Rio Grande Valley Solutions Group

Pilot Project Executive Summary

According to a June 2016 report from the Texas Demographic Center, Texas is getting older and will continue this trend for the next 35 years and beyond. Texas has the third largest elderly population and share of the total U.S. elderly population. The Texas older population grew by 49.5 percent (over 1.0 million), from nearly 2.1 million in 2000 to nearly 3.1 million in 2014, a rate even faster than the nation's. Texas also increased its share of the U.S. older population between 2000 and 2014 from 5.9 to 6.7 percent. Moreover, the older population in Texas is outpacing the growth of the state overall as well as that of younger populations. Additionally, the oldest of the old are growing at a faster rate than the youngest of the older population, following the national trend of increased life expectancy.

According to the Agency for Healthcare Research and Quality (AHRQ), the most common Medicaid readmissions cost hospitals $2.06 billion in 2011, while the most common and expensive Medicare readmission cost $1.75 billion alone. Plus, one in five elderly patients winds up back in the hospital within 30 days of leaving. The Centers for Medicare & Medicaid Services calls avoidable readmissions one of the leading problems facing the entire U.S. health care system,

PROBLEM This aging trend has a significant impact for the American health care system and, in particular, the Texas Medicaid and Medicare programs and other state health services. The number of people who will need personal care services will continue to increase in the future. South Texas, which includes one of the poorest and least healthy populations in the country, suffers from a variety of challenges and problems in delivering quality health care services to the most vulnerable populations: those needing home care services. The litany of problems and abuses has put Texas – and South Texas specifically – in the national spotlight. The fraud and waste of state and federal funds is staggering; more importantly, the abuse suffered by the patients is beyond tragic.

A 2016 report from the Office of the Inspector General of the U. S. Department of Health and Human Services points to a critical – and growing problem across the country – with fraud, waste and abuse in the Medicaid Long-Term Services and Support (LTSS) program, and the Personal Attendant Services (PAS) programs in particular, citing "significant and persistent compliance, payment and fraud vulnerabilities.

The litany of problems with the attendant services are long and well known by state agencies, the Texas Office of the Inspector General and the industry. A short list of the more striking problems includes:

- Threats, neglect, exploitation and abuse against members (patients/clients) by attendants;

- Attendants (who are employed by the provider agencies and provide the direct care) who report more hours than actually worked or not worked at all by easily thwarting the existing reporting and verification systems;
- Collusion between attendants and the member (patient/client) in a variety of ways to defraud the program;
- Repeated transfer of patients from one provider agency to another by unscrupulous attendants for financial gain or to avoid disciplinary actions;
- Widespread violation of anti-solicitation laws by provider agencies to transfer the member (patient/client) for the sole purpose of financial gain;
- Lack effective training for attendants in core competencies that would help to spot and address emerging health issues for member (patient/client);
- Repeated movement of attendants in employment from one provider agency to another (and transferring a member (patient/client) in the process) without significant oversight from MCOs and the state, even when fired for cause, noncompliance, lack of performance or violation of rules;
- Limited effective supervision of attendants and in-home service delivery by MCOs and some provider agencies; and,
- Lack of effective penalties for negative patient health outcomes (hospitalizations, re-hospitalizations, etc.) due to poor performance by attendants and provider agencies.

DANGERS There are, of course, a number of other problems that impact the program. However, these are the most striking and ones that seem to result in the most severe consequences for the patients and the State of Texas. These include, among others:

- Serious health consequences for patients (hospitalizations, re-hospitalizations, infections, falls, poor nutrition, health deterioration, etc.);
- Abuse and exploitation of patients who are at the most vulnerable point of their lives;
- Significant cost increases for the state as patients are hospitalized and re-hospitalized;
- Significant losses to the state from fraud and waste;
- Penalties for hospitals if re-hospitalizations happen, negatively impacting the health care system;
- Corruption as unscrupulous attendants and agencies defraud the state of Texas; and,
- Overall deterioration of the program's services and possible sanctions from federal agencies if these problems are not addressed.

SOLUTIONS The RGVSG proposes a combination of initiatives that will serve to cut costs, improve services and reduce fraud, waste and abuse. This includes legislative/regulatory changes and the development of a pilot program that will implement and test a number of key improvements in the services delivered by the PCS agencies. The pilot program will include, among other elements:

- Increased training for attendants in core competencies that will help them to identify and report potential health problems to medical personnel (nurses and doctors) before they become serious problems or require hospitalizations;
- Increased supervision/compliance for attendants and members on collusion and fraud;
- Improvements to the Electronic Visit Verification (EVV) compliance that will cut waste;
- Strengthened qualifications and screening coupled with increased supervision of PCS attendants;
- Increased coordination of care between provider agencies, MCOs and other health care providers;
- Development of a registry of attendants to monitor frequent employer changes;
- Access of data to identify repeated transfers by attendants to different provider agencies;
- A carve-out of patients in statistically significant numbers for the pilot program;
- Limitations on the transfer of patients from one provider agency to another within the pilot group;
- An increase in the attendant reimburse tied to improved, trackable performance measures; and
- Increased compliance and fraud prevention measures on the part of PCS agencies.

SUCCESS OUTCOMES The pilot program will rely on independent data tracking from the HEDIS and Medicare Star Quality measures. This data will be used to track a number of patient outcomes and cost reductions. Among the key measures (to be tracked by patient, attendant and provider agency) include:

- Patient health outcomes;
- Hospitalizations and re-hospitalizations; and,
- Cost reductions.

It is fully expected that the pilot program will demonstrate that the implementation of the added training, supervision and other elements will result in:

- measureable reduction in hospitalizations and re-hospitalizations,
- increased positive health outcomes, and,

- significant cost reductions.

The multi-year pilot project will allow for the gradual implementation of various components in a smooth, orderly approach that provides patients the best quality home care. It will also include a strong research component using external researchers and evaluators that will follow the project from beginning to end. The costs for this pilot project will be addressed through shared costs savings and will not add to the program's budget.

These are the issues the Rio Grande Valley Solutions Group has proactively been working on for the past two years to address internally and with state agencies and others because they have seen dramatic increases in fraud, waste and abuse first hand. The RGVSG came together to as an incubator for the development of innovative solutions to critical health care issues in South Texas. The companies that have join this effort have done so because they are passionate and committed to improving the lives of the clients they serve. Specifically, they are dedicated to improving the quality of care their employees deliver, improving the efficiency and efficacy of the services they provide, lowering costs, and reducing instances of fraud, waste and abuse in the programs.

Introduction

Medicaid is a vital element of the safety net for the elderly, frail, disabled and others needing crucial personal care services. It provides critical services when these families are at their most vulnerable. Ideally, it would keep them safe and healthy. For the majority of the people covered by the program, the services work well. However, for a significant segment, fraud and corruption have resulted in serious health consequences for the patients and millions of dollars in losses for the state and federal governments through fraud, waste and abuse.

There are some fundamental weaknesses and holes in the program's structure that have long permitted these problems to fester. Unchecked, the problems will continue to grow and result in more negative health outcomes for the very people the program is designed to protect and serve. The Medicaid program and the industry that has been created to deliver the services are facing a critical point in the development of the program.

The Rio Grande Valley Solutions Group proposes the development of a pilot project that will provide an opportunity to test new approaches to the delivery of personal care services that will focus on improving patient health outcomes while significantly cutting costs and reducing fraud, waste and abuse. The pilot project will also provide a strong body of research analysis based on a range of data focused on patient health outcomes.

How the Program Works

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines. Federal law requires states to provide certain "mandatory" benefits and allows states the choice of covering other "optional" benefits. Mandatory benefits include services like inpatient and outpatient hospital services, physician services, laboratory and x-ray services, and home care services, among others.

