this Congress will not tolerate these abuses.

While it is undoubtedly good policy to keep beneficiaries in their homes, it also raises difficult questions which must be addressed.

How do we protect vulnerable people from abuse in their homes, when no one else is around to assess an attendant's performance?

What changes can we make, by both Congress and CMS, to improve the program while maintaining access for Medicaid beneficiaries who need these services?

Both the HHS OIG and the Government Accountability Office have done excellent work to highlight the problems within PCS. These offices have also suggested ways to solve these problems, such as additional beneficiary safeguards, higher standards for attendants, and pre-payment controls.

I am grateful for your work and look forward to hearing more about your findings.

I understand that CMS has already acted to address some of these, but not all, these findings, and we will discuss what CMS is doing to address our concerns.

So thank you to all of our witnesses today for your dedication, and great work to protect Medicaid beneficiaries and root out waste, fraud, and abuse. I look forward to a productive discussion today.

[The prepared statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

The subcommittee convenes this hearing today to examine Medicaid Personal Care Services—a critical lifeline for our Nation's most vulnerable populations.

Medicaid is the largest provider of long-term care services for disabled and elderly individuals. Lately, long-term care has shifted from nursing homes and institutional settings to services provided to beneficiaries in their homes.

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While the move toward home care has undoubtedly improved the lives of Medicaid beneficiaries by allowing them to stay at home—and saves money for taxpayers—we cannot turn a blind eye to waste, fraud, and abuse in the Personal Care Services program.

More than 29 reports by the HHS Office of Inspector General have uncovered systemic fraud in PCS. The OIG has uncovered schemes between PCS attendants and Medicaid beneficiaries to submit claims for services that were not provided. This type of fraud is difficult to detect because attendants can often be a beneficiary's spouse, child or friend.

Even more troubling is the abuse the HHS OIG's investigations found. Stories like that of a beneficiary in my home State of Pennsylvania dying of exposure to the cold while under the care of a PCS attendant. This beneficiary had autism and a history of running away, but the attendant left her alone in a crowded shopping mall and waited an hour to call authorities.

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I am grateful for your work and look forward to hearing more about your findings.

I understand that CMS has already acted to address some—but not all—of these findings, and we will discuss what CMS is doing to address our concerns.

Thank you to our witnesses today for your dedication and great work to protect Medicaid beneficiaries and root out waste, fraud, and abuse. I look forward to a productive discussion today.

Mr. MURPHY. I'll recognize Ms. DeGette for 5 minutes. Our main clock is not working, so as a reminder, I will just tap this when you reach 5 minutes. Thank you.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thanks, Mr. Chairman. Today, thanks to Medicaid, 74 million vulnerable Americans including seniors, children, adults, and people with disabilities have access to quality healthcare. And despite what we often hear from our colleagues on the other side of the aisle, the Medicaid program delivers this care efficiently and effectively. In fact, not only are Medicaid's costs for beneficiaries substantially lower than that of private insurance, but they have also been growing more slowly per beneficiary. What is more, we know that the Medicaid program literally saves lives.

Last year, more than 12 million low-income adults had healthcare coverage because of the Affordable Care Act Medicaid expansion, something I think is an astonishing achievement. Coupled with other important provisions of the ACA, the Medicaid expansion has helped drive the uninsured rate to the lowest level in our Nation's history.

One of the key components of Medicaid is the Personal Care Services program. Personal care services which include assistance with activities like bathing, dressing, and meal preparation are an important part of long-term care that Medicaid offers to bene-

ficiaries. This allows beneficiaries to hold on to their independence longer and to stay in their homes with dignity. Furthermore, personal care services can save the Government money because they can be cheaper than enrolling patients in a nursing home, a lot cheaper.

However, just like other home healthcare services, personal care services can be susceptible to improper payment or even to fraud. Fraud, abuse, and mismanagement happen wherever large amounts of money are spent, both in the public sector and in the private sector, and we need to always look for ways to address this. But that doesn't mean the program is ill-conceived or should be drastically cut. Instead what it means is we need to focus our efforts on ensuring that the program receives more effective oversight and that we prevent and address these issues.

As I pointed out before, the ACA provided the Department of Health and Human Services and its Office of Inspector General with a wide range of new tools and authorities to fight fraud. For example, the ACA provided nearly \$350 million in new funds for fraud control efforts, as well as new means for screening potential providers and suppliers. It also provided the HHS and OIG with new authorities to impose stronger penalties on those who commit fraud and gave the Centers for Medicare and Medicaid Services the ability to temporarily halt payments to those suspected of fraud. These new tools allow program administrators to better protect tax dollars and to move away from the pay-and-chase model by preventing bad providers from ever entering the program. These are positive developments.

But today, we are going to hear from the agencies that there are still vulnerabilities related to the PCS program, as well as additional actions that CMS should better take to oversee this program. For example, an October 2016 investigative advisory from HHS OIG detailed some disturbing cases of PCS fraud and beneficiary neglect. These bad actors not only defrauded the program, they harmed the patients they were supposed to serve. That advisory follows other HHS OIG reports highlighting PCS program vulnerabilities that contributed to questionable care services and improper payments.

The OIG continues to recommend that CMS use its authorities more effectively to oversee PCS programs across all States to improve program integrity and help the risk of beneficiary harm.

Similarly, GAO has also found areas for improvement in the PCS program. Specifically, the State-reported data that CMS relies on for oversight lacks key investigation and there are variations in the program requirements across different States. This is an important point because States are ultimately responsible for overseeing their programs.

Along these lines, the GAO is also going to testify that some States continue to provide inaccurate or untimely data to CMS. We need to explore the challenges that States are facing in collecting this data and determine why States don't have additional resources to better oversee the program. We need to make sure the program is fully resourced and that includes sufficient money to collect and analyze data. Given that the States are on the front lines of run-

ning this important program, I think we need to hear from the States about what they are doing.

And finally, Mr. Chairman, as we talk about waste, fraud, and abuse, we should be mindful that the President's budget blueprint threatens agencies like HHS OIG to oversee these programs. The OIG said on average it has one full-time employee to oversee more than \$680 million a year. So I think we need to remedy that if we want to stop waste, fraud, and abuse.

So anyway, in conclusion, thanks for having this hearing. I think we are all against waste, fraud, and abuse and we all need to work together to make sure that it ends. I yield back.

Mr. MURPHY. I thank the gentlelady. She yields back. I now recognize the chairman of the full committee.

OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. I thank the gentleman for holding this hearing and for our witnesses' good work and good testimony. We are here today to talk about this program which serves our Nation's most vulnerable individuals. Through Medicaid, personal care services provide essential care to millions of elderly people, disabled children and adults, and those who need long-term care to cope with crippling diseases. It used to be that many of these people ended up having to be institutionalized or cared for in a nursing home. Instead, personal care services provide an attendant to help people do the things like shop for groceries, do the laundry, make sure that they are taking their medications right on the schedule.

Without personal care services and home healthcare at large, these folks would not be able to live at home in their communities. Personal care services are quite literally a life saver for many.

I truly believe in programs like personal home services and home healthcare. Oregon experimented in these types of programs a long time ago. The vast majority of personal care workers are really solid people who work hard and take care of people and they care, especially they care for these vulnerable populations. They make their lives better, healthier, brighter, and easier.

That is why it is so disturbing when the Office of Inspector General reported these instances of fraud, abuse, and mismanagement in this very essential program. Stories of attendants stealing pain meds, abandoning mentally ill beneficiaries in public places, leaving elderly folks alone for weeks at a time. This is outrageous and it is unacceptable.

What's worse is that OIG has made clear that these are not just some isolated individual bad actors. The OIG investigations have uncovered more than 200 cases of fraud and abuse in the program just since 2012. And as we learned from witnesses earlier this year, the Government Accountability Office has Medicaid designated as a high-risk program since 2003. So we have an obligation to get to the bottom of this for the taxpayers and for patients alike.

Late last year, GAO released a report on the need to harmonize requirements for personal care services across various States. GAO reviewed the policies and procedures in my home State of Oregon and three other States while performing this work. While I was heartened to learn about the safeguards Oregon has in place to

prevent this fraud, the audit made clear there is more work to be done.

More recently, GAO released a second report on the need for better data on PCS. The most recent data at the time of the audit released in 2017 was from 2012. That was 5 years ago. And the data GAO did release was incomplete. Without complete and up-to-date data, those who are tasked with rooting out waste, fraud, and abuse in this program are frankly hamstrung.

So both the OIG and GAO sounded the alarm for years. This fraud and abuse is happening because the States and the Federal Government failed to put in safeguards to protect these beneficiaries. It is sickening to see hard-earned tax dollars going to people who take advantage and mistreat the elderly and disabled in their own homes. And these beneficiaries are particularly suspect to harm because they are often lack the physical or mental ability to speak up. Many times a personal care worker is the only person a beneficiary may see for weeks at a time, so they go along with the fraud or abuse because they are so dependent on that person for help.

We can do better for them. Our citizens deserve to know the attendant they allow into their home, the attendant paid by State and Federal taxpayers, will take good care of them and have their best interests at heart. And while most do—and most do—it is clear we have a serious problem in the program.

Today, we are here to talk about the steps we're going to take to correct the problems identified for us by the good work by the Office of Inspector General and the GAO.

I would like to thank Ms. Grimm from the OIG, and Ms. Iritani from the GAO, for your extraordinary work that exposed this fraud, abuse, and mismanagement in the program. You have done a good job. Your decades of work culminated in some common-sense recommendations for CMS that will better protect beneficiaries and taxpayers. So I look forward to discussing those recommendations today and also learning about how Congress can do its part to solve these problems.

Mr. Hill, I especially appreciate your testimony today, too. I understand CMS has taken steps to implement some of the recommendations and is working to make other improvements in the program. That is encouraging. I look forward to hearing more about your work as well.

With that, Mr. Chairman, and with apologies to our witnesses, we have a couple of subcommittees going on at the same time and my duties as full committee chairman drag me between the two. So thank you for your good work. I have your testimony. It is most helpful. And I return the balance of my time.

[The prepared statement of Mr. Walden follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

We are here today to talk about a program that serves our Nation's most vulnerable individuals. Through Medicaid, personal care services provide essential care to millions of elderly people, disabled children and adults, and those who need longterm care to cope with crippling disease.

It used to be that these folks had to be institutionalized or cared for in a nursing home. Instead, personal care services provide an attendant to help people do things

like shop for groceries, do the laundry, drive to the doctor and take medication on the right schedule.

Without personal care services—and home health care at large—these folks would not be able to live at home, in their communities. Personal care services are quite literally a life-saver for many.

I truly believe in programs like personal care services and home health care. The vast majority of personal care workers are good people who serve vulnerable populations and make the lives of others healthier, brighter and a little easier.

That's why I was so disturbed when the Office of Inspector General reported instances of fraud, abuse, and mismanagement in this important program. Stories of attendants stealing pain medication, abandoning mentally ill beneficiaries in public places, leaving elderly folks alone for weeks at a time—this is outrageous and unacceptable.

What's worse, is that OIG has made clear that these are not just individual bad actors. The OIG investigations have uncovered more than 200 cases of fraud and abuse in the program just since 2012. And as we learned from witnesses earlier this year, the Government Accountability Office has Medicaid designated Medicaid as a "high risk" program since 2003. We have an obligation to get to the bottom of this, for the taxpayers and for the patients, alike.

Late last year, GAO released a report on the need to harmonize requirements for Personal Care Services across the various States. GAO reviewed the policies and procedures of my home State of Oregon and three other States while performing this work. While I was heartened to learn of the safeguards Oregon has in place to prevent this fraud, the audit made clear that there is more work to be done.

More recently, GAO released a second report on the need for better data on PCS. The most recent data at the time of the audit—released in 2017—was from 2012. Five years ago. And the data GAO did receive was incomplete. Without complete and up-to-date data those who are tasked with rooting out waste, fraud, and abuse in this program are hamstrung.

So, both the OIG and GAO have sounded the alarm for years.

This fraud and abuse is happening because the States and the Federal Government failed to put in safeguards to protect these beneficiaries.

It is sickening to see hard-earned taxpayer dollars going to people who take advantage of and mistreat elderly and disabled people in their own homes.

And these beneficiaries are particularly susceptible to harm because they often lack the physical or mental ability to speak up.

Many times, a personal care worker is the only person a beneficiary will see for weeks, so they go along with fraud or abuse because they are dependent on their attendant for help.

We can do better. Our citizens deserve to know that the attendant they allow into their home, the attendant paid by State and Federal taxpayers, will take good care of them and have their best interests at heart. And while most do, it's clear we have a serious problem in this program.

Today, we are here to talk about the steps we are going to take to correct the problems identified for us by the Office of Inspector General and others.

I would like to thank Ms. Grimm from the OIG and Ms. Iritani from GAO for your extraordinary work that has exposed fraud, abuse, and mismanagement in this program. Your decades of work have culminated in some common-sense recommendations for CMS that will better protect beneficiaries.

I look forward to discussing those recommendations today, and also learning about how Congress can do its part to solve these problems.

Mr. Hill, I appreciate your testimony today too. I understand that CMS has taken steps to implement some of these recommendations and is working toward improvements. That's encouraging, and I look forward to learning more about your work as well.

Thank you, Mr. Chairman, for holding this important hearing today. I yield back the remainder of my time.

Mr. MURPHY. The chairman returns the balance of his time and yields back. I now recognize the gentleman from New Jersey, Mr. Pallone, for 5 minutes.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman. This committee has a long-standing history of examining fraud and abuse in Medicaid and we should continue to find ways to improve the vital programs, including the Personal Care Services program. But it is important to keep these issues in context. Medicaid is a critical program that provides essential healthcare to more than 74 million Americans, including seniors, children, pregnant women, and people with disabilities. Now with the expansion of Medicaid under the Affordable Care Act, more than 12 million people gained health insurance coverage last year. Additional achievements under the ACA have helped improve the quality, accessibility, and affordability of healthcare for millions of Americans.

We have made historic gains and we must not roll back this progress by cutting essential health programs such as Medicaid. The Republican Trumpcare bill which the Republican leadership is still trying to convince members to support, drastically cuts and caps the Medicaid program. It rations care for millions in order to give giant tax breaks to the wealthy and corporations. By allowing a State to arbitrarily cap coverage or provide a block grant for certain enrollees, Trumpcare would result in mass rationing of care for seniors in nursing homes, pregnant women, working parents, and people living with disabilities.

Instead, it is imperative that we make every effort to ensure Federal and State dollars are spent effectively. While Medicaid is already an incredibly lean program that has among the lowest improper payment rates of any Federal health program, we should always be looking at ways to prevent any fraud, waste, or abuse in any Federal program. The HHS Office of Inspector General has reported on improper payments, questionable care quality, and fraud in the PCS program and I am particularly concerned by OIG's investigative advisory that highlighted stories of vulnerable patients who were neglected and even harmed by the PCS providers entrusted with their care.

So I am committed to working with my colleagues to address these issues and the root causes of fraud, waste, and abuse. However, any solution we consider to address the problems in the PCS program should be designed primarily to serve one constituency, and that is vulnerable Medicaid patients. We must root out fraud and abuse, but we should not use potential fraud and abuse as an excuse to harm the people these programs are intended to serve. In other words, the answer to Medicaid fraud is not to cut coverage or reduce benefits. The answer to beneficiary harm and neglect is not to institute work requirements and the answer to abusive providers is not to drug test low-income beneficiaries. Instead, we should be strengthening oversight so that bad actors are not allowed into the program, all beneficiaries get the care they need, and the American tax dollars are protected.

