



November 2016

# MEDICAID PERSONAL CARE SERVICES

## CMS Could Do More to Harmonize Requirements across Programs

# GAO Highlights

Highlights of [GAO-17-28](#), a report to congressional requesters

## Why GAO Did This Study

The number of people receiving in-home personal care services—such as assistance with bathing and dressing—from Medicaid is expected to grow. States can offer these services through one or more programs under which home- and community-based services can be provided, each with different federal requirements. The provision of personal care in beneficiaries' homes can pose risks to safety, and these services have a high rate of improper payments, including instances where services for which the state was billed were not provided. In recent years Congress has directed HHS to improve coordination of these programs, which could harmonize requirements—that is, implement a more consistent administration of policies and procedures—and enhance oversight.

GAO was asked to review oversight of Medicaid personal care services. GAO examined: (1) how selected states ensure that beneficiaries receiving services are safe from harm and that billed services are provided; and (2) steps CMS has taken since 2010 to improve oversight and harmonize requirements across programs. GAO reviewed policies in four states with varied programs; reviewed laws, guidance and documents; and interviewed CMS officials.

## What GAO Recommends

GAO recommends that the Acting Administrator of CMS (1) collect and analyze required state reports on personal care services and (2) take steps to further harmonize federal program requirements, as appropriate, across programs providing these services. HHS concurred with both recommendations

View [GAO-17-28](#). For more information, contact Katherine Iritani at (202) 512-7114 or [iritanik@gao.gov](mailto:iritanik@gao.gov).

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### CMS Could Do More to Harmonize Requirements across Programs

#### What GAO Found

Four states that GAO reviewed varied in how they implemented safeguards to protect beneficiaries receiving in-home personal care services from harm and in their methods to help ensure billed services were actually provided. For example, to help keep beneficiaries safe, the four selected states—California, Maryland, Oregon, and Texas—reported that they monitored beneficiaries by having case managers or nurses periodically check in with beneficiaries, but the frequency and means, such as in-person or by phone, varied among the states and in some cases across programs within a state. The four states also reported using different methods to help ensure that billed services were actually provided. For example, to track attendants' work time, two states required beneficiaries to sign paper timesheets for the attendants, and two states used electronic visit verification timekeeping systems for some or all programs.

The Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), has taken several steps to improve oversight of states' personal care service programs and harmonize requirements but has not collected required state reports or addressed significant differences in program requirements. Since 2010, CMS steps to improve oversight of states' programs include enhancing guidance and conducting webinars to help states address improper payments. To manage risk inherent in the provision of these services, and in keeping with statutory direction to improve coordination of these programs, CMS has taken steps to better harmonize requirements across programs including directing states to follow agency guidance issued for one type of program when implementing a similar type of program. However:

- CMS has not systematically collected required states' reports on personal care services provided under two programs, although CMS stated that guidance for states to submit the reports is under development. Collecting these reports could improve oversight by providing CMS and Congress with information on programs' effects on beneficiaries' health and welfare.
- CMS harmonization efforts have not addressed the significant differences across federal program requirements specific to beneficiary safety and ensuring that billed services are provided. Consequently, the safeguards and level of assurance that CMS has regarding states' beneficiary protections and oversight of billed services can vary by program. For example, one reviewed state requires quarterly or biannual beneficiary monitoring for most programs; but one program monitors annually as federal requirements do not require more frequent monitoring. Similarly, requirements to help ensure billed services are actually provided vary widely among states and programs, contributing to uneven assurances and oversight across programs.

Home- and community-based services, including personal care services, are growing in significance and in demand. A more consistent administration of policies and procedures across programs could help the federal government and states better manage risks to beneficiaries and protect the integrity of the program.

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**Abbreviations**

CMS	Centers for Medicare & Medicaid Services
HCBS	Home- and community-based services
HHS	Department of Health and Human Services
OIG	Office of Inspector General
PCS	Personal care services

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November 23, 2016

The Honorable Thomas R. Carper  
Ranking Member  
Committee on Homeland Security and Governmental Affairs  
United States Senate

The Honorable Fred Upton  
Chairman  
Committee on Energy and Commerce  
House of Representatives

Medicaid, a federal-state health financing program for low-income and medically needy individuals, is the nation's primary payer of long-term care services and supports for people with disabilities and aged individuals. Medicaid spending on long-term care services and supports is significant, representing about one quarter of Medicaid spending annually.<sup>1</sup> The majority of Medicaid long term care spending is for home and community-based services (HCBS)—that is, services and assistance provided to beneficiaries in their homes or communities rather than in institutional settings such as nursing homes. Personal care services (PCS) are a significant component of HCBS. PCS provide assistance to beneficiaries who have limited ability to care for themselves because of physical, developmental, or intellectual disabilities or conditions. These nonmedical services assist beneficiaries with activities of daily living such as bathing, dressing, and toileting. Such assistance can enable people with disabilities and aged beneficiaries to remain in their homes, maintain their independence, and participate in community life to the fullest extent possible. In calendar year 2015, reported federal and state Medicaid expenditures for fee-for-service PCS—those not provided through managed care delivery systems—totaled about \$15 billion. Expenditures associated with PCS provided in managed care delivery systems are

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<sup>1</sup>This amount represents spending on a fee-for-service basis and excludes spending on long-term services and supports provided through managed care organizations. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary, *2015 Actuarial Report on the Financial Outlook for Medicaid* (2015). For the purposes of this report, we consider the District of Columbia a state. When presenting statistics regarding Medicaid, we have attempted to use the most recent and reliable data available; as a result, we present data from different years for different purposes.

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unknown.<sup>2</sup> The demand for PCS is expected to increase as a result of the aging of the nation's population, increased life expectancy, and increased opportunities for aged and individuals with disabilities to live in their homes instead of institutions. The federal cost of long-term services and supports is estimated to increase from \$75 billion in 2015 to \$111 billion in 2026.<sup>3</sup>

Although PCS are an important support for Medicaid beneficiaries that can enable them to remain in their homes and communities, provision of PCS is not without risk, both for beneficiary safety and for improper Medicaid payments. Regarding safety, beneficiaries receiving PCS include aged individuals and individuals with physical, developmental, or intellectual disabilities, some of whom can be vulnerable. Also, when PCS is provided in a private home, other providers or community members may not be present to help discourage or report on questionable activities. Moreover, depending on the state and the PCS program, personal care attendants (attendants) who provide PCS may not be required to have a credential from an organization that trains workers for certain qualifications.<sup>4</sup> The provision of PCS is also at high risk for Medicaid improper payments. The Centers for Medicare & Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services (HHS), estimated that about 6 percent of all states' payments for PCS in 2014 were improper and that the projected dollar amount of payment errors was over \$2 billion, the third highest of all types

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<sup>2</sup>The amount of spending on PCS through managed care is often not quantifiable because managed care organizations do not always report expenditures on specific services.

<sup>3</sup>Congressional Budget Office, *Detail of Spending and Enrollment for Medicaid for CBO's March 2016 Baseline* (2016).

<sup>4</sup>States use different terms for the recipients of PCS, providers of PCS, and PCS delivery models. For purposes of this report, we refer to recipients of PCS as "beneficiaries," providers of PCS as "personal care attendants" or "attendants," and delivery models in which the recipient has direct control over attendants as "participant-directed."

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of Medicaid services.<sup>5</sup> The HHS Office of the Inspector General (OIG) has also identified \$582 million in questioned PCS costs in seven states from 2009 through 2012, such as instances in which PCS providers received payments from state Medicaid agencies for services that were not provided. While ensuring that billed services are provided protects against Medicaid fraud, it also protects health and welfare by making sure beneficiaries receive the services they need to remain safely in their homes and communities.<sup>6</sup>

PCS are one of the many types of services states may provide under their Medicaid programs, which are administered by states and overseen by the federal government. CMS is responsible for broad oversight of Medicaid. To implement various provisions of federal law, CMS issues program requirements in the form of regulations and guidance, approves changes to states' Medicaid plans, provides technical assistance to states, collects and reviews required information and data from states and, in some cases, reviews individual state programs. Under broad federal requirements, states are responsible for the day-to-day administration of their Medicaid programs. States have considerable flexibility to establish multiple Medicaid PCS programs under different provisions of federal law that authorize different types of PCS programs. These different types of programs were enacted at different times and offer states different options for serving beneficiaries; for example, some types of programs allow states to limit services to only beneficiaries who need an institutional level of care. The different types of programs have

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<sup>5</sup>These figures represent only spending on a fee-for-service basis and exclude claims paid as part of a managed care arrangement. Centers for Medicare & Medicaid Services (CMS), *Medicaid and CHIP 2014 Improper Payments Report* (2015). An improper payment is defined by statute as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (2010) (codified at 31 U.S.C. § 3321 note). Additionally, Office of Management and Budget guidance instructs agencies to report as improper payments any payments for which insufficient or no documentation was found.

<sup>6</sup>The HHS OIG recently reported on situations in which such fraud was accompanied by harm to beneficiaries. U.S. Department of Health and Human Services Office of Inspector General, *Investigative Advisory on Medicaid Fraud and Patient Harm Involving Personal Care Services*, Memo to Vikki Wachino, Deputy Administrator and Director, Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services (Washington, D.C.: Oct. 3, 2016).

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different requirements under federal statute, regulation, and guidance. States are responsible for establishing state policies and procedures in accordance with these requirements. The Patient Protection and Affordable Care Act directed HHS to take steps to improve the coordination among, and the regulation of, all providers of home- and community-based services.<sup>7</sup> PCS programs have different statutory requirements that CMS lacks authority to alter. However, harmonization of requirements across programs can improve coordination of program services and potentially facilitate improved oversight to better ensure beneficiary health and safety and that billed services are actually provided. Harmonization does not entail complete consistency but a more consistent administration of policies and procedures across programs in relation to the provision of such services.<sup>8</sup> Given the projected increase in the volume and costs of PCS, the potential vulnerability of program beneficiaries, the risk of improper payments, and the challenge of overseeing different PCS programs with different federal requirements, you asked us for information on federal and state policies administering PCS. This report examines:

1. how selected states ensure that beneficiaries receiving PCS are safe from harm and that billed services are provided; and
2. recent steps CMS has taken, if any, to improve oversight of states' PCS programs and to harmonize requirements across the programs.