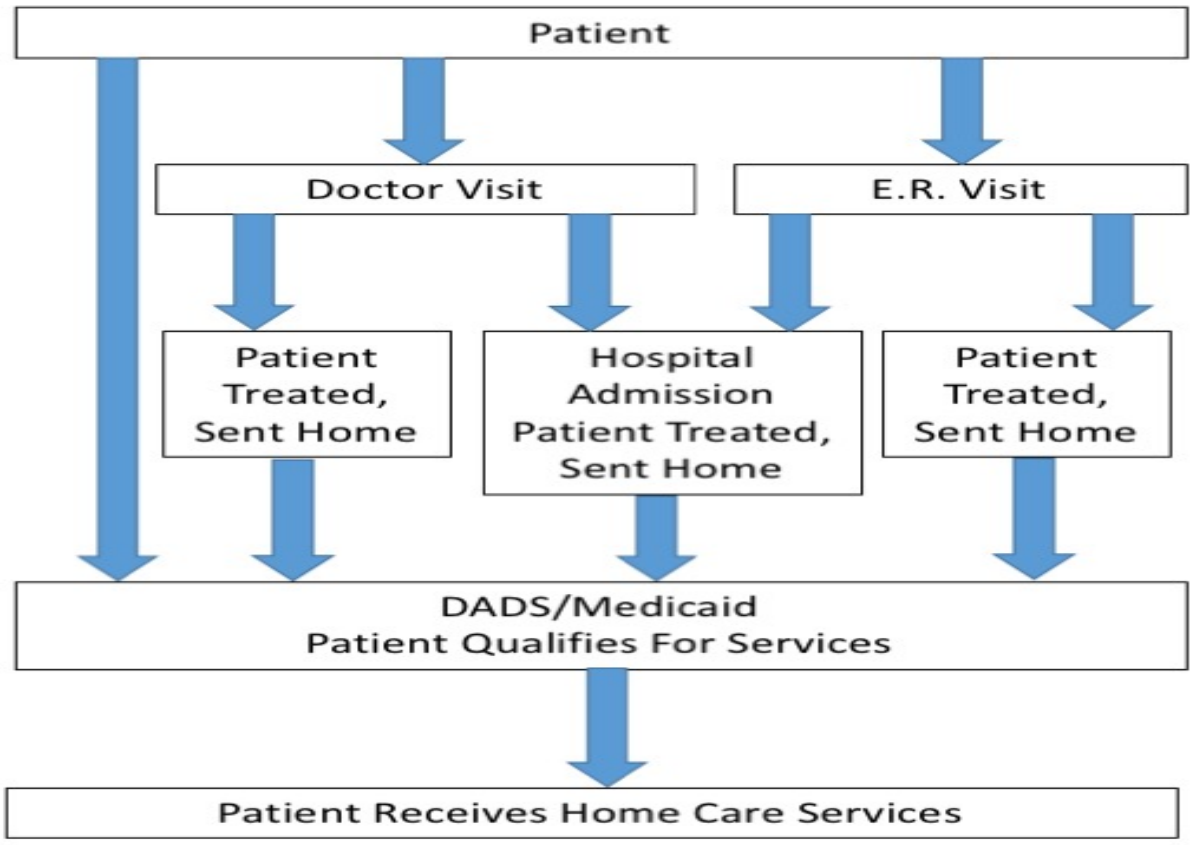
Personal care services are provided by Medicaid when a physician deems it necessary. Personal care services provide nonmedical assistance to the elderly, people with disabilities, and individuals with chronic or temporary conditions so that they can remain in their homes and communities rather than entering a long-term care facility (nursing home).

In addition to the Texas Health and Human Services Commission, which runs the program in Texas, the other major participants include Managed Care Organizations (contracted by the state to implement the wide range of health

benefits to those who qualify), the provider agencies (subcontracted by the MCOs to deliver services and the attendants, who provide the actual personal care services.

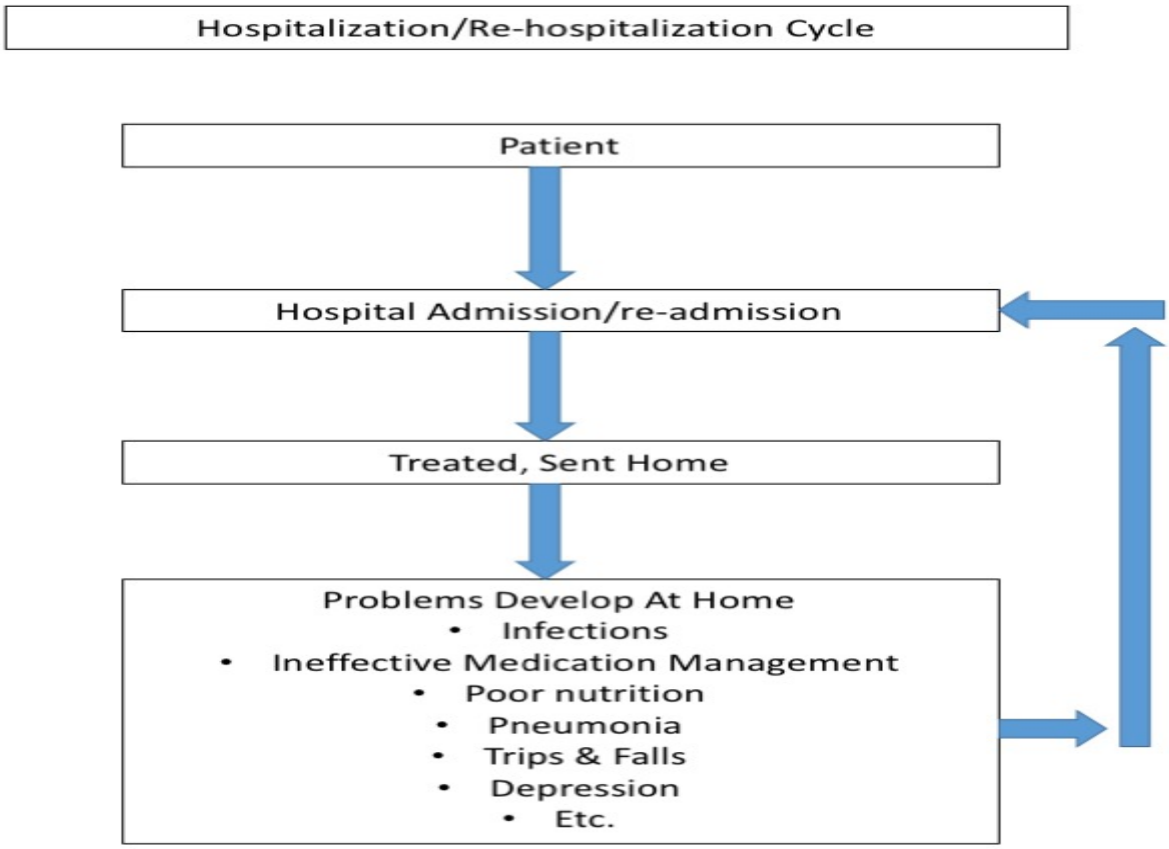
The process is straightforward. Generally, a person receives personal care services in three general ways. First, it may be that the person is assessed by someone from the Texas Department of Aging and Disability Services (DADS) as having a need for Personal Care Services, which would require an attendant. Second, a patient's doctor may determine that the patient needs assistance at home and orders the attendant services. Third, a person may be hospitalized and, upon their release, are provided attendant services.

In all three cases, the purpose of providing attendant services is to help the patient continue their recovery at home and avoid being hospitalized or re-hospitalized or moved to a nursing home or other long-term care facility. The graph below provides a flow chart on how the process happens.



Within the scope of the Medicaid program, once the patient leaves the hospital, it is expected that the patient will not return to the hospital for the same condition/disease if the home care services works. However, re-hospitalizations have become one of the largest costs for the Medicaid program. Naturally, it

has become a priority for Medicaid to work to prevent re-hospitalizations. The flow chart below shows why re-hospitalizations may happen.



Definitions

This project specifically focuses on the problems in the Personal Care Services program. The following definitions will provide a more complete understanding of the program.

Personal Care Services. Personal care services provide nonmedical assistance to the elderly, people with disabilities, and individuals with chronic or temporary conditions so that they can remain in their homes and communities. These tasks are called Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Examples of ADLs include bathing, eating, going to the toilet, dressing and walking, among others. Examples of IADLs include laundry, light housework, and fixing meals, among others. These services are referred to as Personal Care Services (PCS) or Personal Attendant Services (PAS) by the federal and state agencies. For the purposes of this project, we will make reference to the program as the PCS program.

Managed Care Organizations. Medicaid provides for the delivery of Medicaid health benefits (primary medical services, hospitalization, therapy, pharmacy, personal care services, etc.) and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services. The MCOs in Texas, in turn, subcontract with doctors, hospitals and other private sector businesses to provide the actual services to patients. In

Provider Agencies. The MCOs subcontract with provider agencies to provide patients with personal care services. They, in turn, hire the attendants who provide the services. The provider agencies also provide the supervision and support services needed for the proper delivery of services.

Attendants. The attendant (sometimes called "providers" by patients) is the person hired to provide the services to the elderly or others who qualify for the programs.