The PCS program is a great example of the type of crucial services that we should be protecting and strengthening. PCS attendants help patients with daily activities such as bathing and dressing which gives Medicaid patients more freedom and dignity by al-

lowing them to stay in their homes. Medicaid is the majority payer of long term care services and supports for seniors and individuals with disabilities and personal care services are a critical benefit for these populations.

The HHS OIG has done important work on this issue that has benefitted the committee's past bipartisan work and no doubt will continue to benefit this committee if given the proper resources and that is one of the many reasons why I'm so concerned about President Trump's budget blueprint which threatens to undermine the important work of agencies like the HHS OIG.

We will also hear from GAO about the challenges posed by various PCS program requirements across different States and how the States have not provided accurate data on the PCS program. Because Medicaid is a Federal-State partnership, we need both CMS and the States to do their part in conducting oversight.

And finally, Mr. Chairman, I would like to thank the witnesses today for their commitment to strengthening the Medicaid program and serving its beneficiaries. Instead of rolling back the progress we've made, we must continue to find ways to improve oversight of these vital programs and I don't think anybody else wants my time, so I will yield back, Mr. Chairman.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

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Medicaid is a critical program that provides essential health care to more than 74 million Americans—including seniors, children, pregnant women, and people with disabilities.

Now with the expansion of Medicaid under the Affordable Care Act (ACA), more than 12 million people gained health insurance coverage last year. Additional achievements under the ACA have helped improve the quality, accessibility, and affordability of health care for millions of Americans.

We have made historic gains, and we must not roll back this progress by cutting essential health care programs such as Medicaid. The Republican Trumpcare bill, which the Republican leadership is still trying to strong-arm Members into supporting, drastically cuts and caps the Medicaid program. It rations care for millions in order to give giant tax breaks to the wealthy and corporations. By allowing a State to arbitrarily cap coverage or provide a block grant for certain enrollees, Trumpcare would result in mass rationing of care for seniors in nursing homes, pregnant women and working parents, and people living with disabilities.

Instead, it is imperative that we make every effort to ensure Federal and State dollars are spent effectively. While Medicaid is already an incredibly lean program that has among the lowest improper payment rates of any Federal health program, we should always be looking at ways to prevent any fraud, waste, or abuse in any Federal program.

The HHS Office of Inspector General has reported on improper payments, questionable care quality, and fraud in the PCS program. I am particularly concerned by OIG's investigative advisory that highlighted stories of vulnerable patients who were neglected and even harmed by the PCS providers entrusted with their care.

I am committed to working with my colleagues to address these issues and the root causes of fraud, waste, and abuse. However, any solution we consider to address the problems in the PCS program should be designed primarily to serve one constituency: vulnerable Medicaid patients. We must root out fraud and abuse, but we should not use potential fraud and abuse as an excuse to harm the people these programs are intended to serve.

In other words, the answer to Medicaid fraud is not to cut coverage or reduce benefits. The answer to beneficiary harm and neglect is not to institute work require-

ments. And the answer to abusive providers is not to drug test low-income beneficiaries.

Instead, we should be strengthening oversight so that bad actors are not allowed into the program, all beneficiaries get the care they need, and Americans' tax dollars are protected.

The PCS program is a great example of the type of crucial services that we should be protecting and strengthening. PCS attendants help patients with daily activities such as bathing and dressing, which gives Medicaid patients more freedom and dignity by allowing them to stay in their homes. Medicaid is the majority payer of long-term care services and supports for seniors and individuals with disabilities, and personal care services are a critical benefit for these populations.

The HHS OIG has done important work on this issue that has benefitted the committee's past bipartisan work, and no doubt will continue to benefit this committee if given the appropriate resources. That is one of the many reasons why I am so concerned about President Trump's budget blueprint, which threatens to undermine the important work of agencies like the HHS OIG.

We will also hear from GAO about the challenges posed by varying PCS program requirements across different States, and how the States have not provided accurate data on the PCS program. Because Medicaid is a Federal-State partnership, we need both CMS and the States to do their part in conducting oversight.

Mr. Chairman, I would like to thank the witnesses today for their commitment to strengthening the Medicaid program and serving its beneficiaries. Instead of rolling back the progress we have made, we must continue to find ways to improve oversight of these vital programs.

Thank you, and I yield back.

Mr. MURPHY. The gentleman yields back. So let's begin. I ask unanimous consent that the Members' written opening statements be introduced into the record, and without objection the documents will be entered into the record.

I now would look to introduce our panel of Federal witnesses for today's hearing. First, we welcome Ms. Christi Grimm, Chief of Staff of the Department of Health and Human Services, Office of Inspector General. With nearly 2 decades of leadership and expertise in HHS programs, Ms. Grimm manages the operation and resources of the immediate Office of Inspector General and is responsible for effective execution of OIG priority initiatives, advising on a wide variety of policy and operational matters.

Next, we welcome Ms. Katherine Iritani. Have I said that right? Good. Director of Healthcare Issues at the U.S. Government Accountability Office. In her 36-year career with GAO, Ms. Iritani has helped lead a wide variety of programs and evaluation assignments for Congress. In recent years, she has overseen Medicaid financing, payment, access, and long-term care issues, including program oversight issues contributing to Medicaid being designated as a high-risk program.

And last, we would like to welcome Mr. Timothy Hill, Deputy Director for the Center for Medicaid and CHIP Services, CMCS, and the Centers for Medicaid and Medicare Services at HHS. As Deputy Director at CMCS, Mr. Hill leads activities related to national Medicaid and CHIP policy and program operations and works closely with States in the implementation of their Medicaid and CHIP programs.

So I thank all the witnesses for being here today and providing testimony. We look forward to productive discussion on how we can strengthen and combat waste, fraud, and abuse reform in the PCS program.

As you are aware, the committee is holding an investigative hearing and when doing so has the practice of taking testimony under oath. Do any of you have objection to testifying under oath?

Seeing no objections, the Chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do any of you desire to be advised by counsel during testimony today? And seeing none there, then will you please rise and raise your right hand. I will swear you in.

Do you swear the testimony you are about to give is the truth, the whole truth, and nothing but the truth?

[Witnesses sworn.]

Thank you. All of you are now sworn in under oath and subject to the penalties set forth in Title 18 Section 1001 of the United States Code.

We will have you each give a 5-minute summary of your written statement and we'll begin with Ms. Grimm, you are recognized.

STATEMENT OF CHRISTI A. GRIMM, CHIEF OF STAFF, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES; KATHERINE M. IRITANI, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE; AND TIM HILL, DEPUTY DIRECTOR, CENTER FOR MEDICAID AND CHIP SERVICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF CHRISTI A. GRIMM

Ms. GRIMM. Good morning, Chairman Murphy, Ranking Member DeGette, and other distinguished members of the subcommittee. I am Christi Grimm, Chief of Staff of the Office of Inspector General for the U.S. Department of Health and Human Services.

Thank you for the opportunity to appear before you to discuss the importance of protecting Medicaid personal care services from fraud, waste, and abuse and protecting beneficiaries from abuse and neglect. The Personal Care program has been one of OIG's top management concerns for the past 8 years. My testimony today will highlight our work overseeing the Personal Care program and progress the Department has made in implementing our recommendations.

In the last 5 years, often with our State partners, OIG has opened more than 200 investigations involving fraud and patient harm in the Personal Care program. For example, as the chairman pointed out in his opening, in Pennsylvania, a personal care attendant who was hired to provide close supervision to a beneficiary lost her while shopping in a department store. The attendant waited an hour before notifying the authorities. The beneficiary was found the next day dead from exposure to the cold. This harm is something no one should ever have to experience. Systemic problems must be rectified so that the Federal and State Governments can prevent similar tragedies.

In the past decade, OIG has issued more than 30 reports pertaining the Personal Care which recommended the recovery of almost \$700 million. OIG's November 2012 Personal Care portfolio summarized the findings of OIG's body of work which found that

Personal Care payments were often improper because the services did not comply with basic requirements.

OIG's October 2016 Investigative Advisory documented common fraud schemes including payments for services that were unnecessary or not provided and resulted in death, hospitalization, and less degrees of beneficiary harm. Collectively, our work demonstrates the persistent vulnerabilities in personal care that contribute to high improper payments, significant fraud, and that place vulnerable beneficiaries at risk. Bad actors are exploiting policy vulnerabilities and diverting Personal Care resources.

OIG's long history of oversight and enforcement has consistently demonstrated that basic pillars of program integrity prevention, detection, and enforcement are lacking in the Personal Care program. We must prevent bad actors from participating in our programs, detect potential fraud, waste, and abuse and beneficiary harm, and enforce the laws through Federal and State investigations and prosecutions.

When these basic safeguards are in place, they have a dramatic effect on our ability to identify and stop fraud, waste, and abuse. For example, Alaska implemented a requirement that all Personal Care attendants enroll with the State Medicaid Agency. Attendant enrollment data helped Alaska detect potential patterns of fraud and help strengthen cases for prosecution. In 2 short years, that data helped Alaska to investigate and obtain 108 criminal convictions and recover \$5.6 million.

CMS has concurred with our top recommendations for improving the Personal Care program. In 2016, CMS issued a request for information, guidance, and provided training to States and providers resulting in improvements to the Personal Care program. Notwithstanding this progress, much remains to be done. As of today, four OIG recommendations from the 2012 portfolio remain unimplemented.

First, CMS should establish minimum Federal qualifications and screening standards for all personal care attendants.

Second, CMS should require States to enroll or register all personal care attendants and assign them unique identification numbers.

Third, CMS should require that Personal Care claims identify the dates of services and who provided those services.

Finally, CMS should consider whether additional controls are needed to ensure that Personal Care Services are allowed under program rules and are provided.

OIG work has demonstrated that Personal Care is subject to persistent fraud and beneficiary harm. CMS, in partnership with States, must implement basic safeguards to protect this critical benefit that allows millions of beneficiaries to remain in their homes and communities. Combating fraud and patient harm in Personal Care not only protects beneficiaries and programs, but also elevates the many honest, professional, and dedicated care attendants that enable beneficiaries to live independently.

Again, thank you for the opportunity to testify this morning. I am happy to answer any questions you have.

[The prepared statement of Ms. Grimm follows:]



**Testimony Before the United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations**

***Combating Waste, Fraud, and Abuse
in Medicaid's Personal Care Services Program***

Testimony of:
Christi A. Grimm
Chief of Staff
Office of Inspector General
Department of Health and Human Services

May 2, 2017
10:15 a.m.
Location: Rayburn House Office Building, Room 2322

Testimony of:
Christi A. Grimm
Chief of Staff
Office of Inspector General, U.S. Department of Health and Human Services

Good morning, Chairman Murphy, Ranking Member DeGette, and other distinguished Members of the Subcommittee. I am Christi Grimm, Chief of Staff of the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services.

Thank you for the opportunity to appear before you to discuss the importance of protecting Medicaid personal care services (personal care or PCS) from fraud, waste, and abuse and protecting the beneficiaries who rely on those services from abuse and neglect. OIG has an extensive body of work examining vulnerabilities in PCS and recommending improvements to address the lack of program integrity safeguards, high improper payments, and health and safety vulnerabilities. Safeguarding beneficiaries and the Medicaid PCS program through better program integrity continues to be one of OIG's top priorities.

In the last 5 years, OIG has opened more than 200 investigations involving fraud and patient harm and neglect in the PCS program across the country. Sadly, some of these cases have involved loss of life and serious harm to Medicaid beneficiaries who are especially vulnerable. These include cases like the elderly woman in Idaho who was hospitalized to treat malnutrition and dehydration because the caregiver failed to provide water and food. When investigators served a search warrant suspecting she was a victim of neglect, they found that she had been living in filth despite the fact that Medicaid was paying a PCS attendant to care for

her everyday needs. Or the Pennsylvania beneficiary with autism who died of exposure to the cold while under the care of an attendant. The attendant lost the beneficiary in a crowded store and waited an hour to notify authorities.

These are just two of the heartbreaking stories that no one should ever experience, regardless of the State they live in or what type of personal care services they receive. OIG is testifying today to highlight the important needs that an effective Medicaid PCS program serves and identify ways to help the program better fulfill that potential. Systemic problems related to the design and delivery of Medicaid PCS must be rectified so that the Federal Government can help prevent similar tragedies from happening in the future and better combat fraud, waste, and abuse. My testimony today will highlight: our work overseeing the PCS program; the problems we have identified; our recommendations for improvement; and the progress to date.

Background on Medicaid Personal Care Services

PCS enable Medicaid beneficiaries who are elderly, have disabilities (including children with disabilities), or have chronic or temporary conditions to live with as much independence as possible in their homes and communities, rather than in nursing homes or institutions. The services provided by PCS attendants include a broad range of nonmedical services to support Activities of Daily Living – bathing, dressing, toileting, and personal hygiene. PCS can also offer support for Instrumental Activities of Daily Living, such as meal preparation, money management, shopping, and telephone use. The services place providers directly in the homes

of our most vulnerable beneficiaries, heightening the risk of fraud and abuse of the program, and abuse or neglect of the beneficiary.

While PCS is an optional Medicaid benefit, all States provide this benefit to some Medicaid beneficiaries in their State under their State plan or through home- and community-based services waivers. PCS are generally provided under either an agency-directed or self-directed model. Under an agency-directed model, a personal care agency is an enrolled Medicaid provider and employs personal care attendants to provide services in beneficiaries' homes. Under a self-directed model, the beneficiary or their representative has the responsibility for managing the delivery of PCS, including hiring the personal care attendant. These options allow States to have significant flexibility when designing PCS programs to meet the needs of their beneficiaries. As a result, States often have several different programs that provide PCS to a wide range of Medicaid beneficiaries.

Recent data suggest that PCS will continue to grow rapidly, partly because of the aging baby boom population. For example, the U.S. Department of Labor, Bureau of Employment Statistics, in its *Occupational Outlook Handbook*, 2016–2017 edition, projected that employment of personal care aides will grow by 26 percent from 2014 to 2024. This growth is faster than the average for all occupations. As of 2012, more than 3.2 million beneficiaries relied on personal care, and in fiscal year 2014, Federal and State spending on personal care totaled \$14.5 billion, or about 18 percent of Medicaid's spending on home- and community-based services. Growth in personal care and other home- and community-based services has

come about, in part, to fulfill the mandate of the United States Supreme Court in its decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999) to help individuals with disabilities to live and be cared for in their homes and communities whenever possible.

PCS Program Vulnerabilities

For the past 8 years, OIG has identified program integrity for home- and community-based services, particularly PCS, as a top management concern. We have issued more than 30 audits and evaluations, recommending the recovery of over \$700 million and improvements to service delivery. OIG, often in partnership with the State Medicaid Fraud Control Units (MFCU), has investigated hundreds of PCS fraud schemes. Our work demonstrates the persistent vulnerabilities in PCS that contribute to high improper payments, significant fraud, and that place vulnerable beneficiaries at risk for abuse and neglect.

OIG's October 2016 *Investigative Advisory* on Medicaid Fraud and Patient Harm Involving Personal Care Services summarized various PCS fraud schemes OIG has seen in Federal investigations. These cases show that PCS fraud takes many forms. Common schemes involve payments for PCS that were unnecessary or not provided. Some PCS investigations have uncovered schemes organized by caregiving agencies that involve numerous attendants and beneficiaries, while other investigations have targeted individual attendants and the beneficiaries these attendants claim to serve.