To examine how selected states ensure that beneficiaries receiving PCS are safe from harm and that billed services are provided, we selected a nongeneralizable sample of four states to review the policies and procedures they used to administer and oversee their Medicaid PCS programs: California, Maryland, Oregon, and Texas. We selected states that offer PCS under more than one type of Medicaid PCS program; states that provide PCS under the Community First Choice option (the newest type of program that states can use to provide PCS); and states that provided geographic diversity. In each state and for each PCS program reviewed, we administered a structured questionnaire and reviewed the responses and documentation on state oversight requirements, such as laws, policies, and procedures. We also interviewed state Medicaid officials who administer PCS programs and

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<sup>7</sup>Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2402(a), 124 Stat. 119, 301-302 (2010).

<sup>8</sup>Ibid.

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other state and local officials, such as officials from Adult Protective Services agencies. In each state, we reviewed PCS programs administered under a fee-for-service basis and did not review programs administered on a managed care basis.<sup>9</sup> We excluded managed care arrangements because we limited our scope to PCS programs in which the state was directly responsible for administering the programs. Further, we limited our scope to reporting on state practices as reported by states but did not verify implementation of these practices or assess CMS's oversight of these practices or their compliance with any applicable federal requirements. In addition, we interviewed officials from four private entities that provide PCS or administer long term care programs that reimburse participants for PCS. In addition to one private entity that administers a national long term care program, we chose three entities suggested by national HCBS experts that operated within our selected states. We asked officials at these entities about the policies and procedures they use to keep clients safe in their homes and to ensure that services for which states were billed were actually provided.

To examine recent steps CMS has taken, if any, to improve oversight of states' PCS programs and to harmonize requirements across PCS programs, we reviewed applicable federal laws, regulations, and guidance specific to Medicaid PCS programs, including reporting requirements.<sup>10</sup> We also obtained reports by CMS and HHS OIG, and we interviewed officials with CMS. We focused our review on steps taken since 2010, the year in which the Patient Protection and Affordable Care Act was enacted and added a new PCS program option for states, the Community First Choice program.<sup>11</sup> In addition, we reviewed relevant

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<sup>9</sup>In Texas, we excluded one program that provides PCS on a fee-for-service basis, because the state is transitioning the program to a managed care delivery model in the fall of 2016. In California, we excluded PCS that were administered as part of a Medicaid demonstration project integrating services for beneficiaries eligible for both Medicare and Medicaid. We also excluded PCS provided in California under HCBS Waivers and State Plan HCBS because, according to officials, the state provided minimal PCS because the state first provides PCS under other programs. In Oregon, we excluded PCS delivered by provider agencies that employ attendants because these attendants made up less than 1 percent of all attendants.

<sup>10</sup>We did not review Medicaid regulations or guidance of general applicability, such as program integrity requirements set forth in 42 C.F.R. part 455. The regulations issued by CMS that are specific to the provision of PCS services in home- and community-based settings appear at 42 C.F.R. Parts G, J, K, and M (2015).

<sup>11</sup>Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2402(b), 124 Stat. 119, 302-303 (2010).

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standards for internal control in the federal government and risk management standards published by an international standard-setting organization.<sup>12</sup>

We conducted this performance audit from July 2015 to November 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

Medicaid is a federal-state health care program for low-income and medically needy individuals. For fiscal year 2015, estimated Medicaid spending totaled about \$554 billion, and for fiscal year 2014, Medicaid data show it served about 78 million individuals.<sup>13</sup> States administer their Medicaid programs within broad federal rules and according to a state plan approved by CMS, the federal agency that oversees Medicaid. In addition to providing PCS under their state plans, states can also seek permission from CMS to provide PCS under waivers of traditional Medicaid requirements, for example, in order to provide services to a segment of the state's eligible population. Medicaid is jointly financed by the federal government and the states, with the federal government matching most state Medicaid expenditures using a statutory formula generally based on each state's per capita income relative to the national average.

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<sup>12</sup>GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. International Organization for Standardization, *Risk Management – Principles and Guidelines*, ISO 31000:2009(E) (Nov. 15, 2009).

<sup>13</sup>Expenditure data are from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary, *2015 Actuarial Report on the Financial Outlook for Medicaid* (2015). Enrollment data are from Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid and CHIP Data Book* (2015). The enrollment figure represents the total number of individuals ever enrolled in the program in fiscal year 2014. There were about 64 million individuals enrolled in the program at any one point in time in fiscal year 2014.

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## Medicaid Long-Term Services and Supports

### Factors That May Affect Growth of Care in Home and Community Settings

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

Source: GAO analysis of information from HHS, Congressional Budget Office, and the Social Security Act | GAO-17-28

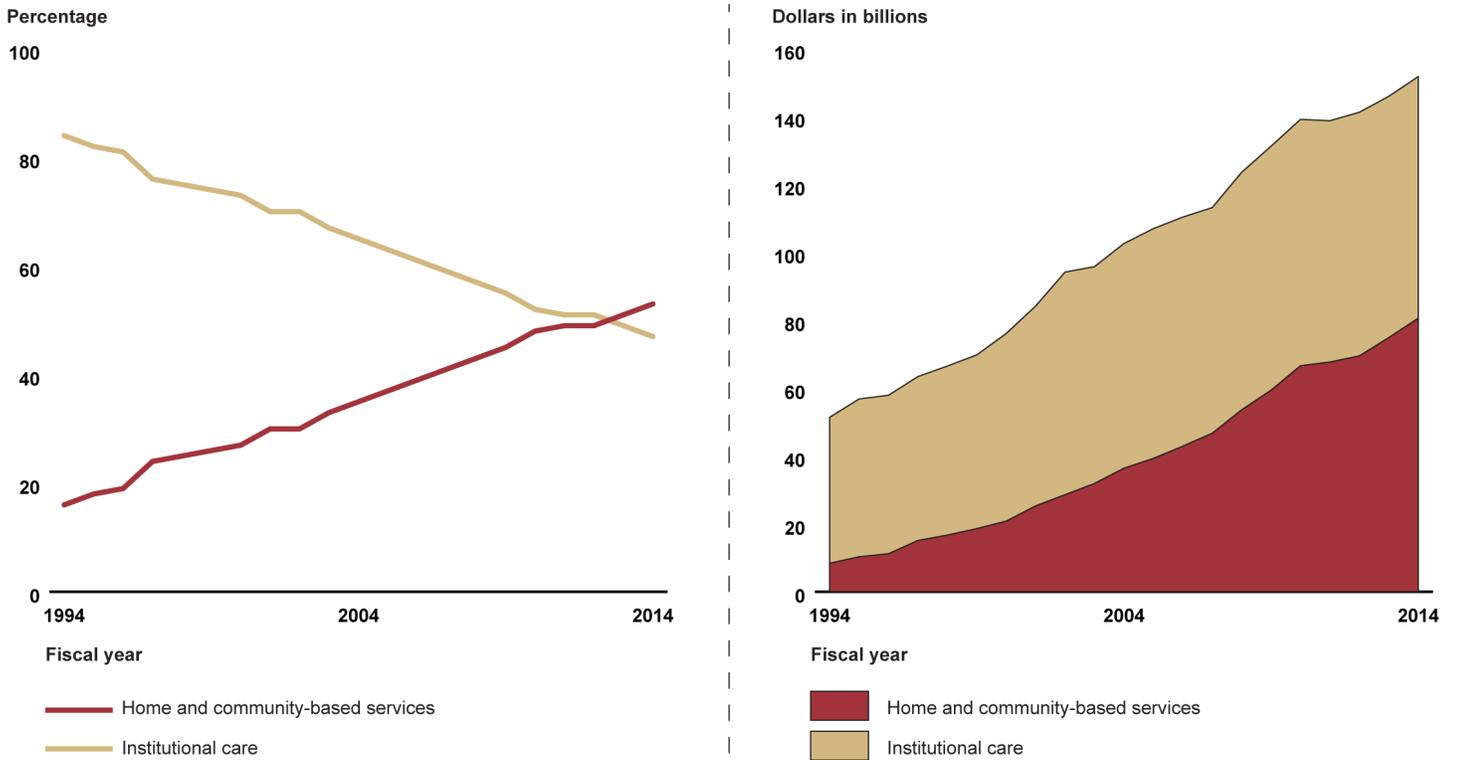
Medicaid is the largest funding source for long-term services and supports in the United States. In fiscal year 2014 (the most recent year for which data are available), total Medicaid spending for long-term services and supports was estimated at \$152 billion.<sup>14</sup> Long-term services and supports represent a broad range of health and health-related services and non-medical supports for individuals of all ages that these individuals need over an extended period of time. Long-term services and supports are generally provided in two settings: institutional facilities, such as nursing homes; and home and community settings, such as individuals' homes or assisted living facilities. Although states' Medicaid coverage of long-term care services provided in nursing homes is generally mandatory and coverage of these services in home and community settings is generally optional, spending on these services in the home and community setting has increased and now exceeds spending on these services in institutions (see fig. 1). All 50 states and the District of Columbia provide long-term care services to some Medicaid beneficiaries in home and community settings, according to a report produced under contract with CMS.<sup>15</sup>

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<sup>14</sup>Steve Eiken, Kate Sredl, Brian Burwell, and Paul Saucier, Truven Health Analytics, *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014* (2016).

<sup>15</sup>Eiken, Sredl, Burwell, and Saucier, *Medicaid Expenditures for Long-Term Services and Supports in FY 2014*.

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



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) and state data collected and published by Truven health Analytics, under contract with CMS. | GAO-17-28

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## Medicaid Personal Care Services

Medicaid PCS are a key component of Medicaid long-term services and supports and include assistance with activities of daily living, such as bathing and dressing, and in some cases instrumental activities of daily living, such as preparing meals and housekeeping. PCS are typically non-medical services provided by attendants—home-care workers who may or may not have specialized training, depending on specific state and federal requirements. Attendants may be employed by a provider agency or self-employed. In some cases, they are friends or family members of the beneficiary and, under certain types of Medicaid PCS programs, can be spouses, parents, or other legally responsible relatives.