Patients. Patients are also referred to as members (as in being members of the MCO) or clients who receive the services under the Medicaid program. To qualify for PCS, a patient must:

- Have a disability, physical or mental illness, or a health problem that lasts for a long time.
- Have a Practitioner Statement of Need signed by a practitioner (physician, advanced practice nurse, or physician assistant) who has examined them in the last 12 months.
- Need help with ADLs and IADLs based on the Personal Care Assessment Form (PCAF).

Texas Health and Human Service Commission. The Texas Health and Human Service Commission (HHSC) oversees the Texas Medicaid program and contracts with the MCOs for the delivery of health services benefits.

Electronic Visit Verification Devices. The Electronic Visit Verification (EVV) devices should be provided to every patient. However, not all provider agencies utilize them. Ideally, the device is permanently attached at the patient's home. When the attendant arrives for their work assignment and when the leave, they press the device button, which provides a code number. The attendant writes down the two numbers and then phones in the two numbers. The two code numbers represent a specific time, date and location. This is how the system would ideally determine that an attendant has actually shown up and done their work assignment. Each MCO uses a different EVV device, but they are all small and portable.

HEDIS. The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance

(NCQA). HEDIS is also used by Medicaid as part of its billing and data collection.

PROBLEMS IN THE MEDICAID PROGRAM

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PROBLEMS IN THE PERSONAL CARE SERVICES PROGRAM

Attendants play a critical – though largely unnoticed – role in health care for the elderly. The large majority are dedicated workers doing sometimes taxing physical labor for pay above minimum wage. They usually work part-time hours, often less than 40-hours per week. In South Texas, they are often unskilled, and many speak little or no English. Also, they are often the primary caregivers for their own families.

Sometimes, they are the only ones who have regular contact with the patients outside of doctors' visits. Increasingly, elderly patients have no relatives living close to them or are neglected by their families. Attendants often become a crucial lifeline for patients. Because of the daily contact and closeness with which they do their work, attendants often develop a true bond with the patients, often going far beyond what the job calls for. The vast majority of attendants are dedicated to their jobs and the patients they serve.

At the same time, attendants fall prey to temptation and pressures. They work largely unsupervised on a day-to-day basis. It becomes easy to cut corners because no one is there every day to make sure they actually show up, to make sure they work all the hours they are reporting, that they are doing all of their assigned tasks, and that they are not abusing or intimidating patients.

A Broken Business Model

The current business model created by this program provides such an uneven balance of patient control that the attendants can easily manipulate both the provider agencies and the MCOs. As noted previously, the attendants operate in isolation. Unlike a doctor's office, hospital or nursing home setting, the attendant works in the patient's home away from any daily, physical supervision. Over the course of their service to the patient, they often develop a close, personal bond. This is a normal occurrence because attendants are required to have close, physical contact with the patient on a daily basis: bathing the patient, changing clothes, changing diapers, feeding them, grooming and other personal contact. Additionally, the attendants often spend four or more hours every day around the patient in casual conversations, sharing personal information, discussing personal challenges and difficulties, and providing mutual emotional support. In some sense, they are like family. In some cases, patients become quite trusting and even dependent on the attendant.

Additionally, the patients have virtually no meaningful connection to the provider agencies or the MCOs. They generally have limited understanding of how the program works and the role of the provider agencies and the MCO in the services they receive. Because their services are provided personally by the attendant, it makes no difference to them which provider agency or MCO they are signed up with. Unless the patient has prior experience with various provider agencies, they would not be able to see that there may be significant

differences in the services provided by different provider agencies. Patients have even less connections to their MCOs.

The close, personal bond is essential to providing good patient services. However, it is also a danger in that it gives attendants, in some cases, greater control over patient services than the MCOs and provider agencies. There are several ways in which this is exploited and becomes a source of fraud, waste and abuse.

- Avoiding disciplinary action. A provider agency may find that the attendant is violating rules (removing the EVV device from the home, reporting but not performing work hours, not doing the required work, etc.) and may seek to reprimand or even hire the attendant. However, the attendant can threaten to quit and take the patient with them because they can easily convince the patient to switch to another provider agency. For some agencies, the threat of losing an income-generating patient may well keep them from taking further action. If the MCO were to be involved and question when a patient asks to move to another provider agency, the attendant would threaten to have the patient switch to another MCO. In both cases, the MCO and the provider agency are driven by their enrollment numbers. Strong disciplinary efforts quickly run into the pressing demand that companies maintain high enrollment numbers in order to keep their business viable. Some attendants quickly learn the dynamics of this relationship and are very brazen in taking advantage of their position of power. This information is also shared among attendants.
- Selling/auctioning of patients. This is the other side of the previous example. Some attendants may approach competing provider agencies and ask for a higher salary because they can bring a patient along with them. This is even more appealing to a provider agency when one attendant works with more than one patient or can convince other relatives and friends who are also attendants or patients. This movement of multiple patients in one stroke gives attendants strong leverage in negotiating higher wages and working conditions (limited oversight, lax requirements on EVV use, etc.).
- Collusion. In some cases, there is collusion between the attendant and the patient. This includes a number of situations where they two share some of the attendant's earnings in exchange for working less hours than reported or not working any of the hours reported.
- Intimidation. Some attendants threaten and intimidate patients to not report work and log-in violations. Because the patients can be isolated and become physically/emotionally dependent on the attendant, the attendant can be abusive by physically harming the patient, neglecting the patient and even stealing money and other valuable items from the patient.

The vast majority of attendants only seek to do their job well in serving their assigned patient. However, the ease with which attendants can take advantage of the system too often leaves patients are risk.

There is also another side of this dynamic. Some provider agencies take advantage of attendants and patients. In doing so, they may violate "bait and switch" provisions in the program rules and state law, including false, misleading or deceptive advertising, and/or advertising not readily subject to verification.

- Bait and switch. Some home care agencies publicize higher wage rates for attendants than the prevailing market wage. However, when a person applies, they are told that there are no current openings at the higher rate, unless they can convince their client to transfer to the new agency or if they can find a client to sign up with their agency. The real goal of this is not to hire attendants but to recruit new patients.
- Poaching of patients. The need to maintain high enrollment numbers drives some unscrupulous provider agencies to take advantage of attendants' situations. They may solicit attendants to have the patient move to their agency in exchange for a slightly higher pay rate. They may also offer other incentives for the attendant to convince the patient to transfer, such as cash card.
- Preying on patient sympathies. Some agencies do door-to-door community outreach directly to clients, which in itself is not a problem. However, they may take advantage of the close bond between a patient and an attendant. Many patients want to help their attendant if possible. The marketers may mention that by switching to their provider agency, the patient can help the attendant receive higher pay. They may even seek to offer a financial incentive (cash card) to the patient in exchange for transferring to the other agency.
- Preying on patient families. When the attendant is a patient's relative (son, daughter, niece, nephew, etc.), the patient may feel an even greater need to help them by switching agencies. If the attendant is not a relative, the marketer may inform the potential client that their son, daughter or other relative could be hired as an attendant if they sign up with or transfer to the agency. This would also seem to be a violation of the anti-kick-back provisions as well as the state's anti-solicitation laws.

There are, of course, other ways in which unscrupulous provider agencies and attendants can subvert the system. These are the most common and the ones that can be addressed by this project. Overall, any action that circumvents the client's free will to choose their preferred agency constitutes a violation of program rules or related state law.

As noted previously, one of the ways that attendants can subvert the log-in requirements is to remove the EVV device from the home and carry it with them instead. As the picture shows, the device is very small, about the size of a USB flash drive. Ideally, the MCO provides the devices with a plastic zip tie with the MCO's name of logo.

The attendant can easily break the zip tie and attach the EVV device to their key chain. The devices have no GPS or other way to report a location. This shows how easy it is for the attendant to report hours that they did not work.

RGVSG Pilot Project Proposal

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PILOT PROJECT

The RGVSG proposes a combination of initiatives that will serve to cut costs, improve services and reduce fraud, waste and abuse. This includes legislative/regulatory changes and the development of a pilot program that will

implement and test a number of key improvements in the services delivered by the PCS agencies. This will be integrated during a multi-year pilot project.

PROGRAMMATIC COMPONENTS

The programmatic components comprise the elements that will address the changes and improvements the pilot program will be implementing and testing to improve the health care system. The pilot program will include a number of key elements, all geared toward improved health outcomes for the patients, preventing hospital admissions/re-admissions, cost savings, improved services, and reduction in fraud, waste and abuse.

Training

Currently, the State of Texas and the Medicaid program have few training requirements for attendants. Beyond being able to understand and utilize the Electronic Visit Verification (EVV) devices and related reporting systems, attendants are not required to have any technical or life skills training. While this is an entry level job, it is a lynch pin in providing critical care for patients.