For example, in 2016 OIG investigated a PCS attendant who submitted duplicate time sheets to claim payment for services not rendered to multiple clients with developmental disabilities. Although Medicaid was paying the PCS attendant to clean and cook for the clients and help integrate them into the community, some clients lived in squalor. The PCS attendant also endangered clients by driving while impaired by pain pills. Increased data and internal controls would have revealed that services were not being provided to the beneficiaries. Federal qualifications and screening standards would have revealed the attendant's own substance abuse problems, providing beneficiaries and their families with valuable background information with which to make care decisions.

MFCUs are often on the front lines of investigating fraud in PCS. MFCUs regularly report PCS as a top fraud concern; between fiscal years 2012 and 2015, approximately one-third of their convictions involved PCS attendants. OIG consistently partners with MFCUs to combat PCS fraud across the country. In June 2016, OIG participated in a National Health Care Fraud Takedown and partnered with 24 MFCU offices on health care fraud issues, including Medicaid PCS fraud. OIG has ongoing work exploring MFCUs' efforts to combat PCS fraud. We expect to issue the results this summer.

Although MFCUs are vital in the fight against fraud because of their position on the front lines, they are limited in their ability to investigate allegations of patient abuse or neglect by personal care attendants. MFCUs lack the authority to investigate Medicaid patient abuse or neglect that occurs in a home- or community-based setting. A legislative change is needed to

expand MFCUs' statutory mission to include the investigation of abuse and neglect in beneficiaries' homes.

OIG's November 2012 *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement* (PCS Portfolio) summarized the findings of OIG's body of work on PCS and made recommendations to improve program vulnerabilities. OIG found that PCS payments were often improper because the services did not comply with basic requirements. OIG also found that there were inadequate controls in place to ensure proper payments and quality of care. PCS services and controls vary significantly from State to State because of a lack of Federal requirements for PCS and PCS attendants. This lack of consistency across and within States regarding the use of internal controls and qualifications makes it difficult to effectively pursue fraud and abuse in the PCS program.

Prevention, Detection, and Enforcement of PCS Fraud and Abuse

OIG's long history of oversight and enforcement has demonstrated that to effectively combat fraud, waste, and abuse and safeguard beneficiaries, action must be taken to

prevent bad actors from participating in our programs,

detect potential fraud, waste, or quality concerns quickly, and

enforce the laws of these programs through Federal and State investigations and prosecutions of fraudulent and abusive practices.

OIG's work has consistently demonstrated that these basic pillars of program integrity are lacking in PCS.

Prevent. First, there is a lack of basic Federal qualifications for PCS attendants. As a result, the Government does not consistently know who they are doing business with and cannot effectively prevent bad actors from serving beneficiaries and billing the Medicaid program. PCS places attendants directly in the homes of elderly or disabled beneficiaries who may be particularly vulnerable, creating a real risk of patient abuse and neglect. Requiring all PCS attendants to meet basic, minimum qualifications, such as having a State identification card, minimum age requirements, and a background check, better ensures that only qualified attendants are providing care. Requiring these minimum qualifications also ensures that necessary steps are being taken to prevent bad actors from committing fraud and harm in this important program. Some States currently require these basic safeguards in some of their PCS programs, but not in others. It is important that States have flexibility to implement various types of PCS to appropriately tailor these programs to the specific needs of their beneficiaries. However, that flexibility must be balanced with the need to provide all beneficiaries with the protections of these basic safeguards. **Thus, OIG continues to recommend that CMS establish minimum Federal qualifications and screening standards for all PCS attendants.**

Detect. Second, PCS attendants are not required by Federal law to be enrolled as providers or otherwise registered by States. As a result, we lack consistent information across States on who is actually entering the beneficiary's home. Without this critical information, we

cannot quickly identify and investigate a bad actor, including those who have engaged in fraud or abuse in other States. A single PCS attendant may provide services to multiple beneficiaries, putting each of them at risk. In addition, that same PCS attendant may have fraudulently claimed reimbursement for services not actually provided by billing for services provided to multiple beneficiaries at the same time. Without knowing the individual who is providing the services to a beneficiary, detecting fraud and abuse is severely hampered. Accordingly, OIG continues to recommend that CMS require States to enroll or register all PCS attendants and assign them unique numbers. This information will make it possible to protect beneficiaries and identify potential fraud more quickly, and assure that minimum qualifications are met.

Enforce. Third, to mitigate improper payments and fraud in PCS, OIG recommends that CMS require that PCS claims identify the dates of service and the PCS attendant who provided the service. When States have adopted measures that make available better data about PCS, it has a dramatic effect on the ability to identify and take action to stop fraud, waste, and abuse. For example, Alaska implemented a requirement that all PCS attendants be enrolled with the Medicaid agency. This allowed the Alaska 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 improved their capability to 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.

As this example shows, better data leads to better enforcement and reduced costs. The savings achieved through better program integrity could provide funding for increased services to a larger number of beneficiaries in need, increasing access to critical care. Access to reliable national PCS data allows fuller visibility into the program operations, vulnerabilities, and even best practices. In addition, service-specific PCS data are critical to ensuring that oversight and enforcement efforts are able to find fraud, waste, and abuse quickly and protect vulnerable beneficiaries from harm.

21st Century Cures includes some promising steps forward to safeguard beneficiaries and makes better data available for the PCS program by requiring that all States implement electronic visit verification systems (EVVS) by 2019. The law requires that EVVS collect information on who receives and who provides the service; the service performed; and the date, time, and location of the service. As States begin implementing these new requirements, it will be important to ensure that the data gathered is complete, accurate, and timely.

As the PCS program grows and evolves, OIG continues to recommend that **CMS consider whether additional controls are needed to ensure that PCS are allowed under program rules and are provided.**

Progress in Implementation of OIG Recommendations

Notwithstanding progress, much remains to be done. To date, four PCS recommendations remain unimplemented, and two have been implemented.

OIG has worked with CMS to explore actions that it can take to address vulnerabilities in the delivery of PCS. CMS has issued an informational bulletin, *Strengthening Program Integrity in Medicaid Personal Care Services* (December 2016), that summarizes program integrity vulnerabilities and highlights safeguards States can use right now to strengthen program integrity in PCS. In addition, CMS has issued guidance, entitled *Preventing Medicaid Improper Payments for Personal Care Services* (July 2016), describing steps that PCS agencies and attendants can take to prevent improper payments. CMS also issued a Request for Information (RFI) entitled *Federal Government Interventions to Ensure the Provision of Timely and Quality Home and Community Based Services* (November 2016). CMS conducted a series of trainings, webinars, and conferences with States. These activities outlined approaches for States to identify overpayments. As a result, OIG closed the two recommendations related to adequate prepayment controls and data States need to identify when beneficiaries are receiving institutional care paid for by Medicare or Medicaid.

We have four recommendations that remain unimplemented:

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

4. Consider whether additional controls are needed to ensure that PCS are allowed under program rules and are provided.

The RFI sought stakeholder comments, information, and data on policy options that CMS can consider to address issues affecting home- and community-based services, including PCS. CMS has indicated that it is currently analyzing the comments it received to determine potential policy options. Depending on the actions CMS chooses to take, these recommendations could be resolved.

Conclusion

OIG work has demonstrated that PCS is subject to persistent fraud and beneficiary harm. CMS, in partnership with States, must implement basic safeguards to preserve this critical benefit that allows millions of beneficiaries to remain in their homes and communities. Combatting fraud and abuse in PCS not only protects beneficiaries and programs, but it also elevates the many honest, professional, and dedicated care attendants that enable beneficiaries to live independently. OIG is committed to the program integrity of home- and community-based services and ensuring beneficiary health and safety. To achieve that goal, OIG will continue to work with CMS and partner with other oversight agencies like MFCUs, the Department of Justice, the Administration for Community Living, and the Department of Health and Human Services' Office of Civil Rights.

Mr. MURPHY. Thank you, Ms. Grimm.
Ms. Iritani, you are recognized for 5 minutes.

STATEMENT OF KATHERINE M. IRITANI

Ms. IRITANI. Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, I am pleased to be here to discuss GAO's work on Medicaid personal care services. The number of people receiving these services is significant and growing. Medicaid is the Nation's primary payer of long-term services and supports including those provided in homes and community settings.

Personal care services are critical to helping people age in place, maintain independence, and participate in community life to the fullest extent possible. These services are not without risk, both for beneficiary safety and for improper payments. Regarding safety, beneficiaries receiving these services include older adults and individuals with disabilities, some of whom could be vulnerable.

Regarding improper payments, personal care services are among the higher types at risk of being improper. One known concern is with Medicaid being billed for care that was never provided to the beneficiary.

My testimony today is based on two recent GAO reports that examined Federal requirements for programs providing personal care services and data available for oversight.

Now, typically, I would start my statement with some key facts about these services, such as the Federal requirements in place to protect beneficiaries from harm and to ensure that services billed to Medicaid were actually provided, and basic facts about these important services, such as the number of beneficiaries receiving them in States and at what cost. But as you'll hear today, these key points of fact are not easily laid out.

I have three key observations from our work. First, there are multiple different program authorities under which States can provide personal care services in Medicaid. Since the program's inception in 1965, States have been required to cover institutional, but not home and community-based care. Since 1975, several different options to provide home and community services have been provided to States. All States have adopted one or more different programs to varying degrees. How States screen, train, and monitor attendants and ensure billed services are provided varies, not only between States, but even within States, by program.

A second key finding in our work: the Federal requirements CMS has in place for oversight of beneficiaries' safety and provision of services vary significantly between the different types of programs. Approaches for measuring quality assurance, defining and monitoring critical incidents, screening attendants to ensure they are not bad actors and then ensuring billed services are provided can and do vary significantly between programs. These differing requirements result in uneven safeguards for beneficiaries, depending on the program they are enrolled in; uneven assurances regarding oversight of billed services; and complexities for States and others administering and overseeing services.

A third key finding of our work relates to the data CMS needs for oversight. Our work found that data available to CMS on the provision of and spending on personal care services are not always

timely, complete, consistent, or accurate. For example, data lags caused by late submissions from States and other problems can mean CMS lacks good data for years on the services States have provided.

At the time of our work conducted in 2016 largely, the best available data were for 2012 and only available for 35 of the States that provided these services. For those 35 States where we had data, 15 percent, amounting to nearly \$5 billion in claims, lacked provider identification numbers; 34 percent, amounting to over \$5 billion in claims, lacked information on the quantity of services provided; and more than 400 different procedure codes were used by States to identify personal care services.

Without good data, CMS cannot effectively perform key management functions such as ensuring State claims are appropriate, ensuring appropriate Federal matching, identifying program risks, and monitoring access and spending trends.

In recent years, Congress has directed HHS to improve coordination of home and community-based programs in Medicaid. CMS has taken steps to do so, and more can be done. In view of the growth in, the demand for, and the cost of Medicaid home and community-based services and the importance of these services to the beneficiaries who rely on them, Federal leadership to improve data and better harmonize requirements among different types of programs is needed.

Mr. Chairman, this concludes my statement. I'm happy to answer any questions.

[The prepared statement of Ms. Iritani follows:]

United States Government Accountability Office



Testimony
Before the Subcommittee on Oversight
and Investigations, Committee on
Energy and Commerce,
House of Representatives

For Release on Delivery
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MEDICAID PERSONAL CARE SERVICES

More Harmonized Program Requirements and Better Data Are Needed

Statement of Katherine M. Iritani
Director, Health Care

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. Irtani at (202) 512-7114 or irtani@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.

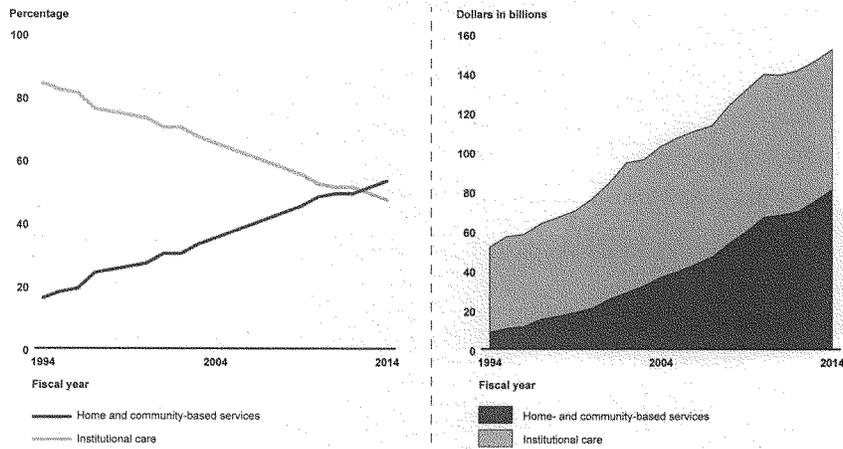
Long-Term Services and Supports, Home and Community Based Services, and Personal Care Services

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 Tuven 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(j) 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).

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
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**

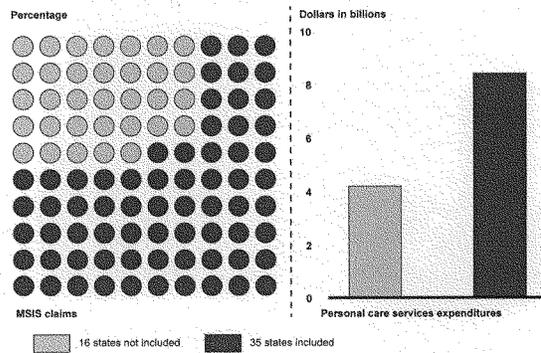
**Claims and Encounter
Data Were Not Timely,
Complete, or Consistent**

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

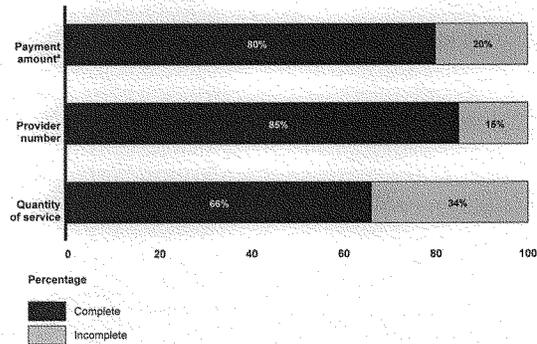


Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-598T

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

*Payment 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**

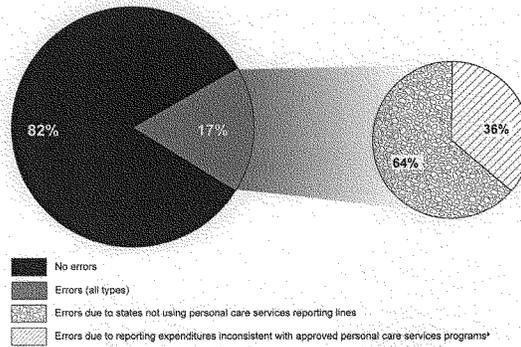
In our 2017 report we found that Medicaid personal care services expenditure data collected were not always accurate or complete, according to our analysis of expenditure data collected by CMS from states for calendar years 2012 through 2015. When submitting expenditure data, CMS requires states to report 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

*Errors 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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Mr. MURPHY. Thank you, Ms. Iritani.
Mr. Hill, you're recognized for 5 minutes.

STATEMENT OF TIM HILL

Mr. HILL. Thank you. Good morning, Chairman Murphy, Ranking Member DeGette, and members of the subcommittee. Thank you for the invitation and the opportunity to discuss personal care services in Medicaid.