States can use different delivery models to provide PCS to beneficiaries. Under an agency-directed model, a provider agency employs attendants. The provider agency hires, fires, pays, and trains the attendant to provide PCS services to Medicaid beneficiaries. Under a participant-directed model, beneficiaries or their representatives have more choice and control over the PCS the beneficiary receives and have the authority to manage PCS services by selecting, hiring, firing, and training attendants themselves. States can implement hybrid forms of these models as well; for example, by using an attendant from a provider agency but allowing the beneficiary to be involved in directly managing the attendant by doing such things as scheduling services, providing training on the beneficiary's specific needs, and, if needed, discharging the attendant.

With approval from CMS, states can choose to provide PCS under one or more types of programs authorized over the past 41 years under different sections of the Social Security Act. The various types of programs provide states with options for permitting participant direction and choices about how to limit services, among other things. For example, two types of PCS programs (HCBS Waiver and Community First Choice programs) only serve beneficiaries who are eligible for an institutional level of care; that is, beneficiaries must have needs that rise to the level of care usually provided in a nursing facility, hospital, or other institution. Some types of PCS programs require the state to provide PCS to all Medicaid beneficiaries who are eligible (PCS State Plan and Community First Choice programs), while other programs (HCBS waivers and State Plan HCBS programs) allow the state to target certain beneficiary populations (see table 1). Appendix I provides more details on the PCS programs offered by the selected states included in our review.

**Table 1: Types of Programs under Which States Can Provide Medicaid Personal Care Services (PCS)**

Program name (Year)	Number of states administering PCS through program	Authorizing statute and program description
State Plan PCS (Implemented in 1975)	25	Starting in 1975, states have had the option of offering personal care services as a Medicaid State plan benefit. In its present form, section 1905(a)(24) of the Social Security Act, enacted in 1993, authorizes states to provide PCS as a covered service in their state Medicaid plans. State Plan PCS can serve beneficiaries who need an institutional level of care or those who do not need an institutional level of care. States must provide services to all eligible beneficiaries and cannot limit the number covered or use waiting lists.
Home- and Community-Based Services (HCBS) Waiver (Enacted in 1981)	48	Section 1915(c) of the Social Security Act authorizes states to seek waivers of certain traditional Medicaid requirements in order to provide home and community-based services, including PCS. For example, the Secretary of HHS can waive the requirement that the state provide services statewide to eligible beneficiaries. States can choose to provide any of a specified range of services to eligible beneficiaries including PCS, case management, habilitation, and respite care. <sup>a</sup> Only beneficiaries who need an institutional level of care are eligible. CMS can waive certain federal requirements, allowing states to target services to specific groups and limit the number of beneficiaries served.
State Plan HCBS (Enacted in 2006)	4	Section 1915(i) of the Social Security Act authorizes states to provide any of the same range of services as available under HCBS Waivers, including PCS. Unlike HCBS Waiver programs, states have the option to cover beneficiaries who need an institutional level of care, but must provide services to beneficiaries who do not require an institutional level of care. States can target services to specific groups of beneficiaries but may not limit access to services based upon the cost of services or the income or location of eligible beneficiaries.
Participant-Directed Option (Enacted in 2006)	9	Section 1915(j) of the Social Security Act gives states additional options for the delivery of PCS and other services. The Participant-Directed Option is not a stand-alone program but, instead, must be offered in conjunction with either State Plan PCS or HCBS Waiver. States can offer beneficiaries the option to receive individual budgets to pay for PCS and other services. Beneficiaries may also be permitted to compensate a legally liable relative, such as a spouse or a parent, for PCS services. States are permitted to limit the number of beneficiaries served and to target services to specific groups. Beneficiaries can be eligible for an institutional level of care or not.
Community First Choice (Enacted in 2010)	8 <sup>b</sup>	Section 1915(k) of the Social Security Act authorizes states to provide PCS and a range of services. States must provide services to all beneficiaries who are eligible. Only beneficiaries who would otherwise need an institutional level of care are eligible. States receive a 6 percentage point enhanced federal match for all services provided under Community First Choice programs.

Source: Social Security Act, Title XIX and CMS. | GAO-17-28

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

<sup>b</sup>The number of states with a Community First Choice program is current as of September 2016.

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Some beneficiaries receiving PCS can be at risk for unintentional harm as well as potential neglect, abuse, and exploitation by their attendants because of their underlying conditions. In October 2016, the HHS OIG reported cases of beneficiaries being abused or neglected by their attendants.<sup>16</sup> For example, one beneficiary was hospitalized for dehydration and malnourishment after her attendant neglected her care. In 2010, the HHS OIG reported that of 55 PCS beneficiaries or their family members interviewed in New York, there were 11 reports of a beneficiary being subject to theft, 5 reports of physical abuse or threats, and 2 reported that they were abandoned by their attendant.<sup>17</sup> Beneficiaries may also be at risk of unintentional physical harm from falling, particularly when the attendant cannot safely transfer clients effectively from a bed to a chair. Some beneficiaries receive care from a friend or family member, but these relationships may not always protect vulnerable beneficiaries from abuse. In addition, beneficiaries may be at risk for self-neglect or other health challenges if their attendants do not show up to provide services when scheduled or are not trained to identify signs of diminished health. A beneficiary's capacity to manage finances and secure possessions may decline with age, onset of dementia, or other cognitive disabilities, and put them at risk of theft or financial exploitation from unscrupulous attendants for example, the unauthorized use of a beneficiary's credit cards by an attendant.<sup>18</sup>

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

The federal Medicaid program requirements governing the provision of PCS derives from statutes enacted at different times in Medicaid's history (see table 1). CMS has implemented these different statutory requirements by issuing regulations, as well as guidance to help states implement their Medicaid programs in accordance with applicable statutory and regulatory requirements. Guidance can include letters to state Medicaid directors, program manuals, and templates to help states apply for CMS approval to provide certain services like PCS. Together with federal statutes, the regulations and guidance issued by CMS

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<sup>16</sup>Office of Inspector General, *Investigative Advisory on Medicaid Fraud and Patient Harm*.

<sup>17</sup>The same beneficiary may have reported more than one incident. U.S. Department of Health and Human Services Office of Inspector General, *Review of Medicaid Personal Care Services Claims Made by Providers in New York State (A-02-08-01005)* (Washington, D.C.: 2010).

<sup>18</sup>GAO, *Elder Justice: National Strategy Needed to Effectively Combat Elder Financial Exploitation*, [GAO-13-110](#) (Washington, D.C.: Nov. 15, 2012).

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establish a broad federal framework for the provision of PCS. States are responsible for establishing and administering specific policies and programs within the federal parameters laid out in this framework. Medicaid program requirements vary by the type of PCS program, but may include the following types of protections depending on the type of program:

- screening attendants to see if they are excluded as Medicaid providers;
- developing minimum qualification standards for attendants;
- establishing quality assurance processes to ensure the services provided protect the health and welfare of beneficiaries;
- identifying and reporting cases of potential abuse, neglect, or other events that harm, or could result in harm to beneficiaries;
- establishing policies and processes to ensure that services for which the state has been billed were actually provided; and
- reporting on the health and welfare of beneficiaries to CMS on a regular basis.

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## States' Implementation of Personal Care Services

The Social Security Act requires each state to designate a single state agency to administer or supervise its Medicaid program. States may designate other state and local agencies to administer and oversee the entirety of their PCS programs, or certain functions, including beneficiary enrollment or beneficiary case management. States may administer different PCS programs because the programs were designed for certain types of beneficiaries. For example, one state administers one PCS program for beneficiaries with developmental disabilities and another PCS program for those with physical disabilities. Sometimes county or other local governments provide certain Medicaid services under state Medicaid agency oversight. For example, many Medicaid programs employ county case managers who help beneficiaries gain access to needed services, including PCS.<sup>19</sup> Other state or local government programs may be involved with Medicaid PCS beneficiaries, but do not directly participate in a Medicaid program. For example, almost all states have Adult or Child Protective Services, agencies that investigate and

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<sup>19</sup>States refer to "case managers" by different terms, such as "support planners." We use "case managers" in this report to refer to those who help PCS beneficiaries obtain needed services.

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take action when allegations of maltreatment are reported. Generally, Adult Protective Service officials may work with both Medicaid beneficiaries and non-Medicaid clients, but are generally not located within a state's Medicaid office according to an expert.

In fee-for-service arrangements, attendants receive payment by submitting claims to state Medicaid agencies for the PCS they provided. Independent attendants—those who do not work for a provider agency—submit claims directly to a state Medicaid agency. Attendants who work for a provider agency typically give that agency information on the services rendered, and then the provider agency submits claims on behalf of the attendant. Both types of claims submitted to state Medicaid agencies generally identify the dates of the service, the types of services provided, and the Medicaid beneficiaries who received the services. Claims for PCS are often paid based on the duration of care.

States must seek approval from CMS to implement one or more types of PCS programs by submitting proposals to CMS that explain how the state will comply with federal requirements. Upon CMS's approval and consistent with any applicable federal requirements, states may impose additional state requirements to implement the programs. While states' policies and procedures for providing PCS can vary across states and within a state across different PCS programs, several key steps are generally involved. As illustrated in figure 2, for Medicaid beneficiaries, states must determine beneficiaries' eligibility for PCS, arrange for the development of a plan of service, and help connect beneficiaries to an attendant who is authorized to provide services. To oversee PCS provided to beneficiaries, states may perform a number of functions such as screening and requiring training of attendants and overseeing the delivery of services.

**Figure 2: Processes States May Use for Establishing Personal Care Services (PCS) for a Medicaid Beneficiary, Overseeing Beneficiary Safety, and Ensuring Billed Services Are Provided**

**Determine eligibility for Personal Care Services (PCS) and develop plan of service**



**Determine PCS eligibility**

After beneficiaries are determined to be eligible for Medicaid, states that offer PCS assess beneficiaries' functional needs, such as the ability to bathe or dress, to determine whether or not the beneficiary is eligible for one of the state's PCS programs (states can offer multiple programs).

**Develop plan of service**

A case manager works with the beneficiary to develop a written plan of service that specifies the PCS tasks and hours of services to be provided.

**Safeguard beneficiaries before services begin**



**Conduct a background check**

Before personal care attendants can begin providing services, states may perform criminal background checks and other screenings.

**Train attendants**

Some states require that attendants receive training or attend an orientation.

**Connect beneficiaries with attendants**

States can help beneficiaries find an attendant who is authorized to provide services, either through an agency or from a registry of attendants. In addition, many beneficiaries receive PCS from people they know, such as family or friends, who must register with the state Medicaid office.