The training component will be developed in conjunction with either a local community college or a health care training firm. The curriculum will focus on a few key core strengths and knowledge. As the pilot project progresses, the curriculum will be adjusted as evaluation/feedback points to needed changes. Among the items for consideration for use in the curriculum are:

- *Recognizing potential patient health care issues.* Attendants are the persons with the most frequent contact with patients, often seeing them up to five days a week. They can notice small, visible changes in a patient's behavior and appearance. They will be trained in identifying some of the more obvious warning signs of some diseases or conditions, such as diabetes. For example, they may ask the patient to take off their socks/shoes to check the patient's feet for sores, wounds and bruises. While they will not be expected to diagnose any specific medical issues, noticing and reporting changes to a nurse or doctor may help in preventing the exacerbation of a condition that could easily result in an ambulance ride to the emergency room and/or re-admission to the hospital. In essence, equipped with some basic knowledge, attendants can be the eyes and ears for primary care givers. The importance of these potential health care issues is that they are the ones most likely to result in a hospital readmission but that could be avoided by a nurse's home visit or a visit to the doctor's office. While an attendant may have an intuitive sense that a patient needs some type of medical attention, they feel that medical personnel and family would disregard their untrained opinion and fail to speak up for fear of being ignored or ridiculed. The training will also include a process for reporting issues and concerns, as

well as emphasizing their responsibility for reporting issues as soon as they see a potential problem.

- *Trip and fall avoidance.* Trips and falls are among the most common problems for the elderly. According the Centers for Disease Control: one out of five falls causes a serious injury such as broken bones or a head injury; each year, 2.8 million older people are treated in emergency departments for fall injuries; more than 95% of hip fractures are caused by falling; they are associated with increased premature mortality; and, adjusted for inflation, the direct medical costs for fall injuries are $31 billion annually, with hospital costs accounting for two-thirds of the total. Attendants can receive training on identifying and helping eliminate potential trip and fall hazards in the home. Again, the importance of falls is that they are among the most likely to result in an avoidable hospital admission/readmission.
- *Basic nutrition and cooking.* Nutrition is another challenge for elderly patients. This is particularly true for many Hispanic patients who are used to their traditional cuisine, which can often be have high amounts of sugar, fats and calories. As they get older and more frail, they may choose to skip meals, not cook as often or rely on pre-packaged, pre-cooked meals they can heat up. These often are heavy on sodium and preservatives and low on fresh fruits and vegetables. Additionally, some medications must be taken with food. With a few nutrition/cooking lessons, attendants can cook or even teach patients to cook healthy, nutritious meals.
- *Medication prompting.* Attendants can help patients manage their medications. While some patients have either a spouse or children who might be able to help them manage their medications routine, in some cases the spouse may also have health problems or the children may not be consistent in checking in on their parents. Attendants can remind the patient on the importance of taking all of their medications on time as prescribed by their doctor. According to the National Institutes of Health, among patients with chronic illness, approximately 50% do not take medications as prescribed. Nearly 50% of people taking a chronic medication stop taking it in the first year, with the biggest drop-off occurring in the first month. In a recent poll of U.S. individuals 65 years old and older who use medications, researchers found that 51% take at least five different prescription drugs regularly, and one in four take between 10 and 19 pills each day. Among those using five or more medications, 63% say they forget doses, compared to 51% among those who take fewer medicines. This poor adherence to medication leads to increased morbidity and death and is estimated to incur costs of approximately $100 billion per year. The failure to keep up with medication can also lead to increased re-hospitalizations.
- *Mobility and activity.* While attendants already help patients maintain their level of physical activity and mobility by encouraging and helping

them take walks and moving around on a routine basis, they can be trained to monitor how well they move and may be able to alert medical personnel to problems with mobility. This extra focus on mobility may help with diabetes management.

- *Other issues.* The curriculum may identify other critical knowledge areas that would be helpful in keeping patients out of the hospital. The project will look at other training programs for similar positions that might be instructive in developing a complete curriculum. The curriculum will also look at how attendants might help in cost reductions.

The training can be done online and through hands-on sessions at the provider agencies' headquarters to ensure full compliance in the training process. The online training will allow the pilot project member agencies to be able to provide consistent training to all the attendants at a low cost. The training can easily be provided in English and Spanish.

Part of the training will be to emphasize what a critical role they can play. It is important that attendants feel truly invested and valued in their work. They need to be acknowledged, recognized and rewarded for their efforts. Providing training that will make them more valued workers and possibly command higher pay will go a long way toward helping them feel invested in their work.

It is also important that the attendants understand that the added training – and possible increased pay – will be tied to specific performance measures. These performance measures will be tied to some of the HEDIS measures. In doing so, this will allow the project to better correlate how the training impacts patient health outcomes and reductions in re-hospitalizations.

Google, one the most data-driven organizations in the world, did extensive research on the dynamics that result in successful teams. Surprisingly, it really did not matter who was on the team. Among the five key dynamics, they identified the main element as psychological safety: can team members take risks in the team environment without feeling insecure or embarrassed? The added training attendants will receive will empower them to be a voice for patients, helping the entire home care program be more successful, particularly in avoiding hospital re-admissions.

The added training will also help attendants be aware of the metrics they will be rated on. As explained in more detail in the evaluation section, performance metrics will be critical in determining the effectiveness of the pilot project.

<u>Increased supervision/compliance</u>

Provider agencies are not reimbursed directly for supervision, particularly for visits and follow-ups at patients' homes. Generally, provider agencies do a home visit upon initial registration of a new patient and when complaints are reported. The MCOs also provided limited supervision as well.

The provider agencies in the pilot project will schedule home visits at least quarterly to confer with the patient on the services being provided, both scheduled and unscheduled. Unannounced visits will also be done when the attendant is scheduled to be at the patient's home. They will be observed as they do their work to ensure that they are completing all of their assignments.

Active compliance on collusion and fraud information

As new patients are signed up, they will be informed of the seriousness of collusion and fraud on the part of patients, attendants and other provider agency staff. The information will include common fraud issues (operating the EVV devices on behalf of the attendant, asking/accepting kick-backs or other tangible goods, etc.). They will be reminded of the penalties and asked to sign a form acknowledging that they were informed of the regulations and consequences. This information is important for patients to know so that they do not inadvertently get involved in fraudulent activities. The information can also be shared with family members so they can be aware of potentially troublesome activities on the part of attendants or other provider agency staff. They will receive information about how and where to report suspicious activity.

As part of their hiring and ongoing training, attendants and other provider agency staff will similarly be made aware of the seriousness of collusion and fraud. Likewise, they will be reminded of the penalties and asked to sign a form acknowledging that they were informed of the regulations and consequences. This information is important for attendants to know so that they do not inadvertently get involved in fraudulent activities. They will also receive information about how and where to report suspicious activity. All of this information will be reinforced at regular intervals, including during training sessions and included in their pay envelopes, email or by text messages.

As part of their hiring process, newly hired attendants will have to go through added review of previous employment as attendants. Pilot project provider agencies will request data from the MCOs to identify repeated transfers by attendants to different provider agencies. For example, if they have worked as attendants elsewhere, recommendations from those previous employers to help identify any potential attendants who have frequently changed employers, which may point to stability issues and problems with performance.

Once hired as an attendant with one of the provider agencies in the pilot project, attendants may switch employers only to those participating in the pilot project if they wish to continue to work with this state program. This is done to maintain data integrity as the metrics to be tracked as part of the pilot program will be related to the training attendants receive. It would also be unfair for the agencies to provide the training only to have the attendant leave for employment with another agency not a part of the pilot project.

The project will also develop a set of uniform personnel policies and procedures that will be used by all the provider agencies in the project. The policy handbook will outline all the potential violations (EVV violations, patient transfers, etc.) and the consequences. Violations will be documented and reported to the MCOs and the OIG in certain cases. The project will develop a "report card" for each attendant that keeps track their performance, including EVV compliance,

More importantly, by limiting attendants to work within the project group, this effectively eliminates the ability of attendants to avoid threatening to take patients to another provider agency to avoid disciplinary actions.

Attendant Registry.

The Office of the Inspector General of the U. S. Department of Health and Human Services, which oversees the Medicaid program, has repeatedly recommended that the state programs "enroll or register all PCS attendants and assign them unique numbers." This would allow the state to track performance linked to patient health outcomes and help in weeding out those attendants who are not meeting standards even after progressive work improvement efforts have been made. This has not been done by the state of Texas, but this project will implement a registry within the pilot project provider agencies. The project will work with the MCOs to implement the registry.