Speaking as a career executive with over 25 years of experience to Medicare and Medicaid service, to Medicare and Medicaid beneficiaries, I can state with confidence that CMS shares your commitment to protecting beneficiaries and ensuring the taxpayer dollars are spent on legitimate items and services. This fiduciary commitment is the forefront of all of our activities. In that regard, we greatly appreciate the ongoing work done by the IG and the GAO to highlight potential vulnerabilities in these important programs and we rely on their recommendations to inform our program improvement activities across all our programs.

As you know, States are primarily responsible for day-to-day operation of the Medicaid program and for designing programs that best serve the needs of the beneficiaries in any particular State. While we at CMS have an important role to play in terms of providing overall guidance and direction, States are in charge of administering the Medicaid programs and have significant flexibility to choose options that enable them to deliver high quality, cost effective care for their residents.

Perhaps nowhere in the Medicaid program is that flexibility more important than in designing and administering home and community-based service programs including the provision of personal care services. Personal care services provide vital, person-centered care that allows individuals to remain in their homes or community instead of a nursing facility or other institution. In Medicaid, coverage of these important services is generally optional for States. However, because States see the value in these services, nearly all 50 States provide some level of coverage.

It's hard to overstate the ways in which maintaining home and community based service programs benefits both the communities and the beneficiaries they serve. These programs cost less for both States and beneficiaries. They empower patients to have more control over their daily lives and the management of their health and they provide essential and culturally appropriate support to patients and their families.

It's precisely because of the importance of these programs to Medicaid that it's paramount that we do all we can to protect these programs from fraud, waste, and abuse. Not solely to protect against financial losses, but as we've heard this morning, but more importantly to protect against abuse or neglect of vulnerable beneficiaries, many of whom are elderly or individuals with disabilities and may have no other practical alternative to institutionalization.

Even one case of fraud, abuse or neglect is too many. In our efforts to protect these programs and the beneficiaries they serve, we pursue a balanced approach that recognizes the unique needs of every State while preserving their flexibility to design programs

that will best serve their residents, while at the same time analyzing when and where to use national standards or guidance.

We take a number of actions and we'll continue to help States safeguard their Medicaid beneficiaries and program resources by providing them with the tools they need to be successful. For example, to help States better understand requirements and share best practices, we publish guidance that highlights suggested approaches to strengthening and stabilizing the Medicaid home care workforce and other options to strengthen program integrity in Medicaid Personal Care Services programs.

We've provided training for State officials and other stakeholders creating space for them to collaborate, share best practices, while staff is simultaneously staying up to date on emerging program vulnerabilities.

CMS also uses focused program integrity reviews, assessing State program integrity effectiveness related to their administration of personal care services, providing States with feedback on vulnerabilities and possible corrective actions.

This year, we plan to conduct focused reviews on PCS in five additional States.

We also use our Medicaid Integrity Resources to work collaborative with States to identify improper payments through review of claims. Using these resources, we've conducted over 40 audits on personal care services in 8 States. In one recent audit of PCS services in one State resulted in over \$500,000 being returned to the Treasury.

Even as we continue to work with States to help them implement their programs, we are interested in understanding what changes need to be made at the Federal level. That is why last November, we published a request for information to gather stakeholder feedback on a provision of HCBS services. We are particularly interested in the benefits and consequences of implementing standard Federal requirements for personal care services and what these standards could include and how they could be developed.

We're reviewing the comments we received to inform our approach to supporting States and their program integrity efforts in a way that maximizes State flexibility while protecting personal care service programs and beneficiaries from fraud, waste, and abuse.

As we continue our efforts for PCS, we must also work to ensure that any additional oversight requirements do not create administrative burden, increase costs or impact beneficiary choice or control. The successful delivery of PCS in Medicaid ensure that both individual needs and preferences are met and that the program has adequate safeguards in place.

We look forward to continuing our work with States, our oversight partners, and other stakeholders. This concludes my statement. I'm happy to take any questions.

[The prepared statement of Mr. Hill follows:]

STATEMENT OF

TIM HILL,
DEPUTY DIRECTOR, CENTER FOR MEDICAID AND CHIP SERVICES

ON

COMBATING WASTE, FRAUD, AND ABUSE IN MEDICAID'S PERSONAL CARE
SERVICES PROGRAM

BEFORE THE

U. S. HOUSE ENERGY AND COMMERCE COMMITTEE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

MAY 2, 2017

**U. S. House Energy and Commerce Committee,
Subcommittee on Oversight and Investigations
Combating Waste, Fraud, and Abuse in Medicaid's Personal Care Services Program
May 2, 2017**

Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee, thank you for the invitation and the opportunity to discuss personal care services (PCS) in Medicaid. We share this Subcommittee's commitment to protecting beneficiaries and ensuring taxpayer dollars are spent on legitimate items and services, both of which are at the forefront of our program integrity mission. Because Medicaid is jointly funded by States and the Federal government and is administered by States within Federal guidelines, both the Federal government and States have key roles as stewards of the program, and CMS and States work together closely to carry out these responsibilities. Under the Medicaid Federal-State partnership, the Federal government sets forth a policy framework for the program and States have significant flexibility to choose options that enable them to deliver high quality, cost-efficient care for their residents.

PCS are one example of Home- and Community-Based Services (HCBS), types of person-centered care delivered in the home and community and can include a variety of health and human services. HCBS, including PCS, can be a critical component in helping beneficiaries maintain as much independence as possible in their homes by providing assistance with basic Activities of Daily Living (ADL), such as bathing or dressing, and Instrumental Activities of Daily Living (IADL) such as meal preparation and money management. This allows beneficiaries to remain in the community rather than in a nursing facility or other institution. Creating and maintaining a Medicaid HCBS program benefits the community and the individuals served in many ways; these programs are usually less than half the cost of residential care, empower patients to have more control over their daily lives and management of their health, and provide essential and culturally appropriate support to patients and their families.¹ CMS takes the oversight of State PCS programs seriously, and the health and well-being of Medicaid beneficiaries are a top CMS priority. Without PCS, many beneficiaries who are elderly and individuals with disabilities may have no practical alternative to institutionalization. Program

¹ <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/hcbs.html>

integrity weaknesses in PCS put vulnerable beneficiaries at risk of substandard or harmful care and put program funds at risk for fraud, waste, and abuse.

We appreciate the ongoing work done by the Department of Health and Human Services Office of Inspector General (OIG) and the Government Accountability Office (GAO) to highlight potential program integrity vulnerabilities and provide recommendations on strengthening safeguards. CMS relies on these recommendations to inform our program improvement activities across our programs, including PCS. We have taken action to address a number of the recommendations made by OIG and GAO, and we will continue to identify and take additional steps to enhance safety and quality of services provided to Medicaid beneficiaries while maintaining the flexibility States need to design Medicaid programs that best meet the unique needs of their residents.

Supporting Independence through Home- and Community-Based Services (HCBS) and Personal Care Services (PCS)

Home- and Community-Based Services (HCBS), including PCS, are types of person-centered care delivered in the home and community and can include a variety of health and human services. HCBS programs address the needs of people with functional limitations who need assistance with everyday activities, like getting dressed or bathing, and are designed to enable people to stay in their homes and community, rather than moving to a facility for care. HCBS programs are often funded by State-requested waivers. Waiver programs are part of a State's Medicaid program, but they provide a special group of services to certain populations. Waiver programs usually have medical and financial eligibility requirements, but eligibility for waiver services may not be exactly the same as the eligibility rules for other Medicaid eligibility groups. Coverage of PCS is optional for States, except when they are medically necessary for children under the age of 21 eligible for early and periodic screening, diagnostic, and treatment (EPSDT) services. When States include PCS, coverage can be established using several State Plan options, under one or more waivers approved by CMS, or both.

Generally, PCS consists of services supporting ADL, such as movement, bathing, dressing, toileting, and personal hygiene, or IADL, such as meal preparation, money management,

shopping, and telephone use. Typically, an attendant provides PCS and rules for attendant qualifications are set by States. Given the nature of the services provided, personal care provider qualifications have tended to be less formal than those for providers of nursing or licensed therapies. Many States have adopted personal care provider qualifications such as minimum age requirements, possession of a valid driver's license, criminal background checks, and completion of training required by the State and specific training required by the beneficiary. Certain Medicaid authorities allow States to offer family members or legal guardians the option to become a paid attendant.

There are generally two models of PCS service delivery that States can choose to make available: agency-directed or self-directed. Agency-directed is the traditional delivery model for PCS. Under this approach, a qualified PCS agency hires, fires, pays and trains personal care attendants (PCAs) to provide services to eligible individuals. A variation of the agency model is the "agency with choice," in which an agency is co-employer with the beneficiary of PCS attendants. Self-directed PCS is an alternative to the traditional delivery model. Under self-directed models, beneficiaries or their representatives have decision-making authority over PCS and take direct responsibility to manage their services with the assistance of a system of available supports. In self-direction, individuals may have the option, and therefore the responsibility, for managing all aspects of service delivery in a person-centered planning process including, but not limited to "Employer Authority" which includes recruiting, hiring, training and/or supervising providers and "Budget Authority," pursuant to which the individual directs how State-authorized Medicaid funds in a participant budget are spent. Beneficiary decision-making and autonomy are hallmarks of self-directed models of service provision, and CMS strongly encourages States to collaborate with stakeholders in considering use of self-directed models with necessary supports and a person-centered planning process. By allowing beneficiaries to choose trusted friends and family as PCS attendants, the use of self-directed programs has assisted in increasing the pool of providers available.

As a result of receiving HCBS, including PCS, many beneficiaries have been able to achieve greater independence and community integration and have been able to exercise self-direction,

personal choice, and control over services and providers.² Maintaining this State flexibility is a critical component in CMS's overall efforts to encourage innovation and facilitate States' abilities to address the specific needs of their residents. Studies suggest the HCBS delivery system is more cost effective than an institutional placement³, and a 1915(c) HCBS waiver can only be approved as long as, on an annual basis, the State can verify that the cost of services in the community does not exceed the cost of services in the associated institutional settings.

CMS Support for State Program Integrity Efforts

While PCS programs vary greatly by State and within States, States must request and receive approval from CMS to operate the programs and specify the services to be delivered, and CMS works in concert with the State through the review process to ensure that the State oversight system is sufficient and that individuals have appeal rights. In addition, in the newer PCS coverage authorities and in the 1915(c) waiver program, States are required to report, track, and evaluate data, including allegations of abuse, neglect, exploitation, and unexplained death. Their reviews of this data are reported to CMS on a regular basis, and we take action as permitted through regulation to address any concerns identified. In an effort to continuously improve the quality of care provided, and in response to GAO and OIG recommendations, CMS has taken a number of steps to improve program coordination by issuing additional guidance, providing technical assistance to States, and modernizing Federal databases.

In January 2014, CMS promulgated a final rule⁴ that harmonized many requirements for HCBS, including PCS. These regulations addressed beneficiary assessments and plan of care provisions for certain programs that provide PCS. The final rule also provided States with the option to combine coverage for multiple target populations into one waiver to facilitate streamlined administration of HCBS waivers, and allowed States to use a five-year renewal cycle to align concurrent waivers that serve individuals eligible for both Medicaid and Medicare. The rule also requires that States safeguard against the provision of unnecessary or inappropriate services and

² <https://kaiserfamilyfoundation.files.wordpress.com/2014/03/8568-medicaid-beneficiaries-who-need-home-and-community-based-services.pdf>

³ <https://aspe.hhs.gov/basic-report/cost-effectiveness-home-and-community-based-long-term-care-services>

⁴ 79 FR 2948, January 16, 2014

supports, relying on principles of person-centered planning to describe the services needed to address issues identified in an assessment of the individual's healthcare status.

More recently, CMS published guidance for providers summarizing some of the key PCS and PCA requirements, a brief explanation of differences between PCS and home health services, an overview of common causes of improper payments, and guidance on how to avoid them.⁵ In February 2016, CMS provided training⁶ to State officials on monitoring fraud, waste, and abuse in home and community-based settings for PCS. The training included information on OIG's recent PCS findings and possible actions States can take to help to identify and prevent PCS waste, fraud and abuse.

CMS has also recently issued Informational Bulletins to States providing suggested approaches for strengthening and stabilizing the Medicaid home care workforce⁷ and other options to strengthen program integrity in Medicaid PCS.⁸ For strengthening and stabilizing the Medicaid home care workforce, suggestions included the implementation of a registry to reflect individuals meeting the State's provider qualifications, if applicable, and the option for States to require basic training to workers without usurping beneficiary decisions on what skills are most appropriate for their homecare workers. To address vulnerabilities regarding improper payments for PCS services, we recommended that States establish adequate post-payment review processes, incorporate prepayment edits that automatically deny unusual activity, such as duplicative billings for the same service and duplicative billing during an individual's institutional stay, and perform ongoing audits. Other options identified to address program integrity within PCS programs included developing and implementing procedures for ensuring compliance with requirements for provider qualifications and screening, and verification of beneficiary need for services.

⁵ <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/pcs-improperpayment-factsheet-082914.pdf>

⁶ <https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-3a-fwa-in-pcs-training.pdf>

⁷ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib080316.pdf>

⁸ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib121316.pdf>

Last November, to better ensure the successful delivery of HCBS, including PCS, CMS released a Request for Information⁹ to solicit feedback on the following:

- The benefits and consequences of implementing standard Federal requirements for personal care workers in agency-directed and/or self-directed models of care;
- The criteria of what standardized qualifications would include, in terms of educational, minimum age, and screening requirements;
- Circumstances in which standardization would not apply or would require different standards;
- The role of State-administered home care worker and/or PCS attendant registries;
- The role of criminal background checks;
- The role of home care worker organizations in providing training to support implementation of Federal qualification standards;
- The feasibility for State Medicaid programs of including home care worker identity on claims submitted for reimbursement;
- Program integrity safeguards that could be used instead of or in addition to OIG's recommended controls for both agency-directed and self-directed PCS; and
- Program integrity safeguard development

CMS received over 500 comments in response, and we are in the process of analyzing this feedback and will incorporate suggestions as appropriate. As we move forward with program improvement efforts, CMS is committed to maintaining State flexibility for PCS, in terms of provider qualifications and oversight.

In February 2017, CMS focused a Medicaid Integrity Institute (MII)¹⁰ course on PCS. The MII is a CMS-funded program that provides training to State Medicaid and program integrity staff. CMS developed the "Emerging Trends in HCBS/PCS" course to bring together State and Federal stakeholders to discuss vulnerabilities, mitigation strategies, and challenges and barriers related to PCS administration. Federal participants included CMS, OIG, and the Department of

⁹ <https://www.federalregister.gov/documents/2016/11/09/2016-27040/medicaid-program-request-for-information-rfi-federal-government-interventions-to-ensure-the>

¹⁰ For more info, see MII "About" page: <https://www.justice.gov/mii/about>

Justice (DOJ). State participants brought clinical, program integrity, policy, operations, social work, law enforcement, and programmatic expertise to the course. This diverse structure allowed participants to articulate and develop a holistic approach to PCS program integrity. As a result, the class participants reached consensus on potential program considerations that support the safe delivery of services to vulnerable populations of beneficiaries eligible for HCBS and PCS and more effective stewardship of program funds.

CMS has also developed focused Program Integrity Reviews related to PCS. The reviews assess State program integrity effectiveness related to PCS, and provide States with feedback in terms of vulnerabilities that may exist as well as resources to correct the vulnerabilities and identify best practices which can be shared with other States. CMS will conduct this type of focused review in five States in 2017 (IA, MS, NY, SD, and TX).