**Safeguard beneficiaries and ensure billed services are provided after services begin**



**Monitor beneficiary**

States may monitor beneficiaries periodically as they receive services to help ensure beneficiaries' health and welfare.

**Address unusual incidents**

States develop processes for addressing unusual incidents that can occur, such as abuse or neglect.

**Conduct quality assurance activities**

States review their processes to determine whether or not attendants and others, such as case managers, are following required procedures.

**Ensure billed services are provided**

States can use different methods to help make sure that services for which the state has been billed are actually provided, such as using electronic timekeeping systems, requiring beneficiaries to sign timesheets, or visiting beneficiaries' homes when services are scheduled to occur.

Source: GAO analysis of state processes. | GAO-17-28

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## Selected States Varied in How They Implemented Beneficiary Safeguards and Ensured Billed Personal Care Services Were Provided

All four selected states—California, Maryland, Oregon, and Texas—reported employing safeguards to protect beneficiaries from harm and had methods in place to ensure billed services were actually provided, but the states varied in how they implemented them and, in some cases, variations existed within states across PCS programs. The four states also reported using different methods to help ensure billed services were provided (see Appendix I for the types of PCS programs reviewed in each state).

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## Selected States Employed Beneficiary Safeguards in Three Common Areas, but Implementation Methods Varied Among and Sometimes Within States

All four selected states reported employing safeguards in three common areas to help ensure Medicaid beneficiaries receiving PCS in their homes are safe from harm: (1) attendant screening and training; (2) beneficiary monitoring; and (3) addressing unusual incidents. However, states' specific safeguard implementation methods and requirements varied by state and, in some cases, varied within a state across PCS programs. According to state Medicaid officials, many factors may affect the methods states choose to implement beneficiary safeguards, such as beneficiary risk levels, the extent to which beneficiaries are responsible for managing their own services, how state Medicaid programs are structured, input from stakeholders such as consumer advocacy groups, and state and federal requirements.

### Attendant Screening and Training

All four selected states reported that attendants are required to undergo some form of background screening in all their PCS programs, but the specific background information checked varied by state. Background screenings could entail, for example, a criminal background check or a determination of whether the individual was listed on certain federal or state lists or registries, such as the HHS OIG list of excluded providers or a state's list of excluded providers.<sup>20</sup> All four selected states reported that attendants in all PCS programs are required to undergo a criminal background check. Three of the four states also required checking

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<sup>20</sup>The HHS OIG list of excluded providers identifies providers that have been excluded from participation in federal health care programs, such as Medicaid. Grounds for exclusion include convictions of program-related fraud and patient abuse, and suspension or revocation of a medical license for reasons bearing on professional competence or performance.

attendants against HHS’s OIG list of excluded providers in all state PCS programs; under Oregon’s Participant-Directed Option, the beneficiary or a representative is responsible for screenings beyond the criminal background check.<sup>21</sup> Each of the four selected states also required some additional background screenings in all or most PCS programs, including checking other federal databases, and three states required checks against state administered provider lists and registries (see table 2). With the exception of the Community First Choice Option, federal PCS program requirements generally leave it to the states to establish specific attendant screening requirements.

**Table 2: Selected States’ Required Pre-Employment Screenings for Personal Care Attendants**

State	Criminal background check	U.S. Department of Health and Human Services Office of the Inspector General exclusions <sup>a</sup>	Individuals or entities suspended or debarred from receiving federal funds <sup>b</sup>	U.S. Social Security Administration’s death records <sup>c</sup>	Other
CA	•	•	○	○	California Department of Health Care Services Medi-Cal Suspended and Ineligible Provider List
MD	•	•	•	○	Maryland List of Excluded Medicaid Providers and Entities
OR	•	• <sup>d</sup>	• <sup>d</sup>	• <sup>d</sup>	Internal Revenue Service Taxpayer Identification Number Matching Program <sup>e</sup>

<sup>21</sup>Medicaid does not permit payment to states for services or items furnished by excluded providers. According to state officials, under Oregon’s Participant-Directed Option, beneficiaries or their representatives are responsible for screening their attendants beyond a criminal background check. Also, according to these officials, under Oregon’s Participant-Directed Option, beneficiaries receive Medicaid funds directly, and Oregon does not consider attendants to be Medicaid providers. In technical comments on a draft of this report, HHS stated that attendants are Medicaid providers, although it did not comment on whether Oregon’s screening practice was consistent with any applicable federal requirements. We informed the agency that they should consider additional review.

State	Criminal background check	U.S. Department of Health and Human Services Office of the Inspector General exclusions <sup>a</sup>	Individuals or entities suspended or debarred from receiving federal funds <sup>b</sup>	U.S. Social Security Administration's death records <sup>c</sup>	Other
TX	●	●	○	○	<ul style="list-style-type: none"> <li>• Texas Health and Human Services Commission Office of Inspector General List of Excluded Individuals/Entities</li> <li>• Texas Nurse Aide Registry<sup>f</sup></li> <li>• Texas Employee Misconduct Registry<sup>f</sup></li> <li>• Texas Debarred Vendor List<sup>f</sup></li> </ul>

Legend: ● = Required ○ = Required for some programs ○ = Not required

Source: GAO analysis of information from states and interviews with officials. | GAO-17-28

<sup>a</sup>Department of Health and Human Services (HHS) Office of Inspector General (HHS-OIG) maintains the List of Excluded Individuals and Entities, which identifies providers that have been excluded from participation in federal health care programs, such as Medicaid.

<sup>b</sup>General Services Administration maintains the System for Award Management exclusions records, which lists parties that are suspended or prohibited from receiving federal funds.

<sup>c</sup>The Social Security Administration maintains records of deceased individuals. Checking against this is intended to prevent enrollment and payment of attendants using the identity of deceased individuals.

<sup>d</sup>Medicaid does not permit payment to states for services or items furnished by excluded providers. According to state officials, under Oregon's Participant-Directed Option, beneficiaries or their representatives are responsible for screening their attendants beyond a criminal background check. Also, according to these officials, under Oregon's Participant-Directed Option, beneficiaries receive Medicaid funds directly, and Oregon does not consider attendants to be Medicaid providers. In technical comments on a draft of this report, HHS stated that attendants are Medicaid providers, although it did not comment on whether Oregon's screening practice was consistent with any applicable federal requirements. We informed the agency that they should consider additional review.

<sup>e</sup>Internal Revenue Services' Taxpayer Identification Number Matching database is used to confirm that the name and identification numbers provided by attendant applicants match Internal Revenue Service records. Attendants in Oregon's Participant-Directed Option are not required to undergo this matching.

<sup>f</sup>The Texas Nurse Aide Registry notes findings of alleged abuse, neglect, or misappropriation by registered nurse aides who are certified to provide services in licensed nursing facilities. The Texas Employee Misconduct Registry lists unlicensed personnel the state has determined to be ineligible for employment because they were found to have abused, neglected, or exploited individuals receiving health services. The Texas Debarred Vendor List is maintained by the Texas Comptroller of Public Accounts. Some Texas PCS programs require employers to review this list.

The four selected states varied as to how they used the results of criminal background checks. Beneficiaries under California's PCS program can hire their preferred attendant in some cases if the attendant has been convicted of certain types of felonies, such as fraud against a social

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services program.<sup>22</sup> Oregon Medicaid officials reported that they exclude attendants convicted of certain crimes, such as murder, robbery, and rape. The state has a weighing process for some crimes, such as theft or financial crimes, to determine whether or not the attendant should be excluded from providing services, according to officials. Texas Medicaid officials reported that under all state PCS programs, the state bars employment of attendants convicted of certain crimes, such as homicide and arson. Maryland Medicaid officials reported that under all state PCS programs, provider agencies decide if they want to hire a particular attendant.

**Balancing Attendant Qualifications with Supply of Attendants**

*In deciding what, if any, training to require of attendants, states may balance making sure attendants are qualified to provide care with the need for an adequate supply of attendants to support the demand for in-home PCS. While more training can be beneficial for beneficiaries, training requirements can pose a barrier to participation for some attendants and diminish the supply of attendants.*

Source: GAO analysis of information from HHS and consumer stakeholders. | GAO-17-28

Regarding attendant training, each of the four selected states reported requiring that attendants receive initial training or complete an orientation for all or most state PCS programs, but specific requirements varied by state and in some cases within a state by PCS program. Under four PCS program types (State Plan PCS, HCBS Waivers, State Plan HCBS, and Community First Choice programs delivering PCS through provider agencies) states may define qualifications for attendants. The Participant-Directed Option program and Community First Choice program permit the beneficiary to train their attendants in their specific areas of personal assistance needs. Some of the selected states may require attendants to complete an orientation, but do not consider to be training. For example, California officials reported that while they require attendants in all programs to complete an orientation, they do not have initial training requirements. Oregon officials also reported that while they have no initial training requirements, they do require attendants to complete an orientation. Attendants may be required to receive additional training if they are going to provide certain healthcare services to beneficiaries, such as medication administration. All four selected states reported that attendants are permitted to perform such services in at least some programs but generally only after they are trained by nurses or other health professionals to perform the specific task. In three selected states this was done through nurse delegation, which allows nurses to delegate specific tasks to unlicensed individuals, accompanied by concomitant training and supervision.<sup>23</sup> California does not permit nurse delegation,

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<sup>22</sup>California officials reported that an attendant, with a record of such crimes, can provide PCS if the attendant: (1) obtains a certificate of rehabilitation or expungement; (2) receives a waiver by the beneficiary; or (3) applies for and receives from the state an exception. In providing technical comments on a draft of this report, HHS indicated that this practice is not consistent with the agency's understanding of California's program and that HHS intends to follow up with the state for clarification.

<sup>23</sup>Nurse delegation may vary based on state law.

but does allow a licensed nurse or other healthcare professional to train an attendant to provide certain services, such as medication administration.<sup>24</sup> All four selected states reported that in all or most PCS programs attendants were required to be trained in, or receive information on, their responsibilities regarding critical incidents, such as whether they are mandated to report incidents and how to recognize and report critical incidents. Critical incidents are events or situations that cause or may cause harm to a beneficiary’s health or welfare, such as abuse, neglect, or exploitation. Texas required attendants to undergo periodic renewal or refresher training in some programs, although requirements vary by program. For example, under the State Plan PCS program provided to beneficiaries under age 21, provider agencies must ensure a continuing systematic training program for all attendants. In addition, Maryland requires attendants to receive training on cardiopulmonary resuscitation every two years. Table 3 shows the type of training or orientation requirements in selected states.