Improvements to the Electronic Visit Verification (EVV) system

The existing EVV devices and system are not difficult to circumvent. As noted earlier, the devices are small and are easily removed from the home and attendants can check in at their scheduled times when they do not provide services or register more hours than actually worked. Sometimes, patients check in for the attendant. This sometimes happens because the patient is doing the attendant a favor, is in collusion with the attendant or is being intimidated by the attendant.

The pilot project will meet with the developers of the current technology to explore various options. The discussions will explore new ideas and concepts. This could be addressed in a number of ways. The devices could be better secured so that they cannot be removed from the home. A GPS component could be added that would sync with the device to assure that the attendant is on the premises. A thumb print scan component could also be used to avoid having the patient check in for the attendant. The goal would be to help the manufacturers and the state develop a better system through the discussions.

Increased coordination of care

Case management is most effective when it is closest to the patient. This will start when a patient is assigned to a provider agency with an effective "hand-off" (providing all the relevant records and information on the patient to the provider agency) whether it comes from the patient's doctor, the hospital, the MCO or when being transferred from another provider agency. While the MCOs have case managers, their workload is such that they do little more than phone calls as case management. The pilot project will establish a workable protocol that allows for greater interaction between provider agencies, MCOs, hospital, doctors, nurses and other health care providers. This will be help to address potential problems and underlying issues that need to be monitored by nurses and/or case workers. This patient-centered case management approach will seek to stem hospital re-admissions. This pilot project will seek to implement a more community-based health care model through the patient-centered case management.

Patient pool size

In order for the pilot project to provide viable data and analysis, it must include a statistically significant number of patients to work with. In the target area (TX HHSC Region 11), there are approximately 85,000 patients receiving attendant services. A reasonable number of patients to be include would be between 15,000-20,000 (15-20%). This would provide a confidence level of 99% and a margin of error within 1% for data analysis and evaluation. The provider agencies currently part of this proposal have approximately 10,000 patients. The target numbers would not be achieved immediately, but would be added over the course of the pilot program. This could be achieved by including those patients who are newly provided services, patients seeking a transfer to another agency and patients left without services when provider agencies are closed or prevented from participating in the program.

Once receiving services from one of the provider agencies participating in the pilot project, a patient will be limited to switching agencies within the pilot project. In this way, they will still have a choice in high quality service providers, and data integrity will be maintained. This will also ensure that patient care is properly followed and addressed.

Attendant training reimbursement

The provider agencies will request an administrative fee to cover the training portion of the project. Increases will be tied to training improved, trackable performance measures rather than across the board pay increases for attendants. Pay increases will be earned by improved performance. Additionally, the provider agencies will work to develop a set of incentives and recognition to motivate attendants to complete trainings and improve their work performance and morale. For example, quarterly evaluations may be used to recognize employee achievements through awards, gift cards, meals, or other

prizes. These pay increases and incentives are critical in attracting quality employees. Attendants will be paid to attend the training sessions on a quarterly basis.

Agency compliance and fraud prevention

While much of the attention on fraud, waste and abuse has been focused on attendants, provider agencies need to be more active in detecting and eliminating fraud, waste and abuse. They should be the front line in this area, along with the MCOs. There are a number of areas where the provider agencies in this pilot project have already started to make effective changes.

The state already requires a fraud prevention compliance plan for each provider agency. The seven pilot project members will work with the MCOs, HHSC and the Texas Office of the Inspector General to find ways to improve fraud prevention measures. The provider agencies in the pilot project will work with the Texas OIG and the Texas Health and Human Services Commission to improve their internal controls and self-reporting. This will include agency-wide training on fraud, waste and abuse. The pilot project will also look at best practices in other sectors that would be used to address these issues. All seven are members of the Texas OIG's Integrity Initiative, which seeks to go beyond what most provider agencies are currently doing. The group will seek to work with an independent agency to certify their new procedures and efforts.

The group members have already initiated are increased training for all staff on anti-fraud policies and procedures, more stringent review of attendant EVV log-ins, unannounced worksite visits, regular telephone check-ins with clients, increased policing of marketing/outreach efforts, greater review of attendant applicants, and audits of various segments of the company's operations on a routine and unscheduled basis.

The pilot project members will work with the MCOs to find ways where the MCOs can be more proactive in detecting and eliminating fraud. This might include more stringent review when clients request a transfer, development of a ranking system for provider agencies, greater scrutiny for provider agencies to ensure that they are meeting minimum requirements, and other options.

PROJECT IMPLEMENTATION

The pilot project will be implemented over a four-year period. The major project components will include: design review, programmatic operations, coordination, research/evaluation, and program closeout. While majority of the work will be done by the individual provider agencies, there will be a need for some central coordination (training, coordinating with MCOs, audits, coordinating the research component, etc.), which will be subcontracted to maintain costs as low as possible.

The design review component involves meeting with various stakeholders (funders, MCOs, HHSC staff, researchers, and others) to finalize the project design into a manageable project that will provide useable data and viable recommendations for improvements to the health care systems.

Programmatic operations refers to the elements described above in the Project Design section above. This includes implementing the training program and the other components.

Coordination is crucial because the pilot project members will work with different stakeholders in the healthcare system (legislators, HHSC staff, MCO representatives, and others) to determine how these other changes can be implemented. This may include advocating for the required changes through legislative or regulatory changes. This would also include developing a dialogue process where stakeholders can work toward consensus on the suggested changes.

Research/evaluation will be subcontracted to an outside group, preferably a university group. The researchers will help the project determine what data points and metrics will be needed and how that information will be captured. They will also provide feedback at different points when possible to help the project adjust as needed. The focus of the research component will be on correlating the changes implemented by the pilot project with patient health outcomes and expected reductions in hospital admissions/re-admissions. This will be compared to the same metrics among those patients not a part of the pilot project. The researchers will provide a final report with analysis and recommendations.

Program closeout will focus on terminating the project, final project reports and any financial closeout procedures. Final reports, research results and other information will be shared with the pilot project provider agencies, MCOs, HHSC staff and legislators. The final project report will also be shared with other stakeholders, including the media, where applicable.

PROJECT COSTS

The pilot project will seek funding for some elements, including the administration, increased attendant pay, training and research components. The long-term costs (increased supervision, increased health care coordination, agency improvement, etc.) will be borne by the provider agencies in the pilot project. The costs will be recouped from expected costs savings to the state's program. As the program currently operates, the MCOs receive a flat reimbursement for each patient to cover all their related health care costs. If the program can determine that it can reduce costs through reduced hospital admissions and re-admissions, the provider agencies in the pilot program will receive half of the cost savings with the MCOs. As a part of the design review, the MCOs and provider agencies will determine ahead of time which metric will be used to determine how the cost savings will be calculated.

RESEARCH COMPONENT

The project will rely on an external group to implement the research and evaluation component. These are necessary to ensuring that the project achieves its goals and that the results are documented. The validity of the various proposals needs to be verified through a rigorous data analysis. In order to do this, the project will contract with an independent health research organization, such as a university program, to conduct the evaluation and research work.

The evaluation will focus on documenting the pilot project implementation of its specific objectives and milestones. The specific elements to be considered as part of the evaluation will be developed in conjunction with the various stakeholders to ensure that all their respective concerns and issues will be addressed through the evaluation. It will also help in determining the progress, success, and effectiveness of the pilot project.

The evaluation process will be an ongoing effort because it will be for a four-year project. This ongoing process will help in adjusting the project as needed before any problems become obstacles.

The research element will focus on the patient outcomes connected to this project. This will target some of the HEDIS (Healthcare Effectiveness Data and Information Set) performance measures in the managed care industry. HEDIS is also used by Medicaid as part of its billing and data collection process. The HEDIS measures focus on specific patient diagnoses. In this way, the project will connect outcomes to specific patient diagnoses. The specific elements of the research component will be worked out as part of a request for proposals for the research work.

ATTACHMENT 1

RECOMMENDATIONS

While the pilot project will test several elements, other changes can be made to the operation of the state's programs as a whole. Some of these may require changes in state policies or even legislation while others may simply require increased enforcement. While the project will explore others ways to improve the industry, some changes can be made in the short term.