Finally, as part of the 21st Century Cures Act (P.L. 114-255) enacted last December, starting in 2019, States must require PCS provided under Medicaid to use an electronic visit verification (EVV) system in order to receive the full Federal medical assistance percentage. EVV systems electronically record the date, time, and, in some cases, location of a PCS provider's visit to a beneficiary by utilizing technology such as cell phone GPS, digital signatures with time and date stamping, or biometric recognition. Already, many States have either mandated or encouraged the use of EVV systems. We look forward to continuing to work with States as they move forward in their design and implementation processes of these systems.

Conclusion

CMS and States have worked for decades to support increased availability and provision of quality HCBS for Medicaid beneficiaries, which is not only a more cost-effective method of service delivery, but is also often the option preferred by individuals receiving services. CMS greatly appreciates the work of OIG and GAO regarding the potential vulnerabilities in the provision of Medicaid PCS, and we look forward to continuing our partnership with these agencies as well as the States. As we continue to improve program integrity for PCS, we must also work to ensure that any additional oversight requirements do not create administrative burden, increase costs and impact beneficiary choice and control. We will continue to assess the

operational feasibility for States of these recommendations and the implications for beneficiary access and quality of services. The successful delivery of PCS to Medicaid beneficiaries must ensure that both individual needs and preferences are met and that the program has adequate safeguards in place, and we look forward to continuing to improve our efforts in these areas.

Mr. MURPHY. Thank you, Mr. Hill. I'll recognize myself for 5 minutes. First of all, Ms. Grimm, Ms. Iritani, I want to commend you and your offices. It doesn't happen a lot in Congress, but in terms of a branch of the Federal Government that do their job, we thank you for doing that. We are absolutely indebted to you for these discoveries, and there's a real trust we have in this committee for the work you do. So please pass that compliment on to your other workers as well.

That being the case, it bothers us about the stories you're telling us, the fraud and abuse and how it really hurts the beneficiaries, the elderly, and disabled individuals.

And there's certain elements of this, Ms. Grimm, that you talked about, the PCS, that make it more susceptible to fraud for the vulnerable. You mentioned in some of your testimony some of the stories that beneficiaries often feel reliant on or loyal to their attendant—it sort of reminds you of the Stockholm Syndrome here—but even if that attendant is committing fraud or abuse and harm. So why is that, and what is in the system inherent in that that leads to that and, of course, how do we change it?

Ms. GRIMM. Thank you for your question. I think inherent to personal care services is sort of the intimate nature of those services, going into beneficiaries' homes and providing services like bathing, dressing, light housekeeping, food preparation. And in many of those instances, as you point out, the beneficiary becomes very reliant on those services, and in their mind services, even if they're suboptimal, are better than no services, and we have found apprehension on having fraud and abuse reported by beneficiaries. Often referrals come to us from families or loved ones that are witnessing neglect.

Mr. MURPHY. Are there threats made, subtle threats in terms of—that sometimes occur under these circumstances?

Ms. GRIMM. I'm not aware of a specific instance where the beneficiary was told they could not report, but we certainly have plenty of examples of harm that's resulted from fraud.

Mr. MURPHY. And I'm wondering in these cases, too, at times maybe a family puts up a hidden camera in the home, too, and also records events. Have those occurred? Have you seen anything like that?

Ms. GRIMM. Hidden cameras in beneficiaries—

Mr. MURPHY. Families many times do that with their babysitters, too, that may actually record some instances where a PCS worker was causing some problems. Have you seen any instances of that yet?

Ms. GRIMM. I don't have any instances of that, but we do have examples of family members that are perpetrating the harm and neglect with the beneficiary, so even in those scenarios where it's self-directed PCS, we are still seeing instances of family members committing that harm.

Mr. MURPHY. So given all of these stories and the heart-breaking nature of them, if you could choose a recommendation you think would make the biggest impact, what would it be?

Ms. GRIMM. We want to know who we're doing business with at the attendant level. So the number one recommendation that I

would put forward is that you enroll and register attendants and make sure that those identifiers are on the claims.

Mr. MURPHY. And background checks, full background checks on them, too?

Ms. GRIMM. We do recommend background checks. Many of the instances that we included in our investigative advisory would have revealed a history of criminal conduct, including drug diversion.

Mr. MURPHY. And what other kinds of backgrounds would be in this besides drugs? Felonies, burglaries?

Ms. GRIMM. We do have another example of a case in Illinois where a nurse had lost her licensure because she was stealing drugs from her employer. And in that instance, she was excluded from all Federal healthcare programs and a check, like we recommend for other programs and looking at the exclusions list, would have revealed that.

Mr. MURPHY. OK, thank you. Ms. Iritani, what impact does CMS have? How is it, in fact, not getting data on time? You made references to this data. How does this affect the oversight ability for CMS on PCS workers?

Ms. IRITANI. Data is critically important to really overseeing the program. CMS needs data to ensure that payments are appropriate and to assess trends and to ensure that the Federal matching is appropriate for what States are claiming from the Federal Government in terms of provided services.

Mr. MURPHY. Thank you. And Mr. Hill, given the kind of things here, what steps do you see moving forward that you could use to improve this whole process?

Mr. HILL. So I think I would focus on two areas that have been highlighted. First, on the policy side and the recommendations with respect to standards. We've talked to the IG. We issued our RFI last year. For us, it's a balance, right, so every State is a little different. The requirements in one State may not be the requirements we want to have in every State, so we're anxious to continue our analysis there to determine whether or not we should be putting more requirements on States that internally have their own set of standards or whether we should be doing that nationally at the Federal level.

Second, and I couldn't agree more, I think, with our colleague from the GAO that the dearth of data in the Medicaid program is a problem. We've done a lot over the last year to get data in in a much more timely way in a way that will let us do analysis, not only for our own selves, but also to give information back to the States about how their programs are operating and so continuing our effort to get data in to make that data timely and accurate I think is very important.

Mr. MURPHY. Thank you. I'm out of time. Ms. DeGette, you're recognized for 5 minutes.

Ms. DEGETTE. Thank you, Mr. Chairman. I'm gratified to hear that members on both sides of the aisle recognize the importance of the Personal Care Services program to Medicaid beneficiaries and also the potential cost savings that we can get. But I do think that we can work together to address where controls need to be improved.

A little note, one of the many little known provisions in 21st Century Cures which, of course, this entire committee worked together on, required an electronic visit verification system for personal healthcare services and home healthcare services under Medicaid. What this requirement said is by 2019 all personal care visits have to be electronically verifiable and that standard background information would be collected on every claim which I think would help. That would be a help.

I just want to ask the panel some of the questions about the scope of the Personal Care Services program and what we can do.

Mr. Hill, you heard Ms. Grimm talk about some of these services, particularly to the elderly who can stay in their homes. I think we all agree this program can be very beneficial to people like that, is that right?

Mr. HILL. It's incredibly beneficial. For every example and every conversation we have with the IG about abuse and the horrible things that are going on, I think there's also as unreported sort of hundreds of examples of folks who are now living in their home, in their community with attendants and workers who make their lives fulfilling in a way that would not be if they were in an institution, people who have suffered broken limbs, broken back or where they have intellectual disabilities or any number of medical conditions that normally keep them in an institution are keeping them in their communities.

Ms. DEGETTE. And not only that, but it also is more cost effective than putting them in nursing homes, is that correct?

Mr. HILL. Absolutely, even as the GAO has noted, the highest spending State for PCS is close to \$30,000 per beneficiary. Nursing homes are easily three to four times that amount.

Ms. DEGETTE. Thank you. Now Ms. Iritani, I think you testified to this, your January 2017 audit found that the CMS data is of limited value for oversight purposes because it's often not timely and it's inconsistent across State lines and has errors. Is that correct?

Ms. IRITANI. That's correct.

Ms. DEGETTE. And also, this is important. Although there are problems with the quality of data, it doesn't necessarily mean there's widespread fraud in the program, is that right?

Ms. IRITANI. That's correct.

Ms. DEGETTE. And so why do you think the States are having such a hard time providing accurate and timely data to the CMS?

Ms. IRITANI. There are a host of different reasons and we didn't look at that specifically. We have on-going work actually looking at challenges that States are having with implementing T-MSIS, the utilization claims system. More work needs to be done. But some of the things that we are aware of in terms of some reasons States haven't submitted is related to new systems that they're putting in, maybe to comply with T-MSIS and other reasons.

Ms. DEGETTE. Don't you think it would be a good idea to work with the States so that we can get the data that we need because we can't really even begin to get our arms around the extent of the problem until we have that data?

Ms. IRITANI. Yes.

Ms. DEGETTE. Can anybody testify what efforts we're making to standardize and to get that data? Mr. Hill?

Mr. HILL. I'll speak briefly on where we are with the data collection. As GAO has pointed out, historically, the Medicaid data that we've gotten into CMCS has not been timely. It's not been accurate. Beginning 4 years ago, we began implementing a transformed system, a new system to collect use data, utilization data, claims data from States in a much more timely and standard format. We now have requirements in terms of what data the States have to submit, how it has to be submitted and the timeliness of that.

We now have 35 States representing more than 60 percent of the beneficiaries and expenditures in the country reporting data into that system. We're beginning to share that data with our partners to do quality assessment and be sure that it's useable and it has fixed a lot of the vulnerabilities that have been identified by the GAO and are hoping, we, CMS, will be ready to accept data from all States by the end of the summer.

Ms. DEGETTE. Great. Let me stop you there because I'm out of time.

Mr. HILL. Yes.

Ms. DEGETTE. Let me just say I think this would be a perfect hearing for the fall, Mr. Chairman, to bring the States in to talk about are they complying with that deadline of this summer and to see what else they need.

Mr. MURPHY. Right, and we also had that briefing before that most States are not even getting data.

Ms. DEGETTE. Right.

Mr. MURPHY. So we're kind of flying blind. So appreciate it.

Ms. DEGETTE. OK, thanks. I yield back.

Mr. MURPHY. I recognize the chairman of the committee for 5 minutes.

Mr. WALDEN. Thank you, Mr. Chairman. Ms. Iritani, in your report on PCS data, you were only able to analyze 35 States because 15 had not reported the data yet, as you all are having this discussion from 2012. So you conducted this audit from July 2015 to January of 2017 and as of then, 35 of 50 States had enough data from 2012 to analyze, correct?

Ms. IRITANI. Correct.

Mr. WALDEN. Why were the data so late? Is this a common problem? Once it gets there, it just seems like it can take several years for CMS to process it, and why is that?

Ms. IRITANI. And I think there are two issues. One is that States submit data late, and it could be because they are largely managed care, and managed-care plans may submit data late or may not submit data at all.

The other problem is that when the data comes in, it is not good and so CMS needs to go through a lengthy validation process which is part of why we only had data for 35 States several years later, is that the data had not been validated for those other States.

Mr. WALDEN. Makes it pretty hard to do appropriate oversight and reconciliation and everything else then?

Ms. IRITANI. Yes.

Mr. WALDEN. Mr. Hill, GAO's January 2017 report raised concerns about these processing times. What's the average time it takes to process 1 year's worth of data, if there is such a thing as an average time?

Mr. HILL. Right, so as identified, the data that the GAO looked at in the system that they were looking at was the system that is prior to the one we're using now. So for a State, for example, that's what we call live, submitting data into our system. For the 35 that I've identified that are processing, we have up-to-date data within a month current to the year, right, so if it's March and they submitted the data on the 1st of—from January and it's consistent, current for January.

Mr. WALDEN. All right.

Mr. HILL. Now as I said, we've built in a lot of the front-end control to be sure that we don't have to take as long as we were taking in the prior system to do the quality check. Those quality checks are built in upfront. So we're confident and hopeful, I should say, and confident that this new system will both provide data much more timely, much more consistently, and in a way that will allow us to do the analysis and the oversight in a way that we could not.

Mr. WALDEN. OK. Ms. Iritani, a question back to your comment about the managed-care plans, could the States or the Federal Government make a condition of the contract with the managed-care plans that they have to submit data on a regular basis in a format that works for the expedited review and do we do that?

Ms. IRITANI. Yes, they are required to. It's more a question of enforcement.

Mr. WALDEN. What's the penalty if they don't?

Ms. IRITANI. I think that will depend on the contract that the States have put in place with the managed-care organization.

Mr. WALDEN. And we could probably weigh in on that contract requirement since we're a partner in this process?

Ms. IRITANI. That would be a policy decision.

Mr. WALDEN. Yes. OK. Ms. Grimm, I understand a beneficiary in Pennsylvania died of exposure to the cold while under the care of a PCS attendant according to some of the reports. In another case, a hot July day, a PCS attendant in Maryland left a beneficiary with developmental disabilities in a locked car while shopping with a companion.

What's the most important thing CMS can do to prevent beneficiaries from being subject to neglect and abuse by PCS attendants?

Ms. GRIMM. Move to require States to enroll or register a care attendant so that we're able to keep track of what's happening at that attendant level.

Mr. WALDEN. OK, and what reaction, if you get any, from the States when this is suggested?

Ms. GRIMM. We have a report coming out at the end of the summer that provides survey data from the Medicaid Fraud Control Unit Directors on the recommendations that we have put forward, also fraud trends related to personal care. We know that that group very much endorses the recommendation that we've put forward related to enrollment and registry. And the report will also have some other solutions States have explored.

Mr. WALDEN. OK, perfect. How do you investigate fraud when it involves beneficiaries' family members because we understand that's a problem, too?

Ms. GRIMM. One thing that I think this committee could also do is to give our Medicaid Fraud Control Units the authority to investigate stand-alone harm in patients' homes. They currently only have the authority to investigate when it's associated with billing fraud. So it does become challenging to investigate harm when it is not linked to some of those other billing issues.

Mr. WALDEN. My time has expired. Thank you again for the good work that you are doing and your counsel to us. We appreciate it.

Mr. Chairman, I yield back.

Mr. MURPHY. All right, I now recognize Mr. Tonko for 5 minutes.

Mr. TONKO. Thank you, Mr. Chair. It's good to see CMS here today to talk about improvements that CMS can make and should make to this program. But let's not forget that the Medicaid program and PCS, in particular, is a partnership between the Federal Government and the States. States are given flexibility to design their given programs to fit the needs of their populations, but in exchange they have to do their part to ensure the integrity of the programs.

States are the first line of defense in protecting Federal and State Medicaid dollars. So with that being said, Mr. Hill, in your testimony you stated, and I quote, "Both the Federal Government and States have key roles as stewards of the program."

So is it accurate to state that CMS cannot perform effective oversight without cooperative State partnerships?

Mr. HILL. I think oversight is always more effective when there's cooperation between us and the States. We have our role. The State has their role. Sometimes there will be tension, right, between what we view as a direction the State needs to be or whether or not they're in compliance with Federal rules. But we always prefer to be working—particularly on issues of beneficiary harm and abuse—working hand in glove to make sure that we mitigate those.

Mr. TONKO. So what does CMS need from the States to improve this whole outcome?

Mr. HILL. As I've indicated earlier, I think in any oversight context, the more data we have and the better data we have with States and States being up to date with submitting that data is going to give everybody a leg up in terms of understanding what our problems are and how we meet those gaps. Beyond that, I think States as identified by the IG, each have their own requirements for how they oversee and maintain the integrity, in particular, of personal care attendants and how those services are being delivered. And we need to make sure that States are following through and enforcing those individual State compliance, right?

We don't have the resources, nor is it our job, to on a day-to-day basis be monitoring claims and understanding how the benefits are being delivered in any particular State. So the State really needs to be in a position to step up and be doing that work on behalf of those beneficiaries.

Mr. TONKO. Thank you. And Ms. Iritani, would you agree that the responsibility for program integrity falls on both CMS and the State Medicaid programs?

Ms. IRITANI. Yes.