**Table 3: Selected States’ Required Personal Care Attendant Training or Orientation**

State	Initial training or orientation	Other training		
		Training on nurse-delegated or paramedical services	Training or information provided on critical incidents	Renewal or refresher training
CA	All attendants must complete an orientation at the time of enrollment that covers program rules and regulations, including those related to timesheets; reporting critical incidents; information confidentiality; and fraud.	•	•	○

<sup>24</sup>California refers to these services as “paramedical services.” Unlike nurse delegation, attendants’ execution of paramedical services does not place ongoing responsibilities on the healthcare professional, according to officials. Paramedical services include the administration of medications; puncturing the skin; or inserting a medical device, such as a catheter, into a body orifice; activities requiring sterile procedures; or other activities requiring judgment based on training given by a licensed health care professional. Beneficiaries (or an authorized representative) must sign a statement of informed consent that he or she has been advised of the potential risks associated with the provision of paramedical services and that they agree to have paramedical services provided by their attendant.

State	Initial training or orientation	Other training		
		Training on nurse-delegated or paramedical services	Training or information provided on critical incidents	Renewal or refresher training
MD	All attendants must receive the following: <ul style="list-style-type: none"> <li>• Cardiopulmonary resuscitation certification</li> <li>• Training and assessment by nurse specific to services attendant will provide</li> <li>• Other training including: identification of situations that require referral to a nurse; information confidentiality; prevention of abuse and neglect; and use of electronic visit verification system.</li> </ul>	•	•	•
OR	All attendants, except those providing services under the Participant-Directed Option, must participate in an orientation that covers timesheets, information confidentiality, and their responsibilities regarding critical incidents, such as whether they are mandatory reporters and how to recognize and report incidents. Beneficiaries or their representatives under the Participant Directed Option are responsible for determining attendant training requirements.	•	◐ <sup>a</sup>	◐ <sup>b</sup>
TX	All attendants must receive some training but requirements vary by program. Generally all attendants must receive training or orientation related to the beneficiary's needed services. Under the state's participant-directed model, the beneficiary or their representative is the employer and provides an orientation on tasks to be provided.	◐ <sup>c</sup>	◐ <sup>d</sup>	◐ <sup>e</sup>

Legend: • = Required ◐ = Required for some Programs ◑ = Not required

Source: GAO analysis of information from states and interviews with officials. | GAO-17-28

<sup>a</sup>Not required under the Participant-Directed Option.

<sup>b</sup>Attendants who wish to be listed on a state registry that lists attendants available for hire must complete four state-approved trainings per year. Attendants have 12 months from the time they enroll to attend the trainings.

<sup>c</sup>Under Texas's participant-directed model (for state PCS programs that permit nurse delegation) the nurse may delegate to the attendant, or the beneficiary or their representative may elect to supervise and train the attendant as long as certain conditions are met, such as the beneficiary or their representative must be capable of training the attendant in the proper performance of the service. Texas does not permit nurse delegation in two programs: (1) the State Plan PCS program that serves beneficiaries who are age 21 or older; and (2) the Community Attendant Services program, an additional type of Medicaid PCS program that only Texas has chosen to adopt.

<sup>d</sup>Not required under State Plan PCS that serves beneficiaries under the age of 21 through the agency model.

<sup>e</sup>Additional training is not required under Texas's participant-directed model; however, the beneficiary or beneficiary representative may require or provide additional training. Under the State Plan PCS program provided to beneficiaries who are 21 or older and the Community Attendant Services program, additional orientation may be provided based on a change in the beneficiary's condition.

## Beneficiary Monitoring

All four selected states reported that beneficiaries' health and welfare is monitored in part by having case managers or nurses periodically check in with beneficiaries, but the frequency and means, such as in-person

versus by phone or electronic message, varied among the four states and in some cases within states across PCS programs.<sup>25</sup> States generally have flexibility on how they monitor beneficiaries, as Medicaid PCS program monitoring requirements are broad and do not prescribe specific frequencies or means for checking in with beneficiaries beyond requirements for annual reassessments or annual reviews of beneficiary plans of care (see table 4).

**Table 4: Required Beneficiary Monitoring in Selected States**

State	Frequency and means of check-ins	Factors that affect additional monitoring	Requirements the same for all state personal care services (PCS) programs
CA	Case manager generally visits in-person annually	Case managers should check in with beneficiaries whenever there is reason to believe there has been a change in the beneficiary's condition or situation.	yes
MD	Case manager calls or emails monthly and visits in-person quarterly Registered nurse contacts every 6 months, with at least one visit in-person every 12 months	Case managers make direct contact with beneficiaries more frequently as needed. Registered nurses may check in on beneficiaries at a frequency based on beneficiary medical condition or clinical status in conjunction with the beneficiary or his or her representative. <sup>a</sup>	yes
OR	Case manager contacts beneficiaries in-person annually Case manager contacts at least quarterly (by phone, email, or in-person) for some programs <sup>b</sup>	Case managers may check in with beneficiaries more often when certain risk factors are present, including when beneficiaries are the subject of Adult Protective Services investigation, or when there is a change in the beneficiary's condition.	no <sup>b</sup>
TX	Case manager visits in-person annually for all beneficiaries. Case manager visits in-person annually, contacts (by phone or in person) every 6 months, or contacts quarterly, depending on the program. The means of quarterly contact varies by program. <sup>c</sup>	Case managers may check in with beneficiaries more often as needed, such as when there is a change in condition for most programs.	no <sup>c</sup>

Source: GAO analysis of information from states and interviews with officials. | GAO-17-28

<sup>a</sup>A beneficiary can sign a form to waive the receipt of nurse monitoring services beyond the minimum required frequency. However, a beneficiary cannot waive nurse monitoring when skilled healthcare services have been delegated to an attendant.

<sup>25</sup>States may have other methods to monitor beneficiaries' health and welfare in addition to check-ins with beneficiaries, such as surveys of beneficiaries about the services they are receiving, tracking critical incidents, and in-home visits with a sample of beneficiaries that is part of a state's Quality Assurance process.

<sup>b</sup>State Plan PCS provided to beneficiaries who are aged or physically disabled do not require this quarterly beneficiary monitoring.

<sup>c</sup>State Plan PCS provided to beneficiaries under age 21 do not require additional monitoring visits in addition to the annual review. State Plan PCS provided to beneficiaries who are 21 or older require case managers to contact individuals every six months. Other PCS programs require quarterly contacts.

State beneficiary monitoring requirements may be based on such factors as federal Medicaid PCS program requirements, as well as on state goals for balancing beneficiaries' safety with respecting beneficiaries' autonomy. Some selected states based the frequency of beneficiary monitoring on the risk level of the beneficiaries. For example, according to officials, Oregon's State Plan PCS program serves beneficiaries who do not need an institutional level of care, and Oregon state officials determined that certain beneficiaries receiving services under this program could be safe with less monitoring than beneficiaries in PCS programs that serve those with greater health needs.

When beneficiaries need healthcare services, such as medication administration, attendants may be allowed to provide these services; doing so may result in additional beneficiary monitoring in some states. Three of our four selected states permitted nurse delegation under all or some PCS programs. These three states—Maryland, Oregon, and Texas—required post-delegation follow-up by a nurse in these cases. For example, if an attendant administers medication to a beneficiary under nurse delegation in Maryland, a nurse must conduct an in-home visit at least every 45 days (see table 5).

**Table 5: Selected States' Monitoring Requirements for Nurse Delegation of Tasks to Personal Care Attendants**

State	Permits nurse delegation	Monitoring requirements
CA	○	Not applicable.
MD	●	A nurse employed by the provider agency performs ongoing supervision at intervals based on the type of skilled service provided by the attendant. <sup>a</sup>
OR	●	Registered nurses determine monitoring frequency based on their assessments of the beneficiary's needs and the attendant's ability to perform tasks.
TX	◐ <sup>b</sup>	All programs that permit nurse delegation (5 of Texas's 8 programs) require ongoing supervision.

Legend: ● = Yes ◐ = Some Programs ○ = No

Source: GAO analysis of information from states and interviews with officials. | GAO-17-28

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<sup>a</sup>The registered nurse shall provide periodic, on-site supervision of care: (a) at least every 45 days if the staff administers medications to the client; (b) at least every 3 months if the staff assists the client with self-administration of medications; (c) at least every 4 months if the staff does not administer medications or assist the client with medication self-administration; or (d) at a greater frequency established by the registered nurse due to the client's medical condition or clinical status.

<sup>b</sup>Texas does not permit nurse delegation in two programs: (1) the State Plan PCS program that serves beneficiaries who are age 21 or older; and (2) the Community Attendant Services program, an additional type of Medicaid PCS option that only Texas has chosen to adopt. Under the state's participant-directed model (for PCS programs that permit nurse delegation) the nurse may delegate to the attendant, or the beneficiary or their representative may elect to supervise and train the attendant as long as certain conditions are met, such as the beneficiary or their representative is capable of training the attendant in the proper performance of the service.

California does not permit nurse delegation, which places ongoing responsibilities on the nurse, such as monitoring. Instead, California permits attendants to perform certain services that a nurse might perform, called "paramedical services," once they are ordered by a licensed professional and the beneficiary (or an authorized representative) has provided informed consent. After training the attendant, the health professional is not required to perform ongoing monitoring of the attendant.

## Addressing Unusual Incidents

All four selected states reported that systems were in place to address unusual incidents, including provider back-up plans and tracking critical incidents involving beneficiaries. Unusual incidents are events that adversely affect or have the potential to adversely affect beneficiary health and safety, such as an attendant missing an appointment, as well as critical incidents. In general, a back-up plan is part of a customized service plan designed to ensure that an individual beneficiary receives the services and supports they need to remain safely in their homes. The plan identifies situations that could jeopardize a beneficiary's safety and establishes a strategy to prevent or manage such situations. A back-up plan typically identifies individuals who may be called if an attendant does not show up as scheduled. Critical incidents include abuse, neglect, or other events that harm, or could result in the harm of, beneficiaries.