- *Limiting patient transfers.* Patients have a right to transfer from one provider agency or to request a different attendant for just cause (poor service from the provider agency, attendant does not complete job duties, theft, intimidation, abuse, etc.). However, frequent changes can be a signal that there may be some underlying issues to consider. Also, some requests for changes may be driven by the attendant (see next point). In some cases, the patient demands services they do not qualify for, sexually harass attendants, or demands kick-backs from the attendants. In such cases, an attendant may lose their job because of a patient's fraudulent behavior. Frequent changes may lead to an interruption in critical health care services and coordination. These frequent changes also drive up costs for the provider agencies, the MCOs and the state. By limiting a patient's ability to change provider agencies, this would help to prevent fraud and lead to long-term cost savings. The limitations can be put in place by the state, such as no more than two changes per calendar year. The provider agencies and MCOs should implement a review process to determine if there are underlying issues that need to be addressed. These types of reviews and onsite visits would reinforce that serious problems with poor service or abuse will be resolved quickly and that fraudulent activities will not be tolerated.
- *Limiting attendant employment changes.* Attendants have the option to change employers at any time. However, when they do so for personal gain at the expense of the patient, this hurts the health care system. For example, as pointed out earlier, there a number of reasons why an attendant might change employers: better pay, more hours, or a work site that is closer to their home. There are also some more troubling reasons why they might change: their current employer has tried to discipline them for cause, their current employer has demanded they do the work they were assigned, etc. In such cases, the attendant may convince or intimidate the patient to transfer to another provider agency to avoid the consequences of their poor work record. In other cases, another provider agency may offer the attendant a slightly higher pay (even just $0.25 more per hour) if – *and only if* – they can convince the patient to transfer to that other agency. In some cases, a representative from the provider agency will approach the patient directly to entice them to transfer to that other agency, saying that it will benefit the attendant

or offering an incentive (cash, cash card or other incentive). In order to prevent this type of fraud, it should be required that an attendant and a patient cannot move to the same agency. The paired movement opens too many opportunities for bad employees to easily avoid enforcement, consequences and fraud detection. If a patient or attendant sincerely believes that the current provider agency is not suited to them, they can easily move without negative consequences while still providing the needed services for patients. Preventing the paired movement would essentially eliminate this type of fraud and waste.

- *Attendant registry.* Attendants currently are subject to background checks. That certainly eliminates many potentially dangerous employees. There is a "do not hire" list of attendants who have been banned for fraud, abuse and other serious issues. However, the registry should also keep track of how often an attendant changes from one agency to another. This type of metric should encourage provider agencies to carefully review the applicant. It might be worth considering whether an attendant should be added to the "do not hire" list if they move frequently, particularly if they have a history to transferring patients.
- *EVV compliance.* It has become common knowledge within the industry and the state agencies that there are some provider agencies that have not implemented the EVV system at all. In some cases, they are using paper records to track attendant hours. This makes fraud far too easy. Additionally, some attendants have convinced their patients to transfer to these types of provider agencies because it means less accountability for the attendant. In order to root out fraud and waste, the EVV system must be used by all provider agencies. There has been more than enough time for them to implement the systems. If a provider agency does not implement the EVV system, it should be barred from participating in the program. There is no reason to delay this critical feature as continued delays threaten patient health and encourage fraud, waste and abuse.
- *Poaching of patients.* As pointed out in an earlier section, there continues to be a serious abuse of anti-solicitation and kick-back laws. Some home care agencies publicize higher wage rates for home care attendants. However, when a person applies, they are told that there are no current openings at the higher rate, unless they can convince their client to transfer to the new agency or if they can find a client to sign up with their agency. This seems to be a violation of "bait and switch" provisions in the program rules and state law, including false, misleading or deceptive advertising, and/or advertising not readily subject to verification. Some agencies do door-to-door community outreach of clients, which in itself is not a problem. However, when dealing directly with clients, they may inform the potential client that their son, daughter or other relative could be hired as an attendant if they sign up with or transfer to the agency. This would also seem to be a violation of the anti-kick-back provisions as well as the state's anti-solicitation laws. There

needs to be a more stringent review of patient transfers to ensure that these rules are not being violated.

- *More aggressive enforcement.* The State of Texas, through the OIG and the HHSC, has estimated that the continuing fraud, waste and abuse is costing the state hundreds of millions of dollars in tax payer funds every year. More importantly, it has led to patient abuse and severe, negative health outcomes for the patients. As much as the provider agencies in the pilot project seek to implement ways for the industry to police itself, more aggressive law enforcement actions need to take place. As in any industry, word gets around quickly when law enforcement starts investigating. Members of the pilot project have reported fraud on a number of occasions but little if anything has come of it. Even if it is just a series of random visits with attendants and provider agencies to make general inquiries and audits, this would go a long way toward letting the bad actors know that they are being watched. Additionally, the MCOs and the state need to work at eliminating the bottom performing provider agencies.
- *Stricter provider agency standards.* As mentioned previously, the members of the pilot project are already moving toward higher standards of operation (Joint Commission accreditation). However, the current quality standards for provider agencies are not geared toward constant service improvement. It is also not outcome-based. Neither the provider agencies nor the attendants are measured on patients' health outcomes or customer satisfaction. This can be done either by the HHSC or MCOs. The patient health outcomes database already exists and can easily be correlated to both attendants and provider agencies. The quality standards do not necessarily have to be up to Joint Commission levels, but they can certainly be more challenging standards. This could be turned into a rating system that would help patients select service providers. It could also serve as a way for force provider agencies to improve their operations or be barred from the program. The improved standards would also help in preventing fraud, waste and abuse.

ATTACHMENT 2

Concept Paper: Home Nutrition Service

This concept paper provides a brief exploration of a service to provide nutritious meals to low-income elderly. It does not provide a detailed discussion of all of the potential issues and alternatives but serves merely to introduce the concept and some of its potential benefits.

Failure To Thrive (FTT) is mostly used to describe problems with babies whose physical development is not progressing as normally expected. According the Johns Hopkins School of Medicine website, "Failure to thrive is defined as decelerated or arrested physical growth (height and weight measurements fall below the third or fifth percentile, or a downward change in growth across two major growth percentiles) and is associated with abnormal growth and development. The reason for failure to thrive is inadequate nutrition." In pediatric cases, there may be other underlying causes.

However, more recently, FFT has also been applied to the elderly whose weight fluctuates because of poor nutrition or malnutrition.

The causes of malnutrition might seem straightforward — too little food or a diet lacking in nutrients. In reality, though, malnutrition is often caused by a combination of physical, social and psychological issues. For example:

- Health concerns. Older adults often have health problems, such as dementia or dental issues, that can lead to decreased appetite or trouble eating. Other factors that might play a role include a chronic illness, use of certain medications, difficulty swallowing or absorbing nutrients, a recent hospitalization, or a diminished sense of taste or smell.
- Medications. Multiple medications may dull or exacerbate their hunger, leading to fluctuating eating cycles.
- Restricted diets. Dietary restrictions — such as limits on salt, fat, protein or sugar — can help manage certain medical conditions, but might also contribute to inadequate eating.
- Limited income. Some older adults might have trouble affording groceries, especially if they're taking expensive medications. They might also not have easy access to nutritious foods (food deserts), including fresh fruits and vegetables.
- Reduced social contact. Older adults who eat alone might not enjoy meals as before, causing them to lose interest in cooking and eating.

- Depression. Grief, loneliness, failing health, lack of mobility and other factors might contribute to depression — causing loss of appetite.
- Physical Limitations. They may be unable to cook because their eyesight and mobility are limited and rely on microwaveable and highly processed foods rich in sugars, salt and unhealthy fats. Their mobility issues may also force them to skip meals.
- Traditional Foods. They rely on traditional foods they are used to, which may also include high amounts of sugars, salt and unhealthy fats and may not know to cook nutritious meals to properly address their own medical conditions (diabetes, high cholesterol, etc.).

Malnutrition in older adults can lead to various health concerns, including:

- A weak immune system, which increases the risk of infections
- Poor wound healing
- Missing medication doses if they are to be taken with food
- Muscle weakness, which can lead to falls and fractures
- Overall sense of unwellness

Malnutrition can also lead to:

- Increased doctor's office visits
- Increased hospitalizations
- Increased need for home visits and home care
- Increased costs for the health care system

While there is no easy or comprehensive way to address adult nutrition. However, one approach might serve to mitigate some of those issues. A home meals service that provides a variety of options:

- Pre-packaged, pre-portioned ingredient packs for a one- or two-person meal with simple cooking instructions
- Pre-cooked single- or double-portioned meals for reheating or microwaveable

The service would focus on nutritious meals produced locally without preservatives. It would also strive to provide meals fitting local tastes and utilizing traditional flavors as much as possible to make the meals more attractive and palatable to the elderly, who are often wary of new or different foods.

By providing these meals, the service would seek to address some of the malnutrition issues impacting the elderly. The service would also cut food waste.

The service would target the most vulnerable: the frail, low-income elderly. However, it would be open to anyone, elderly or otherwise, in need of such

services. This would be a fee-for-meals/food program that could be paid by SNAP and other benefits programs. Others would be charged.