Mr. TONKO. So the OIG has done a lot of excellent work looking at different State programs and pointing out vulnerabilities and short comings. I understand that OIG's audits of some States have found problems with PCS claims such as providers claiming more hours than were recorded.

And again, that being said, Ms. Grimm, it seems clear that States need to make improvements. Do you believe that the provision passed by the last Congress which does require States to ensure PCS visits are electronically verified will help address some of the issues that have been raised by the OIG?

Ms. GRIMM. Thank you for that question. We very much appreciate some of the protections and collection of data that's offered by that provision in 21st Century Cures. We know that that does not currently include managed care and, with the high percentage of services in Medicaid being provided through a managed-care model, it definitely does not sort of wrap around those services, but it is a terrific step forward and it does collect some of the information that would allow our criminal investigators to detect potential patterns of fraud. Yes.

[The HHS Office of Inspector General submitted the following amended portion of Ms. Grimm's response:]

We know that that may not currently include managed care and, with the high percentage of services in Medicaid being provided through a managed-care model, it may not sort of wrap around those services, but it is a terrific step forward and it does collect some of the information that would allow our criminal investigators to detect potential patterns of fraud.

Mr. TONKO. Thank you. And what additional resources do States need in order to conduct better oversight of the PCS programs?

Ms. GRIMM. I think having uniformity in the kinds of standards that are required, the qualifications, some floor requirements for the care attendants upon which States can build and customize according to the special needs of those States. I think that would better put States in a good position to make sure care being rendered to their beneficiaries is of a high quality.

Mr. TONKO. Thank you. And Mr. Hill, what steps is CMS taking to encourage or require States to do more in this area?

Mr. HILL. So we've taken a number of steps in terms of working with States on education, giving them best practices and feedback about program integrity, methods and standards, be it through review of claims, how to put edits in place to review claims for high-dollar or unsubstantiated services, helping them think about putting together registries or enrollments for PCS attendants. But beyond that, we're also working with States to provide direct training. We have a facility where we can bring States in and bring our law enforcement partners in to do hands-on work to understand better how to do investigations around PCS types of work and what kind of policies to put in place to prevent those types of abuses from occurring.

And finally, we're doing our own work to understand whether or not more Federal requirements are needed beyond just requiring States to have their own internal policies, particularly around enrollment of attendants should there be a Federal standard, should

we have nationwide standards for how these attendants ought to be monitored and overseen.

Mr. TONKO. And that training is up and running now?

Mr. HILL. Yes, we had training back in February. We had 36 States, a number of our partners from law enforcement and the oversight community, and we'll continue to do that.

Mr. TONKO. Thank you very much, Mr. Chair. I yield back.

Mr. MURPHY. Thank you, Vice Chairman Mr. Griffith is recognized for 5 minutes.

Mr. GRIFFITH. Thank you very much. Ms. Iritani, it's my understanding that States can receive more Federal money in the form of a higher match for some activities related to collection and compliance with Federal reporting requirements. Am I correct in that?

Ms. IRITANI. Yes, that's correct.

Mr. GRIFFITH. And so you're having difficulty getting States to get some of the reporting and so forth. And I'm going to switch gears in a minute on that. But do you have a stick? You've got the carrot. Do you have a stick that they might receive a lower match if you they're not collecting some of the data that you want?

Ms. IRITANI. CMS does have authority to reduce the Federal matching for system areas that are experiencing problems from a 75 match to a 50 percent match.

Mr. GRIFFITH. Now let me switch gears a little bit because I am worried about the States and I think that some of the resistance from the States may come from a fear that they'll chase some folks out of this industry, particularly when you're dealing with family members and we all want to stop the abuse, but when you're talking about family members I heard, I believe it was you who earlier said that some States had 400 different codes, and so it was hard to get the coding straight. And I can see a family member who is trying to take care of their loved one is receiving some monies for bathing or doing some daily activity where the mom or the dad of theirs needs help and then they're faced with having to learn 400 codes. So I think if we're going to do something, we have to make it simple. Would you not agree?

Ms. IRITANI. Yes, we would agree with the harmonization of requirements. The 400 codes was actually at the Federal level in terms of how PCS was coming in in terms of the coding.

Mr. GRIFFITH. So if we're going to require electronic verification which I think is fine as long as it can be done on the phone because most people will have their electronic phones with them, their little gadgets, and this is where tele stuff can be of great help, technology can be of great help to us, but it needs to be simplified because you're going to have a hard time—if you're just a 50-some- or 60-some-year-old child trying to do the best you can for your parents because Mr. Hill, you did point out earlier, we see in the news all the horror cases. What we don't see are the thousands of people, whether they be the professionals who are coming in or the agencies that are sending people in or whether it's a family member, where that person's life is greatly enhanced by having a PCS individual helping them out through one of these programs and I get that.

It also raises some concerns for me that not only do we have to simplify it, but we have to be careful because there's a difference

between somebody who's working for an agency that sends in folks and that family member. Because while we want family members monitored to a certain degree, I'm not sure we want to create a whole new bureaucracy to monitor them. We have the Department of Social Services, at least in the Commonwealth of Virginia that already is aware of that and if something is going on a neighbor can report and they go out just like they would with a child, for child abuse, and look for that.

Then we also have this whole thing where everybody is like let's do background checks. The question is if we're going to do background checks and I'm not against that, but we need to make sure that we're not throwing the baby out with the bath water. Because absolutely, if you've got a history of child abuse or spousal abuse or abuse of a parent, even if you're a family member, you ought not be involved. But a theft—I was a criminal defense attorney, by the way, for 28 years—so a theft of four tires off of an automobile when you're 18, it's a theft, Mr. Chairman raised that issue and he was right to do so. It's a theft. It may want to be something that you take a look at, but I'd hate to see a son who's now in his 40s or 50s being precluded because he came back with a felony conviction 20-some years ago on stealing tires or doing something that, when you look at the facts, it's a whole different case than just running it through.

And the problem is when Government gets a hold of a criminal background check, oftentimes they come up with hard and fast rules. If you've been convicted of X, you can't be involved. And I think we need to set that bar fairly high. I'm not sure it shouldn't be our responsibility. What do you all have to say about that?

Go ahead, Ms. Grimm. I think you're the right person to start on that.

Ms. GRIMM. OK, I very much appreciate the question and that context absolutely matters. We believe that those background checks can reveal information that consumers can use and their family members can use to make informed decisions about the care that's provided.

Mr. GRIFFITH. OK, so you would look for if we were going to craft some language along those lines to say have the background check done, but then it would be the family members who would decide or it would be forwarded to Department of Social Services, something along those lines? Would that be your proposal?

Ms. GRIMM. I think we would want there to be guidance to be accompanying the types of convictions and histories that are revealed through those background checks, but we have not gone forward with a recommendation that says this specific kind of crime should preclude them from providing personal care. CMS can provide some exemptions and we've had those conversations with CMS.

Mr. GRIFFITH. And if you all decide to go with guidance, I'm happy to assist in any way I can to have you come up with ways that you may be able to ferret out the bad actors without throwing out the folks who might have made a mistake at one point in time. Likewise, maybe you all can help us come up with the proper guidelines to put into the legislation that would give you that authority.

With that, Mr. Chairman, I yield back.

Mr. MURPHY. I recognize the gentleman from California, Dr. Ruiz, for 5 minutes.

Mr. RUIZ. Thank you very much, Mr. Chairman. I think everyone can agree that we must do all that we can to maintain program integrity in the Medicaid Personal Care Services program and continue to work to eliminate fraud and abuse, and we must continue to identify common sense improvements to this program such as better data collection and Federal baseline standards, but we must do so by maintaining patient access to this critical program that allows individuals to remain at home and live independently when they might otherwise be forced to move to a nursing home or assistive living facility.

Data collection is integral in evidence-based policy development. And I think many of you had mentioned that there are some exciting opportunities here and if we don't use data, then we're at the whims of ideological partisanship that then kind of makes the wrong decision, contrary to what's best for the patient and for the American people.

One of the problems we've seen regarding this program integrity in the Personal Care Services program is inadequate data. A GAO report stated that CMS is developing an enhanced Medicaid claims data system known as the Transformed Medicaid Statistical Information System pronounced as "T-MISSIS," right? Under T-MSIS, States will be expected to report claims data that are more timely and more complete.

Mr. Hill, it's clear that T-MSIS is a critical tool to ensure timely, accurate, and complete data from States, and it is my understanding States have been working for years to implement the new system. What steps has CMS taken to complete T-MSIS this year?

Mr. HILL. So this year, we've actually had a good year this year. As I mentioned earlier, we've now got 35 States reporting and I think most of them are current with their data reporting. We're working with the remainder of the States to meet them where they are, to make sure that they have everything they need in place to begin reporting and will be ready to take their data by the end of the summer. Whether they can meet that deadline or not is something we'll continue to work with them on.

Mr. RUIZ. How many States? What's the percentage? And what year do you think we'll have everybody on board?

Mr. HILL. I'm hopeful that by the end of this year we can have all States in. Now again, that all depends on whether States are going to be able to internally meet their own deadlines. As you know, Medicaid is incredibly complex at the State level and they're integrating State data from many State systems. And so it's a challenge for them to be able to put it into a common core.

Mr. RUIZ. So what additional claims information will be included under T-MSIS, and how will this improve the integrity of the Medicaid claims data?

Mr. HILL. I think the single biggest piece of information that we'll have out of—and this is where—it's hard to know when you're supposed to correct a congressman, but it's "T-M-SIS."

Mr. RUIZ. "T-M-SIS."

Mr. HILL. When we have the T-MSIS data in, particularly data around providers, right, so there's just a statutory requirement now to be providing, referring, and ordering information on a claim so we'll know who referred, who ordered a service and we'll know more information about the providers that are submitting claims. Under the old prior information, we didn't have that enrollment information and we didn't have the ordering and referring information from providers.

Mr. RUIZ. Ms. Iritani, how will any further delay impact the integrity of the Medicaid claims data in the near future?

Ms. IRITANI. Significantly. Reliable data is really important for overseeing improper payments and other functions, and we have recommendations to CMS on personal care services in particular that CMS should issue guidance that is standard on reporting of personal care services and, with regard to T-MSIS, should really prioritize the data that CMS needs for oversight.

Mr. RUIZ. So I understand that while there are reported benefits of implementing T-MSIS, it is not a cure-all, correct?

Ms. IRITANI. Correct.

Mr. RUIZ. For example, in your report, you stated that CMS will need to develop plans for how it can be used for oversight. Can you give me some examples of how that can be used for oversight?

Ms. IRITANI. Well, ensuring, for example, that the Federal matching for what States are claiming as expenditures is appropriate. Our work found, for example, that 17 percent of the expenditure line reporting for personal care services was incorrect.

Mr. RUIZ. Would you say this is the number one most impactful way to start providing oversight for potential fraud and abuse, is if we were to focus on one thing would it be the data collection system, Mr. Hill?

Mr. HILL. For me, I mean we are focusing on it now and it continues to be a priority. You can't run a program of the size and scope of Medicaid without good, accurate data.

Mr. RUIZ. So what do you need to finish this in a timely manner?

Mr. HILL. We need the continued cooperation of States to get their data in and to do the work they need to do to get the data in a timely way and we have that and we'll continue to work with them.

Mr. RUIZ. Thank you very much.

Mr. MURPHY. Mr. Collins, you're recognized for 5 minutes.

Mr. COLLINS. Thank you, Mr. Chairman. I want to thank the witnesses also.

Now I'm a private-sector guy. I spent 30 years in the private sector and at one point I also was the county executive of the largest upstate county in New York. It was bankrupt. I'm a Lean Six Sigma guy. I brought Lean Six Sigma into a large municipal government for the first time in the United States about 8 years ago. And it worked. But we also had a program called Just Do It. We would put together a team of a lot of different commissioners and we'd deep dive some issue that touched on a lot of different departments and it would take us 6 months. And then every once in a while we'd come up with what we'd called the Just Do It. It was so obvious, so direct. We knew the problem. We really knew 90 per-

cent of the solution. We said why are we going to waste our time with this 6 months' program. Let's just do it.

And kind of sort of what I'm hearing today is a lot of just do it. So what am I missing here? The Federal Government sends money out to the States. In the case of New York, our program is \$60 billion a year. So with 6 percent of the Nation's population, we spend 12 percent of the Nation's Medicaid money and it just keeps flowing.

In the private sector, if I have a vendor and he sends me an invoice and he doesn't have the proper numbers on it, I don't pay it. If he sends me an invoice and whatever requirements that I've had aren't there, I don't pay it. So here's my just do it.

Now no disrespect intended, but why are we wasting our time analyzing 2012 data? It's worthless. Completely, utterly worthless. There's nothing to compare 2012 to 2017. If we've got a bunch of people crunching 2012 data, if I'm Tom Price or Seema Verma, I'd go what? Are you joking me?

So if we've got the power of the purse strings, why don't we just stop paying people, sending money to States who don't adhere by our responsibilities? The requirements. Why don't we? Why don't we?

OK, there's my just do it. I call you and I say we're just going to do it. No money goes out without the data in a timely fashion. Thirty-five States—well, 15 States—just wouldn't be getting any more money. If you start cutting off the flow of cash, you will get their attention and you will get your data. You'll get your data in a timely fashion. And if you have—I'm just somewhat dumbfounded by this. The solution is staring us in the face and we're sitting here talking about something. I don't get it. What am I missing?

Ms. IRITANI. Well, we agree that CMS needs to take immediate steps to—

Mr. COLLINS. So why don't we do it? Do it today. Is there a reason? We can do it today.

Ms. IRITANI. To improve the data, yes.

Mr. COLLINS. Today.

Ms. IRITANI. And to issue guidance to States on standard elements that they should be reporting.

Mr. COLLINS. Require that the attendants register. And if there's not a number, they don't get their money.

Ms. IRITANI. There has been a longstanding, also, interest in making sure that there is access to services.

Mr. COLLINS. We do. But money talks.

Ms. IRITANI. Yes.

Mr. COLLINS. The minute you cut off the funds, I mean, that's what I find. When we talk about waste, fraud, and abuse, and we find that the Federal Government is sending this money out and then we're finding out after the fact through data that's 5 years old when in the case of 15 States they don't submit data, you know where the problem lies, in CMS, for sending the money out, for approving the voucher. Don't we have to approve payments?

Mr. HILL. So a couple of issues to unpack there, and I think it's a fair comment and it's a true comment that the money speaks. Right? And if we withhold funds, States are definitely going to get

somebody's attention much quicker than other corrective actions. I think for us to consider, as we talk to States and try to—particularly on their compliance issues, not so much now talking about program abuse of providers, billing inappropriately.

Let's talk about States meeting our requirements, for example, for submitting data. We try very hard, recognizing it's a complex system to get States to get into compliance in a way short of having to withhold the funds. It's sort of nuclear, right, to say we're immediately going to go to withholding funds from the State of New York or any other particular State without first going through as much as we can with the State to be sure they've got all the TA, all the information they need, all the help they can get from us to get into compliance. If after that, they still are unwilling or unable to come into compliance, then the purse strings is definitely the place that we go to sort of make sure that we have their attention.

Mr. COLLINS. And I do agree. You want to give somebody at least a glide path, 3 months, even 6 months, but to hear that we're analyzing 2012 data, I mean what a tragic waste of time. 2012 doesn't tell you anything about 2016, '17. I mean truly not to be insulting here, I think we could get there very quickly. I'm certainly hoping that Tom Price and Seema Verma get there quickly and this has been kind of eye opening again in a frustrating way.

Thank you, Mr. Chairman. I yield back.