All four selected states reported requiring individualized provider back-up plans for beneficiaries in all or most of the PCS programs they administer. California and Maryland require provider back-up plans for beneficiaries in all state PCS programs. Oregon requires provider back-up plans under the Participant-Directed Option and Community First Choice, but not under State Plan PCS. Oregon Medicaid officials explained that this is because the majority of beneficiaries receiving services under State Plan PCS receive a small number of hours—typically 20 hours or less—of services per month. Texas requires provider back-up plans under all state PCS programs delivered under the agency-provider model. Under

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programs operating under Texas’s participant-directed model, according to officials, the beneficiary or beneficiary representative must develop a provider back-up plan under some circumstances, such as when having a back-up plan is required by the rules of the program.

All four selected states reported that the state tracked information about critical incidents involving Medicaid beneficiaries receiving PCS; however, what information they tracked and the type of data system or systems varied by state and in some cases within states by PCS program. With the exception of State Plan PCS, states are required to implement processes or systems to address critical incidents in PCS programs.<sup>26</sup> One way states can attempt to assure that beneficiary safeguards are working is by tracking information such as the frequency and type of reported incidents. Tracking incident information can also promote beneficiary safety by making it easier for states to identify trends or patterns that can lead to improved program safety.

All four selected states reported that they tracked information on incidents that they define as critical, and all four states’ definitions of critical incidents included, at a minimum, beneficiary abuse and neglect. California, Maryland, and some programs in Oregon and Texas, however, added other types of incidents to their definitions of critical incidents, such as accidental injuries. Two states, Oregon and Texas, defined critical incidents differently under different types of PCS programs. For example, Oregon operates PCS programs through separate departments that serve different beneficiary populations. The department that serves beneficiaries who are aged or those with physical disabilities includes abuse, neglect, and exploitation. The department serving individuals who have intellectual or developmental disabilities includes additional incidents such as serious illness or accidents. Three states—Maryland, Oregon, and Texas—identified and tracked in their data systems the type of critical incident that occurred. How states tracked information also varied by state, with two of the four states (California and Maryland) using a single statewide case management data system to track critical incidents, and the other two states (Oregon and Texas) using multiple systems (see table 6).

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<sup>26</sup>For HCBS Waiver programs and State Plan HCBS programs, states are required to identify, address, and seek to address critical incidents, as well as demonstrate that an incident management system is in place. States implementing Community First Choice are required to have a quality assurance system that includes a process for mandatory reporting, investigation, and resolution of incidents.

**Table 6: Features of Selected States' Critical Incident Data Systems for Personal Care Services (PCS) Programs**

State	Single statewide incident data system for all PCS programs	Critical incidents include other incidents in addition to abuse and neglect	Description of incident data system(s)	System(s) tracks type of incident
CA	● <sup>a</sup>	●	County staff document incidents in a case management and payroll system for all PCS programs statewide. Information recorded is limited to the date and entity the county referred the incident to, such as Adult Protective Services.	○
MD	● <sup>b</sup>	●	State-authorized personnel record incident information into a critical incidents module within the statewide case management system. Information recorded includes, but is not limited to, incident type, incident details such as individual(s) present at the time of the incident, and incident referral notations.	●
OR	○	● <sup>c</sup>	Incident information is tracked in multiple data systems maintained by different state agencies. Two state agencies provide PCS: one that served the aged and physically disabled; and one that served the intellectually and developmentally disabled. Each agency defines critical incidents differently. <sup>d</sup>	●
TX	○	● <sup>e</sup>	Incidents involving abuse, neglect, and exploitation are tracked by Adult Protective Services staff in the statewide Department of Family Protective Services caseload system. This agency is separate from state Medicaid agencies and investigates incidents involving Medicaid beneficiaries and non-Medicaid clients. Two state Medicaid PCS programs require providers to enter critical incidents in a separate data system. The information includes allegations and substantiated cases of abuse, neglect, and exploitation provided by the Department of Family Protective Services, as well other types of incidents, such as serious injuries.	●

Legend: ● = Yes ○ = Some Programs ○ = No

Source: GAO analysis of information from states and interviews with officials. | GAO-17-28

<sup>a</sup>California officials reported that the state separately tracks in a spreadsheet information about critical incidents discovered during quality assurance reviews, including the type of incident.

<sup>b</sup>Maryland officials also reported that the state developed a spreadsheet that tracks critical incidents to monitor review and follow-up efforts and to identify patterns in quality of care issues.

<sup>c</sup>In Oregon, the department that implements PCS for the aged or physically disabled defines critical incidents as those investigated by Adult Protective Services, which include abuse, neglect, and exploitation. The department that implements PCS for people with intellectual or developmental disabilities includes additional incidents in its definition, such as serious illness and accidental injuries.

<sup>d</sup>Oregon Medicaid officials reported that they are developing a centralized system to track critical incidents involving Medicaid PCS beneficiaries across programs serving the aged and physically disabled and people with intellectual or developmental disabilities.

<sup>e</sup>There is no definition of critical incidents under the State Plan PCS program serving beneficiaries under the age of 21; however, licensure rules require agencies that provide PCS under this program to have a written policy for reporting abuse, neglect, and exploitation of a beneficiary by an agency employee. Two programs administered under Community First Choice define critical incidents as including abuse, neglect, and exploitation. The State PCS Program serving beneficiaries who are 21 or older and the Community Attendant Services program include additional incidents in their definitions, such as hospitalizations. Two other programs administered under Community First Choice also include additional incidents, such as medication errors and serious injuries.

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Critical incidents involving Medicaid PCS beneficiaries can be reported to and investigated by entities other than state Medicaid agencies, such as Adult Protective Services for adult beneficiaries. Adult Protective Services officials are generally not located within a state's Medicaid office; as a result, Medicaid staff may not learn of incidents involving Medicaid PCS beneficiaries that are reported directly to Adult Protective Services unless Adult Protective Services staff share this information. We asked Medicaid officials in each of the four selected states about the extent to which state Adult Protective Services staff share information with state Medicaid staff when Adult Protective Services investigates a case involving a Medicaid PCS beneficiary. California officials reported that while there is no policy requiring Adult Protective Services to share such information, such communication is allowed. Maryland officials reported that there is no statewide policy requiring Adult Protective Services to communicate information and findings to Medicaid case managers, but that they can generally find out whether an allegation is substantiated or not.<sup>27</sup> Oregon officials told us that there can be an ongoing dialog between Adult Protective Services and case managers about beneficiaries, and it is expected that Adult Protective Services will notify a beneficiary's case manager when there is a substantiated finding against the beneficiary's attendant. The case manager then notifies the Medicaid program to take action against the attendant.<sup>28</sup> In Texas, Adult Protective Services reports the results of its investigations to Medicaid officials at the originating state agency, according to state officials.

Medicaid officials in each of the four selected states described whether they permitted the state Medicaid agency to terminate an attendant if the attendant poses a risk to the beneficiary yet has not been convicted of a crime. Maryland and Oregon (in some programs) permitted termination.<sup>29</sup>

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<sup>27</sup>Maryland Medicaid officials reported the execution of a memorandum of understanding that might increase information sharing across state agencies. The memorandum was entered into by the Maryland Department of Health and Mental Hygiene and the Maryland Department of Human Resources, including local departments of social services, Adult Services, Adult Protective Services, Child Protective Services, and Foster Care. The purpose of the memorandum is to allow for the sharing of confidential data and Protected Health Information among the agencies for "assessment of risk, development of a service plan, implementation of a plan to support safety, or investigation of a suspected case of abuse or neglect."

<sup>28</sup>Oregon's Adult Protective Services is located within the state agency that administers Medicaid.

<sup>29</sup>Oregon can only terminate an attendant under the Participant-Directed Option if the attendant committed certain crimes.

In California, an attendant can be terminated if the attendant has been convicted of certain types of crimes. Texas Medicaid officials reported that the attendant’s employer, not the Medicaid agency, makes employment decisions based on the results of an Adult Protective Services investigation. The attendant can either be employed by a provider agency or by the beneficiary or beneficiary representative.

**Selected States Used Various Methods to Ensure Attendants Provide Billed Services, including Newer Technology to Verify Visits Electronically**

The four selected states in our study reported using various methods to ensure attendants provided billed services to beneficiaries. For example, for at least some PCS programs, two states required beneficiaries to sign timesheets, two states used electronic visit verification timekeeping systems, and all four states performed quality assurance reviews for some PCS programs to ensure billed services are received.<sup>30</sup> Among our four selected states, Maryland and Texas used electronic verification systems in at least some programs, Oregon is in the process of acquiring a system, and California does not use such a system (see table 7).

**Table 7: Methods Selected States Use to Ensure Billed Services Are Provided**

State	Beneficiaries required to sign timesheets	Use electronic visit verification system	Quality assurance reviews	Examples of quality assurance reviews
CA	●	○	●	Case file reviews and subsequent in-home visits of a sample of beneficiaries.
MD	Not applicable	●	●	Review service records from electronic verification system to ensure consistency with beneficiary’s authorized services.
OR	○ <sup>a</sup>	In process of acquiring <sup>b</sup>	● <sup>c</sup>	Review of timesheet signatures and attendant service hours.
TX	○ <sup>d</sup>	● <sup>e</sup>	● <sup>f</sup>	Review of billing records during monitoring visits to contracted attendant agency providers.

Legend: ● = Yes ○ Some programs ○ = No

Source: GAO analysis of information from states and interviews with officials. | GAO-17-28

<sup>a</sup>According to state officials, under Oregon’s Participant-Directed Option, the beneficiary is responsible for paying the attendant and therefore is not required to sign timesheets. In providing technical comments on a draft of this report, HHS indicated that this practice was not consistent with

<sup>30</sup>State quality assurance procedures help assure state Medicaid PCS programs are meeting quality standards and are to be implemented in compliance with federal and state program requirements. States design their own quality assurance procedures in accordance with federal Medicaid PCS requirements, which vary by Medicaid PCS program and are subject to approval by CMS. In general, quality assurance procedures across the four states we reviewed include monitoring such as case file or record reviews and in-home visits to make sure required procedures were followed.

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the agency's understanding of Oregon's program and that HHS intends to follow up with the state for clarification.