In order to keep the program viable, a commercial side could be developed that would be available to anyone. This would be modeled along the line of commercial home meals delivery services such as Blue Apron, which provides pre-portioned ingredient packs with cooking instructions. This might provide for larger family-sized portions or daily ready-cooked meals for pick up. This would be a service targeting young adults, young families and professionals with limited time for cooking.

This venture would require a commercial kitchen, delivery vehicles and appropriate staff. There are potential partnerships with other organizations, including hospitals (already have existing commercial kitchen capacity), catering companies (commercial kitchens), home health agencies, primary care providers, adult day care centers, and others. The health care entities would help in identifying those elderly who may benefit from the service and share information about the service with the patients and their family.

Again, this concept paper does not aim to address all of the issues and serves only as a starting point for a discussion. There may be fatal flaws not yet seen.

ATTACHMENT 3

This attachment is a copy of the OIG's recent report on some of the more serious problems within the Medicaid program.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

OCT - 3 2016

TO: Vikki Wachino
Deputy Administrator and Director
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services

FROM: Gary Cantrell
Deputy Inspector General for Investigations

SUBJECT: Investigative Advisory on Medicaid Fraud and Patient Harm Involving Personal Care Services

The Office of Inspector General's (OIG) extensive body of work examining Medicaid personal care services (PCS) has found significant and persistent compliance, payment, and fraud vulnerabilities. With Medicaid growing rapidly[1] and individuals increasingly receiving care in their communities rather than in institutional settings, effective administration of PCS takes on heightened urgency. OIG continues to recommend that the Centers for Medicare & Medicaid Services (CMS) more fully and effectively use its authorities to improve oversight and monitoring of PCS programs across all States. OIG believes that if CMS issues regulations consistent with our recommendations, it will be better able to prevent and detect improper payments, facilitate enforcement efforts, and reduce the risk of beneficiaries being exposed to substandard or otherwise harmful care. This investigative advisory highlights several of the most significant program vulnerabilities related to PCS that OIG continues to encounter during the course of Federal investigations.

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[1] Medicaid is the largest health care program in the United States, with approximately 73 million individuals enrolled as of July 2016. Centers for Medicare & Medicaid Services (CMS), Department of Health & Human Services, *Medicaid & CHIP: July 2016 Monthly Applications, Eligibility Determinations and Enrollment Report*, September 27, 2016. Accessed at https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/july-2016-enrollment-report.pdf on September 27, 2016. It represents one-sixth of the national health care economy, and from 2015 through 2024, Medicaid expenditures are projected to increase at an average annual rate of 6.4 percent and to reach $920.5 billion by 2024. CMS, Department of Health & Human Services, *2015 Actuarial Report on the Financial Outlook for Medicaid*, July 2016. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2015.pdf on August 26, 2016.

Background

Personal care services provide nonmedical assistance to the elderly, people with disabilities, and individuals with chronic or temporary conditions so that they can remain in their homes and communities. Typically, an attendant provides PCS. In many States, PCS attendants work for personal care agencies, which are enrolled in the Medicaid program and bill for services on the attendants' behalf. States are required to develop qualifications or requirements for attendants to ensure quality of care. PCS is an optional Medicaid benefit that States may choose to provide under State plan options and/or through Medicaid waiver and demonstration authorities approved by CMS.

PCS has continued to grow since a United States Supreme Court case, Olmstead v. L.C., 527 U.S. 581, in 1999, held that unjustified institutionalization of people with disabilities is a violation of the Americans with Disabilities Act.[2] The Department of Health and Human Services has promoted States' efforts to provide Medicaid beneficiaries who are elderly or have disabilities with the choice of remaining in their homes and communities, as opposed to moving to nursing homes or other institutional care options.

OIG has issued numerous reports highlighting vulnerabilities in PCS that are believed to have contributed to high improper payments, questionable care quality, and high amounts of fraud. Notably, these include a 2012 Portfolio report that made recommendations to CMS based on nearly a decade's worth of OIG work related to Medicaid PCS.[3] OIG is concerned that State PCS programs will remain susceptible to fraud unless CMS takes preventive, nationwide action to address systemic vulnerabilities.

Investigative Advisory

This investigative advisory[4] summarizes fraud schemes in Federal investigations involving PCS from November 2012 through August 2016.[5] The fraud schemes identified in this advisory build on those outlined in the 2012 PCS Portfolio report that OIG issued to CMS. The Portfolio provided recommendations to improve program vulnerabilities detected in more than two dozen previously published audits and evaluations and hundreds of completed investigations. OIG believes that, if CMS implements the basic recommendations identified in the Portfolio,

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[2] As Medicaid grows, recent data also suggest rapid growth in PCS. 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, much faster than the average for all occupations. This increase will be due, in part, to the fact that as the baby boom population ages, the number of beneficiaries requiring PCS will increase.

[3] *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement* (PCS Portfolio or Portfolio), OIG-12-12 (Nov. 15, 2012), available at https://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf.

[4] The *Quality Standards for Investigations,* issued by the Council of the Inspectors General on Integrity and Efficiency, state that "[s]ystemic weaknesses or management problems disclosed in an investigation should be reported to agency officials as soon as practicable." Accordingly, OIG's Office of Investigations is providing you with this investigative advisory containing details on recent PCS cases involving patient harm.

[5] CMS provided technical comments to this advisory, which we addressed, as appropriate. OIG is providing CMS with additional information regarding the cases discussed in this investigative advisory.

including establishing minimum Federal qualifications and screening standards for PCS workers, CMS would help to prevent and quickly detect instances of fraud and patient harm and neglect. These recommendations further CMS's goal of reducing "pay and chase" activities.

This investigative advisory is part of new work that OIG is conducting to examine vulnerabilities in the PCS program related to billing, payment, fraud, and patient safety. OIG's ongoing work will include a survey of State Medicaid Fraud Control Units (MFCUs) about fraud trends in the PCS program, the results of which OIG will summarize in a data brief expected to be released in the spring of 2017. These products are intended to provide CMS and States with information to help improve program integrity.

Since the OIG Portfolio report was issued in 2012, OIG has opened more than 200 investigations involving fraud and patient harm and neglect in the PCS program across the country. Although this advisory does not capture the trends observed by State MFCUs, MFCUs report PCS as a top fraud concern. Moreover, OIG regularly partners with State MFCUs to combat Medicaid fraud, including PCS fraud. For example, OIG works in Strike Forces consisting of law enforcement partners, including MFCUs, to target law enforcement efforts. In June 2016, OIG participated in a National Health Care Fraud Takedown, and, as part of this effort, partnered with 24 MFCU offices on Medicaid fraud issues, including PCS. This effort resulted in the charging of 17 suspects for alleged PCS fraud. Previously, in the June 2015 National Health Care Fraud Takedown, PCS fraud was one of three key areas of focus, and OIG, in partnership with the MFCUs, charged 11 suspects for alleged PCS fraud. Given the significant vulnerabilities in the PCS program, including a lack of internal controls, and that PCS fraud continues to be a persistent problem, OIG anticipates that its enforcement efforts will continue to involve PCS cases.

PCS Fraud Schemes

Cases investigated by OIG 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 that these attendants claim to serve. From OIG's experience, PCS providers, including agencies and individual attendants, have commonly used aggressive tactics when recruiting Medicaid beneficiaries to participate in PCS fraud schemes. Likewise, OIG has observed Medicaid beneficiaries voluntarily participating in such schemes.

PCS fraud is often difficult to detect by reviewing documentation alone. Often fraud involves showing that PCS attendants and providers submitted false documentation of activities. At present, most fraud cases involving PCS come to the attention of law enforcement only through referrals from individuals who know the people committing the acts. However, if the availability and quality of PCS data were improved, States, CMS, and OIG could analyze the data to identify and follow up on aberrancies and questionable billing patterns. For example, PCS attendants and agencies that commit fraud often bill for impossibly or improbably large volumes of services; for services that conflict with one another (e.g., an attendant purports to provide many hours of services to multiple beneficiaries on the same dates); or for services that could not have been

performed as claimed because of geographical distances between beneficiaries purportedly served by the same attendant on the same day. Also, many States do not enroll, register, or identify attendants on claims submitted for payment. If claims contained more specific details, including the exact dates of service and the identity of the attendants, such irregular billings could be more easily and systematically discovered through claims analysis by State program integrity units.