Mr. MURPHY. Thank you. I now recognize the gentlewoman from Illinois, Ms. Schakowsky from Illinois.

Ms. SCHAKOWSKY. I want to thank all of our witnesses. First of all, care services are incredibly important and I really want to emphasize that, even as we try and make it better, I hope all of us are really committed to making sure that those services are provided.

In Illinois, we have the Community Care program which is one of the home and community-based care services provided by the Medicaid benefit, to Medicaid beneficiaries and provides services to about 84,000 individuals.

We also know that these are the very programs that often are slated for huge cuts. In Illinois, unfortunately, we haven't had a budget for 2 years and Governor Bruce Rauner proposed cutting \$200 million from the Community Care Program in his budget proposal which is one of the many reasons Illinois hasn't had a budget.

In addition to funding for those programs, a high quality personal care workforce is absolutely critical to ensuring that beneficiaries have access to the services they need. As GAO has reported, many of the personal care service programs differ from State to State. We know that. And that includes the training or lack thereof that service agencies provide to the workforce. In some States, training is offered or required, either for new entrants into the workforce or for continuing education of existing workers. In other States, there's actually little or no guidance on training or continuing education for those workers.

Mr. Hill, let me ask you, have you investigated what percentage of agencies providing personal care services in Medicaid have orientation or training programs that are in place?

Mr. HILL. So as I sit here, I couldn't give you statistics by State where those requirements lie, which States require that and which particular agency.

Ms. SCHAKOWSKY. Let me ask Ms. Iritani, do you know that or either one of you know that?

Ms. IRITANI. We know that it varies, yes.

Ms. SCHAKOWSKY. OK. But you don't know.

Ms. IRITANI. No.

Ms. GRIMM. An analysis that we did in 2010, we did find 301 sets of qualifications across States.

Ms. SCHAKOWSKY. OK, and that would include the kind of orientation and training programs?

Ms. GRIMM. It would include that in the qualifications.

Ms. SCHAKOWSKY. Back to Mr. Hill. Do you know what percentage—or any of you know what percentage of those specifically educate their employees and what constitutes waste, fraud, or program abuse?

Mr. HILL. As I indicated earlier in response to a question, we have issued guidance to States on best practices. While I can't say which States require it as I sit here, I could not tell you which States require that level of training. We have identified for States that training, particularly around compliance issues, is the best practice for attendees. And we would expect that States would require that of particularly the attendant agencies to be sure that the folks that are coming into those agencies are properly trained, not just for patient safeguards, but also on the compliance side.

Ms. SCHAKOWSKY. Well, what it seems to me is that the word has gone out that this would be important, but nothing has been done really to enforce that or to even survey that to find out who's doing exactly what when it comes to worker training.

Finally, I just want to note that when a worker comes forward to report cases of waste, fraud, or neglect on behalf of the personal care agency they work for, I really think that it's critical that they are provided whistleblower protections.

And again, to any of you, I'm just wondering if whistleblower protections are built in.

Mr. HILL. Speaking for CMS—and I'm sure the IG and others would have it—we review tips and whistleblower complaints as valuable sources of information as we conduct investigations in concert with our law enforcement partners. I think the whistleblower protections vary by State in State law and that's something that—we value those sorts of activities highly, and it's something that we would encourage States to continue to support.

Ms. SCHAKOWSKY. Well, again, are they protected by law if they were to come forward?

Mr. HILL. On the whistleblower side, I think it's a State-by-State determination as to how the State whistleblower laws apply.

Ms. SCHAKOWSKY. Well, then let me just say I think we need to standardize that because one of the ways that I think that we can make the program operate effectively without waste, fraud, and abuse is to protect the out front, the upfront workers that are doing it because they are the most likely to see it.

In my experience with those home care workers is that these are really dedicated people who are doing often for very little money some of the most important work in our country and I yield back.

Mr. MURPHY. Thank you. I now recognize Mr. Walberg for 5 minutes.

Mr. WALBERG. Thank you, Mr. Chairman. Thanks to the panel. My wife and I were extremely concerned when a personal care worker stole a credit card from my mother and that was a deal from that point on dealing with the bank and then dealing with the court system. But I was disturbed, as I read the released investigative advisory coming from OIG, that there are significant number of instances where PCS workers steal painkillers and other medications from their beneficiaries.

In the case, Ms. Grimm, that you noted in 2016 in Vermont specifically, how did OIG discover that?

Ms. GRIMM. So Vermont, that involved the husband. It was a wife, the beneficiary was a husband and the wife was splitting payments with the care attendant and as part of that scenario she would get or he would get pain pills as a form of payment. I don't know how that came into our office, but that was the scenario that was uncovered.

Again, going back to some of the recommendations that we've offered, had there been a background check in place, it would have revealed a pattern of drug abuse.

Mr. WALBERG. How often is this happening? Is this a common occurrence that you're finding?

Ms. GRIMM. I think fraud is very common in personal care. We've opened 200 investigations since 2012 and our Medicaid Fraud Control Units, it comprises one third of their criminal convictions and have upward of 8,000 cases that have been opened in that time frame.

Mr. WALBERG. Are the painkillers that are stolen generally used by the individual themselves or are they selling this?

Ms. GRIMM. We've seen patterns of both of them using painkillers for themselves and then also selling those. Drug diversion is a big issue in the fraud that we see.

Mr. WALBERG. Yes, and that's a concern when we see about the opioid problems, etcetera. The OIG recommended establishing some minimum Federal qualifications and screening standards for PCS workers. What kind of minimum qualifications do you have in mind?

Ms. GRIMM. We have recommended minimum age requirements, background checks, and we endorse training. Just to sort of demystify things, all of those things right now are voluntary. They're not something that's required at the Federal level, so to the extent that it's happening, it's the State sort of acting on it. It is not currently required at the Federal level.

Mr. WALBERG. With the screening and the background checks, it makes sense to prohibit individuals with felony convictions for drug-related crimes and social services fraud. Is that part of your recommendation?

Ms. GRIMM. We have not specified, but there are guidelines in place for care workers that have direct interaction with patients in

the home health context. And I think some good parameters could be taken from that context.

Mr. WALBERG. OK. It seems like that would make sense.

Mr. Hill, is CMS able to enact stricter standards?

Mr. HILL. We can certainly regulate. The question is how to regulate. As you know, we issued our request for information last fall, asking all the affected stakeholders on these very particular issues about whether or not Federal standards for enrollment or background screening or any number of things that the IG has recommended should be put in place.

As you know, it's a tension between State flexibility and the flexibility of any particular program in terms of who it is and how it is they're overseeing those programs and the imposition of a Federal requirement. So before we were to implement a Federal requirement, we want to be sure that it's going to meet the needs of all the States, both from a program integrity standpoint and also from the service delivery standpoint as well.

Mr. WALBERG. Well, I appreciate that. I guess I would echo some of Mr. Collins' statements as well that it's time to push. And as you indicated as well, the financial push is sometimes the best way to get these recommendations dealt with and the States to get on board. Because it's one thing for an elderly lady with dementia to lose her credit card. That can be fixed. When you get into in this particular area of medications, painkillers, getting out and misused, it impacts lives and maybe get a good handle on that.

Thank you. I yield back.

Mr. MURPHY. Thank you. I now recognize Ms. Clarke for 5 minutes.

Ms. CLARKE. Thank you, Mr. Chairman. Mr. Chairman, I'm glad that we've had the opportunity to talk about the Medicaid program and how many people it helps across the country. Roughly 74 million Americans depend on Medicaid for healthcare coverage and the program is a lifeline to these individuals.

The Affordable Care Act authorized States to expand Medicaid for low-income adults, helping to fill a major gap in insurance coverage. As a result, more than 12 million low-income adults were able to gain coverage last year.

As Republicans are contemplating repealing the Affordable Care Act's Medicaid expansion and making sweeping changes to Medicare, I'd like to put this program in context.

Mr. Hill, CMS has reported that the ACA's Medicaid expansion has helped reduce the rate of uninsured to its lowest level in our Nation's history. Is that correct?

Mr. HILL. That's correct.

Ms. CLARKE. And in a report this past January, CMS stated, and I quote, "Medicaid is the most efficient healthcare program we have, covering people at lower costs than commercial insurance coverage or even Medicare. And at the same time Medicaid has that proven track record of enabling access to care, improving health, and helping children succeed in life."

Mr. Hill, do you agree that Medicaid is an efficient program and that it covers people at lower costs than Medicare and commercial coverage?

Mr. HILL. My judgement is that Medicaid is an important program doing a lot of good for the 74 million people that we cover.

Ms. CLARKE. In CMS' January report, the Agency stated, "Research has shown that Medicaid expansion has helped improve quality, access, and affordability of care."

Mr. Hill, can you briefly explain how the Medicaid expansion has improved the healthcare coverage of its beneficiaries?

Mr. HILL. Without speaking directly to the January report, let me just say that as a general proposition somebody who is covered, whether they're covered through the marketplace or whether they're covered by their employer, they have coverage through Medicaid. If you have health insurance coverage, you generally are going to be in a better place vis-a-vis be uninsured, particularly if you get sick.

Ms. CLARKE. So in addition to expanding Medicaid coverage to millions, the ACA also created the Community First Choice program. This program encourages more States to offer personal care services by providing an additional six percent Federal matching payment to these services. Unfortunately, in addition to gutting the entire Medicaid program, one provision of Trumpcare would actually repeal this option.

Ms. Iritani, I understand from your report that States have begun to participate in the Community First Choice program, is that correct?

Ms. IRITANI. That's correct.

Ms. CLARKE. Can you tell me more about States' participation in this program?

Ms. IRITANI. Well, we know from our work that eight States, as of the time of our report, were participating in the Community First Choice program. And one of the concerns we have leading to our recommendation about harmonizing requirements is making sure that for those people who are in that program who require institutional level of care that the safeguards are in place to ensure beneficiaries' safety are similar to other programs that have served similar beneficiaries, because many States are moving their beneficiaries from waiver programs that have really strong or stronger safeguards into the Community First Choice program.

Ms. CLARKE. So you're saying that the Community First Choice program doesn't have strong safeguards?

Ms. IRITANI. I think that it doesn't have the same level of safeguards as others, other programs' authorities.

Ms. CLARKE. Are you saying that you believe that that may put some of its participants at risk?

Ms. IRITANI. We recommend that CMS actually needs to harmonize the requirements in place between programs to ensure that common risks for beneficiaries, depending on their level of need, are addressed in common ways across the programs.

Ms. CLARKE. And the Community First Choice program, do you believe that their services are less than traditional?

Ms. IRITANI. No, we did not do that work, no.

Ms. CLARKE. OK. Mr. Chairman, I hope my colleagues recognize the importance of this program, how many people rely on Medicaid for their insurance. Trumpcare proposes to dismantle the Medicaid program as we know it, capping coverage for children, pregnant

women, individuals with disabilities, and of course, those who have gained coverage from the Medicaid expansion, not to mention Medicaid is the primary insurer of long term care services and support in this country.

I hope my colleagues will reflect on that point and the immense responsibility we have to strengthen Medicaid and not tear it down. And I yield back.

Mr. MURPHY. Thank you. I now recognize Mr. Costello for 5 minutes.

Mr. COSTELLO. Thank you, Mr. Chairman. Ms. Grimm, Mr. Hill, between 2014 and 2015, the improper payment for personal support services which includes PCS, as you know, nearly doubled from 6.3 percent in 2014 to 12.1 percent in 2015. That's a lot. Why did the error rate increase at such a level in your opinion?

Mr. HILL. So some of it will have to do with measurement, right. That's not necessarily a statistically significant way to measure those services. I'm not discounting the fact that there's an error rate meaning to worry about it, but just as a technical matter, it's hard to make comparisons year to year the way the PERM rate is put together.

I also think that the roll out of requirements around requiring ordering and referring physicians on claims began to get implemented over that time period. And so while in PCS that may not be an issue that category of services you had identified, there are claims in there that require ordering the referring physician to be on the claim. And I know States have had a struggle coming into compliance with that requirement.

Ms. GRIMM. I missed it, did you say Ms. Iritani or Ms. Grimm? I'm sorry.

Mr. COSTELLO. Ms. Grimm.

Ms. GRIMM. So the work that we've done, so we've looked at error rates in personal care services across eight States, and we have consistently found very high error rates in personal care services.

Looking at recent information, Missouri, upwards of 47.8 percent in error rate; New Jersey, 30.9 percent; New York City, 18 percent. And this is consistent across States. So I think the core point there is that we do find high error rates in personal care services, so it's unsurprising that the error rate in PERM is what it is for personal care.

Mr. COSTELLO. Thank you. The Electronic Visitation Verification piece of the Cures Act I think holds great promise, and I would ask you to share, for those watching, the EVV captures exact time, date, location, and duration of each visit.

The question—and there are several, so I'm just going to go through them and then open up to all three of you—is, where is CMS in the process of implementing that change and how much flexibility do States have? How much flexibility should States have in how they choose to use EVV? What enforcement mechanisms will CMS use to ensure State compliance with implementation by 2019? Have you seen any success stories so far? And finally, how can Congress be helpful?

For GAO and OIG, do you believe EVV implementation will help curb fraud and result in more complete, accurate, and timely data

and do you care to elaborate on any GAO or OIG recommendations to ensure smooth EVV implementation?

So Mr. Hill and then right on down the line with those questions.

Mr. HILL. Let me take these in turn. In terms of State flexibility and what we need to do to implement the provision, as you know, the effective date is 2019 with respect to the financing of EVV. And so between now and then we'll be regulating and as part of that process we'll have to make a determination as to how much flexibility, if flexibility is given to States in terms of how we implement. So there's a lot of policy work that we need to do in terms of the State flexibility on EVV.

The enforcement here is withholding FFP. As you know, the statute articulates if the State doesn't have a program, we can reduce the Federal share. In terms of success stories, we know there are two States, Missouri and Texas, already who have begun rolling out EVV. We're working with them and learning all we can for how those particular States are rolling this out so that we can expand those successes and lessons learned in our oversight activity.

Ms. IRITANI. I can't speak to the implementation of EVV, but what I can speak to are the benefits. We spoke to four States, two have EVV in place. They spoke of cost savings when they implemented it, improved timekeeping, more accurate timekeeping, more accurate data, and absolving the beneficiary of the responsibility of having to record time charges.

Additionally, EVV can help ensure that there is a process for notifying the agencies if an attendant doesn't show up.

Mr. COSTELLO. Have you offered any—will GAO be offering any recommendations as it relates to implementation?

Ms. IRITANI. We don't have current work on that.

Ms. GRIMM. Implementation is going to be key. I think that we've heard that just because the requirement exists doesn't necessarily mean that the data are going to be collected and that they're going to be reported and that there are any usable time or usable way to be used. Reduction in—so in that enforcement mechanism, the reduction in FMAP for EVVS is also going to be important. The enforcement authority, without the willingness to act on that enforcement authority, I think poses a little bit of an issue. But certainly the data that EVVS collects, that verification of services will go a very long way. A lot of our fraud schemes show that they're billing for services that were never rendered.

Mr. COSTELLO. Have you or will you be sharing your recommendations on usability with CMS to make sure that the data is in a workable manner for you to be able to audit?

Ms. GRIMM. We don't have any work specifically devoted to EVVS right now, but we do have a report looking at T-MSIS that is very close to completion that will point out issues related to complete list, accuracy, and timeliness.

Mr. COSTELLO. Thank you.

Mr. MURPHY. Thank you. I now recognize Ms. Brooks for 5 minutes.