<sup>b</sup>Oregon Medicaid officials reported that they are in the process of engaging a contractor with the goal of implementing an electronic visit verification system that will be used across Medicaid PCS programs and as of July 2016 expected to have a system in place in two years.

<sup>c</sup>Under Oregon's Participant-Directed Option, the state relies on either the individual receiving the services or their representative, as well as case managers to confirm that services have been received.

<sup>d</sup>Under the state's participant-directed model, the beneficiary or beneficiary representative determines signature requirements when timesheets are used. Under programs administered under Community First Choice, when paper timesheets are used, either a designated "timekeeper" or attendant is required to sign timesheets.

<sup>e</sup>Whether electronic visit verification is required varies depending upon the program and delivery model.

<sup>f</sup>Texas Medicaid officials reported that their quality assurance process does not explicitly seek to confirm whether or not billed services have been provided under the State Plan PCS provided to beneficiaries under age 21.

Electronic visit verification timekeeping systems are newer, technology-based systems that electronically record when attendants begin and end providing services to a beneficiary.<sup>31</sup> Such systems may include features to verify the attendant's location and make sure the attendant is in the beneficiary's home. These systems require a device like a phone, computer, or other device to track attendants' start and stop times. For example, HHS reported on one electronic visit verification system. The system relied on attendants clocking in and out via a telephone in the beneficiary's home, and if the attendant did not clock in within 15 minutes of the scheduled visit, an electronic alert was sent to the provider agency.<sup>32</sup>

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<sup>31</sup>As of September 2016, legislation pending before Congress would require, if enacted, all state Medicaid programs to use electronic visit verification for in-home services provided by PCS and home health care attendants. Helping Families in Mental Health Crisis Act of 2016, H.R. 2646, 114<sup>th</sup> Cong. § 207 (2016). The Congressional Budget Office estimates that enacting this legislation would reduce annual spending for PCS and home health services by less than 1 percent, on average, from 2017 to 2026—a savings of about \$290 million.

<sup>32</sup>Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, *Did They or Didn't They?: A Brief Review of Services Delivery Verification in MLTSS* (2013).

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### Private Sector Use of Electronic Visit Verification Systems

Three out of the four private entities we spoke with cited electronic visit verification, among other safeguards, as a key practice that helps both to keep clients safe and to ensure that billed services are provided. Some private sector entities we spoke with said they used electronic visit verification to track and verify attendants' check-in and check-out times to help ensure that they are showing up to deliver services. For example, the systems allowed one entity to compare hours billed to those worked, and another entity to review daily log notes, such as the tasks performed, to gather details on specific shifts. An electronic visit verification system can generate alerts when an attendant's time-in or time-out recordings fail to match a client's schedule or the scheduled duration of services, when an attendant records visit information in a location other than a client's home, or when the tasks performed do not match the signed authorization. One private entity we spoke with uses a system that has more sophisticated capabilities; for example, attendants can use the system to report clients' changes in health condition—such as a decline in the client's ability to perform an activity of daily living—and can send messages to a third party, such as the client's case manager, when further assistance or consultation is needed.

One private sector entity reported that electronic visit verification decreased costs. An official from this entity stated that the technology helped reduce costs related to travel time by 10 percent because the system resulted in more accurate time and travel reporting. The official stated that the technology creates efficiencies; for example, it streamlines processes, allowing administrative staff to focus on quality rather than on paperwork. In addition to direct financial savings, this official believed that electronic visit verification may deter people with nefarious intentions from seeking home care employment because of the level of monitoring these systems add.

Source: Information from four private sector entities that operate in multiple states. | GAO-17-28

Medicaid officials from Maryland and Texas described the benefits they found using electronic verification systems:

- Maryland Medicaid officials cited four benefits of electronic visit verification: (1) more accurate and valid reporting of time; (2) realizing cost savings because the state is only paying for services when the attendant has verified through the system that they are in the beneficiary's home; (3) collecting data, which allows the state to more easily review trends and identify potential service issues; and (4) absolving beneficiaries from the responsibility for verifying that an attendant's timesheets are correct.
- Texas Medicaid officials reported they were motivated to use electronic visit verification because fraud is a concern, noting that the system captures when attendants actually start and stop providing services. Officials explained that attendants could easily record on paper timesheets the times they were supposed to provide services instead of the times they actually provided services. Officials reported that the use of an electronic visit verification system has saved the state money.

Oregon Medicaid officials reported that the state is in the process of acquiring an electronic visit verification system and anticipate that the system will be able to track attendants' time more accurately than paper timesheets. California Medicaid officials reported that they have no current plans to use electronic visit verification. California officials explained that they do not think this is an effective option because a high percentage of attendants in the state's PCS program are friends or family members, some of whom live with the beneficiary.

Three of the four private-sector entities we interviewed named electronic visit verification systems as a key practice for ensuring billed services are provided (see Text Box, "Private Sector Use of Electronic Visit Verification Systems"). Other practices used by these entities include: communicating with clients and their families, conducting unannounced monitoring visits, training attendants, and conducting attendant background checks. The private entities reported providing PCS to clients in multiple states, but have established some similar policies and procedures to use regardless of location.

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## CMS Has Taken Steps to Improve Oversight of States' Personal Care Services Programs and Harmonize Requirements, but Issues Remain

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### CMS Has Taken Steps to Improve Oversight through Guidance and Program Reviews but Does Not Collect Required State Information

Since 2010, CMS has taken several steps to improve oversight of states' PCS programs to help ensure that beneficiaries are safe and that billed services are provided. CMS has taken the following steps:

- Issued guidance to strengthen HCBS Waiver requirements. In March 2014, CMS issued guidance to strengthen requirements for beneficiary health and welfare and ensure that billed services are provided in HCBS Waiver programs by adding more detailed requirements.<sup>33</sup> For example, CMS added requirements that states ensure that an incident management system is in place to address incidents that could harm beneficiaries and provide evidence that payments are only made for services rendered.
- Reviewed annual HCBS Waiver information submissions. In September 2014, CMS contracted with a private company to review information states submit to CMS on HCBS Waiver programs. The information includes measures that states track to ensure the health and welfare of beneficiaries and that billed services are provided.<sup>34</sup> The contractor identified concerns such as variation in both the frequency and methods states used to monitor attendants. The contractor also noted positive findings such as states' implementation of policies and processes to verify that attendants have provided care.
- Developed a toolkit, webinars, and training for states on how to prevent improper payments. Since 2010, CMS has also taken several

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<sup>33</sup>CMS, *Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers* (Baltimore, MD: March 12, 2014).

<sup>34</sup>HCBS Waiver programs require states to report regularly to CMS on health and welfare and financial accountability.

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steps to assist states' efforts to reduce PCS improper payments. CMS issued a toolkit and conducted three webinars that describe program integrity concerns and best practices for addressing them. In addition, CMS's program integrity training center for state officials, the Medicaid Integrity Institute, has held a number of courses on issues related to PCS or HCBS. For example, in June 2013 the Institute held a course on fraud related to personal care attendants.

- Reviewed state PCS programs. Since 2013, CMS has assessed and issued reports on three state PCS programs. All three reviews identified vulnerabilities to improper payments and two identified vulnerabilities in beneficiary safeguards. Findings included attendants being paid for more hours than authorized, billing for services not rendered, a lack of a process to track attendants that have been subject to disciplinary actions, and infrequent updates to attendant background checks and screenings. CMS made a number of recommendations to individual states, such as: refunding the federal share of one state's overpayments; requiring background screenings at least once every five years; and tracking attendants who have received disciplinary sanctions.

In contrast to the steps CMS has taken to improve oversight of states' PCS programs, as of August 2016 CMS had not systematically collected all required state information and measures of beneficiaries' health and welfare for the Participant-Directed Option and Community First Choice programs, nor had CMS implemented a process for states to submit the information to CMS for these programs. CMS officials told us that they are working to develop guidance for states to submit some of the information. In addition, CMS also had not exercised its authority to request information that states are required to maintain on the quality measures they use to evaluate their PCS programs, as of August 2016. CMS is responsible for monitoring and overseeing states' implementation of federal requirements.

- Required reporting. Federal law requires states to report certain information related to the health and welfare of beneficiaries to CMS for two PCS programs. This required reporting will help inform CMS and Congress about the health and welfare of beneficiaries receiving services from these programs. CMS officials told us that they are working on developing guidance for states to submit the required information.

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- For the Participant-Directed Option program, CMS has not collected the evaluations states are required to provide every 3 years.<sup>35</sup> States are required to provide an evaluation of the overall impact of the program on the health and welfare of participating beneficiaries compared to non-participants. The first state was approved for a Participant-Directed Option program in 2007, and eight other states were subsequently approved, all in 2008 through 2010. In 2008, CMS stated that it would issue further guidance on the requirement, but this guidance has not been completed. Officials from one state told us that although CMS did not request the required information, the state submitted it to CMS. CMS officials stated that they have not analyzed the data from that state as of June 2016.
  - For the Community First Choice program, CMS has collected data once in the 4 years that states have been approved to provide PCS under Community First Choice, despite the requirement for states to submit the data annually.<sup>36</sup> HHS collected required state data on the physical and emotional effects of the programs on beneficiaries; these data were summarized in a report on Community First Choice released in 2016.<sup>37</sup> CMS officials told us in August 2016 that they are working on developing guidance for states to submit the required information and expect to issue guidance for the Community First Choice program in 2016.<sup>38</sup>
  - Reporting measures. CMS may collect other information on the Participant-Directed Option and Community First Choice programs. States are required to track quality measures on an ongoing basis as part of their quality assurance systems. The measures must be made available to CMS upon request.
    - For the Participant-Directed Option program, CMS officials told us that they were not aware of any CMS requests for information from states on the quality of care measures they use to monitor the performance of their PCS programs, such as the percentage

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<sup>35</sup>See 42 U.S.C. § 1396n(j)(2)(E).

<sup>36</sup>See 42 U.S.C. § 1396n(k)(3)(E).

<sup>37</sup>U.S. Department of Health and Human Services, *Community First Choice: Final Report to Congress* (released March 15, 2016).

<sup>38</sup>As of October 6, 2016, the guidance has not been issued.

