DEPARTMENT OF HEALTH AND HUMAN SERVICES

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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.