Ms. BROOKS. Thank you, Mr. Chairman. It was actually 2012 to Mr. Collins' point earlier relying on data, but in 2012 it was when HHS Office of Inspector General released the portfolio highlighting waste, fraud, and abuse in the PCS program and to date, CMS has

yet to implement four of the recommendations. And I'm not going to list all of them or read through all of them because I want to get to the questions, but they include reducing significant variation in the State PCS attendant qualifications and improving CMS' and States' ability to monitor billing and care quality.

I can go into greater detail if you don't know which four, but you know which four. So rather than spend my time on that since it's been nearly 5 years since these recommendations for improving PCS were suggested and while I appreciate that CMS has adopted some of the recommendations, there are still these four.

So Mr. Hill, why has CMS not adopted all of the HHS OIG recommendations after nearly 5 years? And do you disagree with any of the recommendations?

Mr. HILL. So obviously the controls that the recommendations are articulating are controls we'd like to see States have in place.

The question for me is, it's not—so there are four recommendations, but overarching all of them is CMS is showing a Federal standard and regulating here and requiring States and holding States accountable to those four standards. And it's that balance that we're trying to strike here as to whether or not we should regulate and create a Federal standard or whether or not we should be allowing States as they are now or requiring States to have more stringent standards at the State level. So it's not a disagreement necessarily with the fact that we ought to have standards for attendant qualifications. The question is should that be a Federal standard or should that be a standard that's left to the State with us ensuring that the State is following through on that and complying.

Ms. BROOKS. And while I understand that that's what the differences are, it's been 5 years since the recommendation came out and so what is the problem? Is there an internal deadline at this point for CMS to adopt these recommendations?

Mr. HILL. So we issued a request for information last fall after a lot of conversation with the IG to gather more information on the question that I just articulated, in terms of Federal standards or not. We're going through that information and the data that we gathered as part of that RFI and we'll be considering that as we move forward in the regulatory agenda for Medicaid generally.

I should just be very clear, there's not an internal deadline for when we have to have a reg out or not. We're going through those comments now.

Ms. BROOKS. Would you agree that a lot of people work best when there are deadlines?

Mr. HILL. I do. I understand the point, yes.

Ms. BROOKS. So that might be something you might consider at this point after 5 years is setting a deadline?

Mr. HILL. I will be sure to raise that. I can't set the deadlines. I'm a deadline follower, but I do report to the folks who set deadlines.

Ms. BROOKS. And you talked about the qualification issue, what about is that a similar problem with respect to the monitoring of the billing and care quality?

Mr. HILL. The data and information on claims, all the controls that the IG has quite appropriately identified, we have to regulate if we were going to have to require a State to implement those.

Ms. BROOKS. Ms. Grimm, and so Mr. Hill has talked about have there been conversations between OIG and Mr. Hill and others at CMS regarding the length of time that's passed since you've issued these recommendations and have there been any reasons as to why you believe there's been a delay that we could maybe address in implementing the recommendations?

Ms. GRIMM. We have a number of processes in place for all of our unimplemented recommendations to follow up on the status of those recommendations. We have met beginning in November 2015 with CMS leadership in person many times to talk about options and possible solutions.

Ms. BROOKS. So you're following your processes for following up on recommendations. What has been the primary reason for delay in moving forward since it's been years and you've been following your process since November of '15?

Ms. GRIMM. We certainly have provided a lot of technical assistance to CMS. I think that's a great question for my colleague, Mr. Hill.

Ms. BROOKS. Mr. Hill, so we'll bring it back to you.

Mr. HILL. I fear I will not have a satisfactory answer for you to be able to say exactly why a reg hasn't been implemented. As you know, we sort of went through sort of a set of conversations last year. We've now had a transition. We have a new administration and we're beginning to think about what that agenda looks like.

Ms. BROOKS. I'll be anxious to see with respect to those that you work with at CMS that we've set an internal deadline and move forward on many of these recommendations. With that I yield back.

Mr. MURPHY. The gentlelady yields back. And I now recognize Mr. Carter for 5 minutes.

Mr. CARTER. Thank you, Mr. Chairman, and I thank all of you for being here. You know, I think we've established the fact that the personal care services are extremely important. Before I became a member of Congress, I was a practicing pharmacist, so I had some experience with this, particularly in the way of medication management and drug therapy. I was also a consultant pharmacist, as well as being a community pharmacist. And one of the primary reasons that people are admitted to a nursing home or to a personal care home is medication management. It's one thing that we have to be careful of.

Representative Walberg alluded to some of the abuse and certainly I have witnessed some of the abuse that can take place with that, but I've also witnessed a lot of the benefit that it can have. And the benefit of allowing someone to stay in their home and not having to be institutionalized, it's a great benefit to them personally and it saves money for a lot of us, but obviously, there is a lot of room in that particular scenario for abuse and for fraud. And it's difficult. I get it. I understand it's difficult to identify that and hopefully our healthcare professionals such as pharmacists are helping us with that. And whenever they might see a trend or a tendency there where medication goes missing or someone is not getting their medication, maybe a physician can identify why is

your blood pressure going up, you know? Are you getting your blood pressure medication or something and why is your pain level going up? Perhaps they're not getting it like they're supposed to. But nevertheless, I agree it is a good program, but it is a program that obviously we wouldn't have you here today if we weren't looking into the fraud, the waste, and the abuse that exists in the program.

I want to start by very quickly talking just about the self-directed Medicaid service models because as I understand it a lot of the fraud that's involving the personal care services is conspiracy, if you will, between the PCS and the beneficiary.

Tell me, Mr. Hill, what has CMS done to combat that? What can you do and what's been beneficial and what's worked?

Mr. HILL. So self-direction—I think, particularly for those of us, myself included, who have sort of spent a lot of time thinking about the medical model and how we do insurance and provide services, self-direction is sort of the most out-of-the-envelope way to think about how people are getting services. You know, having a beneficiary pick and understand and have a lot more control over who's coming into their home and how that service is being delivered is a challenge. Sometimes, as we've identified a family member or a friend, so there is a range of things that we've done to help, not just beneficiaries, but States and agencies who are sometimes involved in that model to build in practices and policies to mitigate against abuse.

We've talked about training. We've talked about compliance work with the folks who are doing the service work. Some States—and many States—have requirements for enrollment and background checks, all of the things that we've talked about work in self-direction as well as they're going to work in agency. But again, because the beneficiary will be at the center of that planning, at the center of identifying who is coming into their home, the self-directed model is one that provides, presents unique challenges.

Mr. CARTER. Ms. Grimm, let me ask you, it's my understanding that most of the fraud is proven through by showing—most of the fraud is by people who have come and actually testified and through referrals from individuals who have turned them in, if you will. How can Health and Human Services do a better job with that? Is there anything? How can we incentivize people to report these types of abuse or fraud?

Ms. GRIMM. I appreciate your question. I think yes, it is true that a lot of the fraud that we see is in self-directed models. They've shored up a number of different requirements for self-directed so that things like the flow of cash isn't as easily sort of shared with others. So CMS has taken steps in that regard. But it would be easier, consistent with our recommendations for us to know who we're doing business with. Right now, we don't know the identities and the dates and the types of services being provided at the attendant level. So that's something that I think is critically needed for oversight.

Mr. CARTER. Great. Well, my time is about up. But again, I want to stress that I've seen the benefits of this program. The benefits are good. But I hope that we can do something to address some of the problems that we have because I've also seen the fraud that ex-

ists in there and it does exist. And trying to get those bad actors out is difficult, but we need to get them out. Thank you very much and I yield back.

Mr. MURPHY. The gentleman yields back. I want to thank our panel here. This has been very enlightening for us, and I want to follow up on my friend and colleague's recommendation that we bring the States in. We would look forward to hearing from you if you have suggestions of what States that might be, so we can hear about what's working, what's not working. And in the meantime, please let us know if there's other things we need to pay attention to.

I thank all of the witnesses and all the Members who participated in today's hearing. I will remind Members they have 10 business days to submit questions for the record, and I ask that the witnesses give us timely responses to those and respond promptly to those questions. And with that, this subcommittee is adjourned.

[Whereupon, at 12:04 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]



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.

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.

Majority Memorandum for May 2, 2017, Subcommittee on Oversight and Investigations Hearing
Page 3

- 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

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

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.

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (2021) 225-2927
Minority (2021) 225-3641

May 31, 2017

Ms. Christi Grimm
Chief of Staff
Office of Inspector General
U.S. Department of Health and Human Services
300 Independence Avenue, S.W.
Washington, DC 20201

Dear Ms. Grimm:

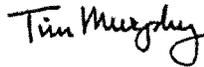
Thank you for appearing before the Subcommittee on Oversight and Investigations on Tuesday, May 2, 2017, to testify at the hearing entitled "Combating Waste, Fraud, and Abuse in Medicaid's Personal Care Services Program."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Wednesday, June 14, 2017. Your responses should be mailed to Elena Brennan, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to Elena.Brennan@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

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.

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"

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.

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 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>.

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"

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.

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS
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Majority (202) 225-2927
Minority (202) 225-3641

May 31, 2017

Ms. Katherine Iritani
Director, Health Care
U.S. Government Accountability Office
441 G Street, N.W.
Washington, DC 20226

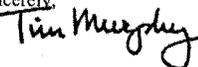
Dear Ms. Iritani:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Tuesday, May 2 2017, to testify at the hearing entitled "Combating Waste, Fraud, and Abuse in Medicaid's Personal Care Services Program."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment



U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

June 14, 2017

The Honorable Tim Murphy
Chairman
The Honorable Diana DeGette
Ranking Member
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
House of Representatives

This letter responds to your request that we address questions submitted for the record related to the May 2, 2017, hearing entitled *Combating Waste, Fraud, and Abuse in Medicaid's Personal Care Services Program*. GAO's responses to these questions are enclosed and are based on previous work related to the areas addressed.

If you have any questions about these responses our need additional information, please contact Katherine at [REDACTED]

[REDACTED]

Katherine Iritani
Director, Health Care

Enclosure

cc: Emily Felder
Kevin McAloon

GAO Responses to Questions for the Record
Following the Committee's May 2, 2017 Hearing,
"Combating Waste, Fraud, and Abuse in Medicaid's Personal Care Services Program"

The Honorable Frank Pallone

QFR 1a. How do different program requirements affect beneficiary safeguards, as well as fiscal oversight?

Differing federal requirements across the different types of Personal Care Services (PCS) programs can result in significant differences in beneficiary safeguards and fiscal oversight:

- Beneficiaries may experience different health and welfare safeguards depending on the program in which they are enrolled. For example, in one state we reviewed, the state requires quarterly or biannual monitoring of beneficiaries for most of its PCS programs. For another program operated under the PCS state plan authority (Social Security Act § 1905(a)(24), the state requires only annual monitoring contacts. Officials told us that the reason for this difference was because, for that type of program, the state was not required to provide assurances to the Centers for Medicare & Medicaid Services (CMS) that they safeguard beneficiaries' health and welfare.
- States can use different processes for each PCS program to ensure that billed services are actually provided, and some state programs may not be subject to any specific federal PCS requirements in this regard. For example, in one state we reviewed, steps taken to ensure billed services are provided under some types of PCS programs are not required in another of the state's programs. The state reported that it used its quality assurance process in some of its PCS programs to meet with and verify service delivery with the beneficiary in an effort to ensure that billed services are provided. In one PCS program, a supervisor must visit the beneficiary and document whether the attendant is delivering the authorized PCS tasks, a recommended practice.¹ The state did not apply the same process to another of its programs, and federal requirements for this particular program type do not include specific requirements that states help ensure that PCS billed services are provided.

¹Centers for Medicare & Medicaid Services, *Increasing Fiscal Protections for Personal Care Services*, webinar (2016), accessed October 24, 2016, <https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-increasing-fiscal-protections-v6.pdf>.

**GAO Responses to Questions for the Record
Following the Committee's May 2, 2017 Hearing,
"Combating Waste, Fraud, and Abuse in Medicaid's Personal Care Services Program"**

The Honorable Frank Pallone

QFR 1b. What steps should CMS take to harmonize requirements across PCS programs?

CMS's efforts to harmonize personal care services requirements have not addressed the significant differences across federal program requirements specific to PCS related to beneficiary safety and ensuring that billed services are provided.² We found that how states screen, train, and monitor attendants, and ensure billed services are provided, varies, not only between states but even within states, by program. In our view, CMS could take a number of steps to improve the coordination among and regulation of all PCS programs, such as:

- Analyze requirements across all authorities to identify similarities and differences;
- Solicit input from stakeholders on what PCS requirements should be more consistent or coordinated; and
- In view of this information and our findings, consider changes to future guidance that would harmonize HCBS and PCS programs by streamlining and making requirements more consistent across programs.

We note that the HHS OIG has observations similar to GAOs. Based on numerous reviews of state PCS programs, the HHS OIG recommended that CMS issue regulations to reduce the significant variation in states' PCS requirements for documenting claims for payment for services, supervision of attendants, and attendant qualification standards.³

²For purposes of this analysis, we reviewed regulations specific to PCS services, which appear at 42 C.F.R. Parts G, J, K, and M, as well as any PCS-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 PCS programs.

³The OIG listed this recommendation—to reduce the significant variation in states' PCS requirements for documenting claims for payment for services and supervision of attendants—among its 25 most crucial unimplemented recommendations. The OIG reported that CMS had not yet implemented these recommendations as of April 2016. U.S. Department of Health and Human Services, Office of the Inspector General, *Compendium of Unimplemented Recommendations* (Washington, D.C.: April 2016).

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (202) 225-2927
Minority (202) 225-3641
May 31, 2017

Mr. Timothy Hill
Deputy Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Hill:

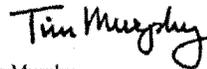
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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

Tim Hill's Hearing on
"Medicaid Personal Care Services"
E&C O&I
May 2, 2017

Attachment Additional Questions for the Record

The Honorable Tim Murphy

1. **OIG's investigations found that the most common fraud schemes involve conspiracies between PCS attendants and beneficiaries - "OIG has found a growing number of instances in which beneficiaries are being changed as co conspirators because they accept cash or other benefits in exchange for participating in the fraud." These cases appear to be especially relevant when PCS attendants are close with or even related to beneficiaries. Do you agree that beneficiary fraud is a growing problem, and that beneficiaries' close relationships to their attendants can be a potential cause of that problem?**

a. What are some ways in which CMS can prevent beneficiary fraud?

Answer: CMS has taken a number of actions to improve the Medicaid PCS program and to close recommendations made by the OIG. We take oversight of state PCS programs seriously and have conducted program integrity reviews, as well as provided states with guidance, training and other educational resources to enhance their oversight of PCS in their states. As you know, under the Medicaid Federal-state partnership, the Federal Government sets forth a policy framework for the program and States, who are well-positioned to know what their residents need, have significant flexibility to choose options that enable them to deliver high-quality, cost-efficient care for their residents.

CMS recognizes the unique and intimate nature of personal care services, and supports states offering self-direction options to beneficiaries to exercise more control over who provides those services to them. Many self-direction programs permit beneficiaries to select family members as care providers, and CMS and our state partners understand the necessity of ensuring appropriate fraud prevention measures are utilized in these programs.

CMS has also released a request for information to solicit feedback on improvements that could be made to personal care services, including what program integrity safeguards states should have in place to reduce fraud, waste and abuse.¹ We received hundreds of responses and are now reviewing them to determine the best path forward.

¹ <https://www.federalregister.gov/documents/2016/11/09/2016-27040/medicaid-program-request-for-information-rfi-federal-government-interventions-to-ensure-the>