The following cases illustrate instances of PCS fraud:

> An investigation in Washington revealed that two PCS attendants billed a State waiver program for visits that were not made for the same beneficiary. The caregivers persuaded the beneficiary to sign blank time sheets and submitted claims for periods when the beneficiary was out of the country.[6]
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> An investigation in Alaska involved the criminal prosecution of more than 40 individuals associated with a PCS agency that maintained a provider agreement with the Alaska Medical Assistance Program. The owner of the agency admitted that the company committed fraud in multiple ways. For example, the owner knowingly authorized employees to submit false time sheets for services not provided to Medicaid recipients. The agency also billed Alaska Medicaid for services provided by employees who were not legally authorized to bill Alaska Medicaid.[7]
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> A PCS attendant in Illinois submitted claims seeking more than $34,000 for services that she did not provide to the beneficiary. The caregiver was an employee of an agency that provides PCS and received payment for over a year despite having been excluded from all Federal health care programs. The attendant had been excluded as a result of her nursing license being suspended for allegedly diverting controlled substances from her employer. The caregiver claimed to have provided care while she was on vacation in the Caribbean and Central America.[8]
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> A PCS attendant in Missouri submitted claims for providing care to four beneficiaries simultaneously while working a full-time job. The attendant was paid for services that were not rendered. Her time sheets for more than 130 days in 2013 indicated that she was in two places at the same time.[9]

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[6] Settlement information on this case may be found at: Washington State Office of the Attorney General, *Bellevue women settle allegations of roughly $4K in Medicaid theft,* July 10, 2013. Accessed at http://www.atg.wa.gov/news/news-releases/bellevue-women-settle-allegations-roughly-4k-medicaid-theft on August 26, 2016.

[7] Settlement information on the case against the owner of the PCS agency may be found at: Jerzy Shedlock, "Home health care service owner gets 3 years for Medicaid fraud," *Anchorage Dispatch News*, December 11, 2015. Accessed at http://www.adn.com/crime-justice/article/good-faith-services-owner-gets-3-years-medicaid-fraud/2015/12/12/ on August 26, 2016.

[8] Settlement information on this case may be found at: U.S. Department of Justice (DOJ), *O'Fallon Woman Sentenced for Healthcare Fraud.* Accessed at https://www.justice.gov/usao-sdil/pr/ofallon-woman-sentenced-healthcare-fraud on August 26, 2016.

[9] Currently, settlement information does not appear to be publicly available for this case.

A PCS attendant in Virginia billed Medicaid for care not provided, including 20 hours of respite care per week over a 2-month period. The respite care was for time supposedly spent accompanying the beneficiary to doctors' appointments. The number of hours billed by the attendant approached the annual billing limit for respite care. The attendant never accompanied the beneficiary to a doctor's appointment. The PCS attendant was able to claim these hours by having the beneficiary sign blank time sheets.[10]

PCS Attendants and Patient Harm

In addition to the financial loss associated with PCS fraud, investigations have also revealed concerning incidents of patient harm. Some of OIG's cases have involved the abuse or neglect of beneficiaries by PCS attendants that have resulted in deaths, hospitalizations, and less severe degrees of patient harm. Other cases have involved attendants caring for beneficiaries while impaired, sometimes by drugs that had been prescribed to beneficiaries in their care. Often vulnerable beneficiaries are unable to report the abuse and neglect because of limited communication skills or are reluctant to report attendants on whom they feel dependent. Moreover, most attendants deliver care on a daily basis without supervision from other providers, which causes beneficiaries to be primarily responsible for monitoring the delivery of care. In some instances, Medicaid beneficiaries receiving PCS may have physical or cognitive impairments such that it may be difficult for them to closely supervise or monitor their attendants.

The cases below heighten OIG's concern that CMS and the States do not have sufficient controls for individuals entering beneficiary homes to provide Medicaid-funded services:

A beneficiary in Pennsylvania died of exposure to the cold while under the care of a PCS attendant who provided inadequate supervision. The beneficiary had a pervasive developmental disorder and a history of running away. The beneficiary's plan of care called for one-on-one supervision. For an unexplained reason, the attendant took the beneficiary shopping in downtown Philadelphia. The attendant lost sight of the beneficiary in a crowded department store and then waited an hour to call authorities.[11]

A beneficiary in Idaho suffered from severe dehydration and malnourishment and was hospitalized after her son, who was employed as his mother's PCS attendant, neglected her care. The hospital medical staff contacted Adult Protection Services because they suspected the beneficiary was a victim of abuse and/or neglect. While serving a search

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[10] Settlement information on this case may be found at: Nancy Drury Duncan, *Va. woman gets 3 months for Medicaid fraud*. Accessed at http://www.delmarvanow.com/story/news/local/virginia/2016/01/08/medicaid-fraud/78510618/ on August 26, 2016.

[11] Settlement information on this case may be found at: Joseph Slobodzian, "Caretaker pleads guilty in death of autistic woman," *The Philadelphia Inquirer*, November 20, 2015. Accessed at http://articles.philly.com/2015-11-20/news/68416188_1_pagano-christina-sankey-casmir-care-services on August 26, 2016.

warrant at the home shared by the mother and son, investigators found the home filthy with drug paraphernalia, trash, and dog feces among the piles of clutter.[12]

On a sunny and hot July day, a PCS attendant in Maryland left a beneficiary with developmental disabilities in a locked car while shopping with a companion. The beneficiary was not supposed to be left unsupervised at any time. Police responded to the call of a concerned citizen who noticed that the beneficiary was in distress.[13]

OIG investigations have also revealed PCS providers who commit fraud and subject beneficiaries to harm. The following cases illustrate instances in which fraud was accompanied by patient harm:

In Illinois, a concerned neighbor who had been unable to reach a beneficiary for days found the beneficiary in an incoherent state, covered in dried excrement. The investigation revealed that the PCS attendant had not seen the beneficiary, her mother, for a week before the incident. The attendant had also submitted claims to the Illinois Home Services Program for unallowable payments for visits that were not made and for times when the beneficiary was hospitalized.[14]

A PCS attendant in Vermont submitted claims for 456 hours of services that were not provided as part of the Choices for Care Medicaid program. The attendant allegedly had an arrangement with the patient's wife to evenly split the payments for services. The attendant was also allegedly compensated by the wife using the patient's prescription opioid painkillers despite the patient appearing to be in significant discomfort and the attendant being on probation for drug possession. The attendant was eventually fired by the patient's wife because of her drug use.[15]

OIG and CMS have been discussing administrative actions that CMS can take to address vulnerabilities in the PCS program, including issuance of an informational bulletin to States that outlines steps they can take to improve internal controls for PCS. These discussions have included policy options that would respect and protect patient preferences, as appropriate. Issuance of an informational bulletin would be a partial first step in improving the integrity of the Medicaid PCS program in the near term.

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[12] Settlement information on this case may be found at: State of Idaho Office of the Attorney General, *Draine sentenced for Abuse, Neglect, and Medicaid Fraud*, April 3, 2014. Accessed at http://www.ag.idaho.gov/media/newsReleases/2014/nr_04032014.html on August 26, 2016.

[13] Settlement information on this case may be found at: Maryland Attorney General, *Catonsville Woman Pleads Guilty to Neglect of Disabled Adult,* July 15, 2014. Accessed at https://www.oag.state.md.us/Press/2014/071514.html on August 26, 2016.

[14] Settlement information on this case may be found at: DOJ, *Granite City Woman Sentenced For Healthcare Fraud,* February 9, 2016. Accessed at https://www.justice.gov/usao-sdil/pr/granite-city-woman-sentenced-healthcare-fraud on August 26, 2016.

[15] Settlement information on this case may be found at: State of Vermont Office of Attorney General, *Perkinsville Woman Convicted For Falsely Obtaining Monies From The Vermont Medicaid Program*, October 28, 2014. Accessed at http://ago.vermont.gov/focus/news/perkinsville-woman-convicted-for-falsely-obtaining-monies-from-the-vermont-medicaid-program.php on August 26, 2016.

OIG continues to recommend that CMS prevent fraud and patient harm and neglect in Medicaid PCS by implementing the following key unimplemented recommendations from OIG's PCS Portfolio:

- 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 PCS are allowed under program rules and are provided.

OIG believes that CMS needs to take regulatory action to establish safeguards that will prevent fraudulent or abusive providers from enrolling or remaining as PCS attendants and better protect the PCS program from fraud and patient harm and neglect.[16]

[16] We recognize that CMS has issued guidance identifying existing tools for supporting the PCS workforce, issued a 2014 booklet regarding preventing improper payments in PCS, and plans on issuing further guidance to address vulnerabilities in PCS. We look forward to working with CMS as it implements our PCS recommendations.