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of beneficiaries' cases reviewed in which a critical incident occurred.<sup>39</sup>

- For the Community First Choice program, officials told us that CMS has not requested information from states on the measures they use to assess beneficiaries' outcomes resulting from the PCS services they receive, particularly for health and welfare. CMS officials have stated, however, that the measures are an important component to help ensure quality, and plan to collect the information after guidance related to collecting the measures is issued.

Because CMS does not collect or analyze the required reports on beneficiary outcomes or the available data on quality measures used, CMS may not know the effects that these programs are having on beneficiaries' well-being and may not be able to assess the extent to which the quality measures being used by states actually reflect the quality of care beneficiaries receive.

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### CMS Has Taken Steps to Harmonize Requirements for Beneficiary Safeguards and Fiscal Oversight across PCS Programs, but Significant Differences Remain

CMS officials cited some steps the agency has taken to harmonize requirements across the different types of PCS programs. Agency officials described CMS's efforts towards harmonization of requirements:

- CMS issued a final rule in 2014 that will help result in some harmonization across HCBS Waiver programs, State Plan HCBS programs, and Community First Choice programs, agency officials told us. The rule established new requirements for what constitutes a home- and community-based setting, among other things.<sup>40</sup> For example, the 2014 final rule provides clarification and guidance to determine what community care settings other than a beneficiary's home—such as assisted living facilities—can be considered non-institutional settings and be eligible for home and community-based services. The rule also required that beneficiaries' plans of care reflect

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<sup>39</sup>Nationwide, four Participant-Directed Option programs are paired with HCBS Waiver programs and seven Participant-Directed Option programs are paired with State Plan PCS programs. Under HCBS Waiver programs, states must report information to CMS on the health and welfare of beneficiaries. Under State Plan PCS programs, states do not have to report such information (see Table 8).

<sup>40</sup>State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers, 79 Fed. Reg. 2948 (Jan. 16, 2014).

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risk factors and have measures in place to minimize them, including back-up plans for beneficiaries who need them. These requirements were new for HCBS Waivers and State Plan HCBS program. Community First Choice programs had already been required to address risk factors. For HCBS Waiver, State Plan HCBS, and Community First Choice programs, the rule added requirements that states assure that services and supports will not harm beneficiaries.<sup>41</sup>

- CMS's contractor's ongoing review of states' annual HCBS Waiver reports could result in some harmonizing between programs that provide PCS. As CMS's contractor develops findings on how states' compliance with HCBS Waiver requirements, CMS officials stated that where information can be shared across authorities to ensure efficiencies and consistencies, CMS will do so in the future.
- CMS has implemented an effort to harmonize requirements for two types of PCS programs. CMS officials stated that states seeking approval for a State Plan HCBS program are directed to requirements in CMS guidance for HCBS Waivers. CMS officials said that State Plan HCBS and HCBS Waivers offer many of the same services and it makes sense to oversee them in a similar manner. CMS has not issued the guidance directing states to use HCBS Waiver guidance as of August 2016, but rather, CMS regional office staff communicate the requirements for HCBS Waivers to those states requesting approval for State Plan HCBS programs, according to CMS officials.

However, we found that CMS's efforts have not addressed the significant differences across federal program requirements specific to PCS related to beneficiary safety and ensuring that billed services are provided.<sup>42</sup> For example, states implementing an HCBS Waiver program or a State Plan HCBS program must describe to CMS how the state Medicaid agency will determine that it is assuring the health and welfare of beneficiaries. To do so, states must describe: the activities or processes related to assessing or evaluating the program; which entity will conduct the activities; the entity responsible for reviewing the results; and the frequency at which

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<sup>41</sup>For Community First Choice, states must assure that interventions and supports will cause no harm when they are provided in a setting that is owned or controlled by the provider. For HCBS Waivers and State Plan HCBS, states must provide this assurance regardless of the setting.

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

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activities are conducted. In contrast, this level of detail on the evaluation process is not required for states implementing a State Plan PCS program or a Community First Choice program.

Similarly, states implementing an HCBS Waiver program or a State Plan HCBS program must demonstrate that an incident management system is in place, which requires states to document and provide the following details to CMS:

- indicate whether the state operates a critical incident reporting and management process;
- list and define critical incidents;
- identify entities or individuals who must report critical incidents and the reporting method (for example, phone or web-based reporting system);
- specify the timeframe within which critical incidents must be reported and the entity to which reports are made for each type of incident;
- identify the entities responsible for evaluating reports of critical incidents and how the incidents are evaluated;
- identify the entity responsible for following up on investigations of critical incidents and the time frame for completing an investigation; and
- explain the process and time frames for informing the beneficiary and other relevant parties of the results of an investigation.

In contrast, states implementing a State Plan PCS program or a Community First Choice program are not required to provide similar information on their critical incident management process but, more generally, are required to describe their “process for the mandatory reporting, investigating and resolution of allegations of neglect, abuse, or exploitation.”<sup>43</sup> The State Plan PCS program does not have incident management reporting requirements. Other significant differences among PCS program requirements relate to ensuring that billed services are provided. States implementing HCBS Waiver programs and State Plan HCBS programs are required to provide evidence that the state is only paying claims when services are actually rendered, while the State Plan PCS and Community First Choice programs are not required to do so.

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<sup>43</sup>See, for example, 42 C.F.R. § 441.585(a)(2) (2015).

See table 8 for state Medicaid program requirements for ensuring the health and welfare of PCS beneficiaries and that billed services are provided.

**Table 8: Federal Medicaid Personal Care Services (PCS) Program Requirements on Safeguarding Beneficiaries and Ensuring Billed Services Are Provided, by Program Type**

Requirements for states <sup>b</sup>	PCS Program Type <sup>a</sup>			
	State Plan PCS	State Plan Home- and Community-Based Services (HCBS)	HCBS Waivers	Community First Choice
<b>General health and welfare</b>				
Assure necessary safeguards have been taken to protect the health and welfare of beneficiaries	○	●	●	●
Describe health and welfare safeguards	○	●	●	●
Measure and improve performance in meeting assurances	○	●	●	○ <sup>c</sup>
Submit performance measurement evidence to determine whether or not an assurance has been met	○	○	●	○ <sup>c</sup>
Annually report on the impact of the program on the health and welfare of recipients	○	○	●	● <sup>d</sup>
Assure that interventions and supports will cause no harm to the individual	○	●	●	● <sup>e</sup>
The beneficiaries' plan of care must reflect risk factors and measures in place to minimize these factors, including back-up plans when needed.	○	●	●	●
<b>Quality assurance related to health and welfare</b>				
Quality assurance (general)	●	●	●	●
Quality assurance system that continuously monitors health and well-being	○	●	●	●
Quality improvement strategy to measure individual outcomes	○	●	●	●
<b>Critical incidents</b>				
Quality assurance and improvement plan must identify critical incidents	○	●	●	●
Quality assurance system must include a process for the mandatory reporting, investigation, and resolution of allegations of critical incidents	○	○	○	●
Demonstrate that on an ongoing basis, the state identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death	○	●	●	○ <sup>f</sup>
Demonstrate that an incident management system is in place	○	●	●	○ <sup>f</sup>

<b>Attendant Qualifications, Training, Screening, and Monitoring</b>				
Set standards for training	○	○	○	●
Develop provider qualifications or standards	●	●	●	● <sup>g</sup>
Monitor uncredentialed providers	○	●	●	○
<b>Ensuring that services for which a state has been billed are provided</b>				
Assure financial accountability and submit to an independent financial audit	○	●	●	○
Provide evidence that claims are only for services rendered	○	●	●	○
Describe the processes to validate provider billings to help ensure that services were provided	○	●	●	○
Monitor service delivery for participant-directed services	●	●	●	○

Legend: ● = Required ○ = Not required

Source: GAO analysis of Section XIX of the Social Security Act; Personal Care Services Regulations; CMS guidance | GAO-17-28

<sup>a</sup>One other type of PCS program is called the Participant-Directed Option (see table 1). It is not a standalone program; instead, states pair it with either State Plan PCS or HCBS Waivers. The requirements of the underlying paired authority apply to programs offering the Participant-Directed Option.

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

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

<sup>d</sup>States must report on beneficiaries' "physical and emotional health."

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

<sup>f</sup>For Community First Choice, states must have quality assurance plans that include a process for reporting critical incidents, but are not required to have prevention programs.

<sup>g</sup>This requirement applies to attendants who work for a provider agency that is approved by the state to provide PCS to beneficiaries.

Based on numerous reviews of state PCS programs, the HHS OIG recommended that CMS issue regulations to reduce the significant variation in states' PCS requirements for documenting claims for payment for services, supervision of attendants, and attendant qualification standards.<sup>44</sup> Harmonizing requirements across similar programs is also

<sup>44</sup>The OIG listed this recommendation—to reduce the significant variation in states' PCS requirements for documenting claims for payment for services and supervision of attendants—among its 25 most crucial unimplemented recommendations. The OIG reported that CMS had not yet implemented these recommendations as of April 2016. U.S. Department of Health and Human Services, Office of the Inspector General, *Compendium of Unimplemented Recommendations* (Washington, D.C.: April 2016).

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consistent with federal internal control standards. These standards state that agencies should establish control activities that appropriately cover the objectives and risks of an entity's operations.<sup>45</sup> Further, risk management standards published by an international standard-setting organization suggest that a consistent process and comprehensive framework can help to ensure that risk is managed effectively, efficiently, and coherently.<sup>46</sup> In the case of PCS, a consistent internal control process could include having policies and processes in place that would provide comparable assurances for protecting Medicaid beneficiaries from harm and ensuring that state and federal funds are paid only when services are actually provided, regardless of the program in which beneficiaries are enrolled.

In addition, the Patient Protection and Affordable Care Act directed HHS to take steps to improve the coordination among and regulation of all providers of home- and community-based services—which includes PCS provided under different federal authorities—to achieve a more consistent administration of policies and procedures across programs.<sup>47</sup> Our prior review of selected states' implementation of HCBS options also suggests that states could benefit from more harmonization of HCBS guidance, as officials in selected states noted the complexity of operating multiple programs.<sup>48</sup> In that review, officials from one state reported that the complexity resulted in a siloed approach, with different enrollment, oversight, and reporting requirements for each program. The administration and understanding of the programs available to beneficiaries is difficult for state staff and beneficiaries, according to officials in another state. The officials indicated that they would prefer CMS issue guidance on how states could operate the different HCBS program types together, rather than issuing guidance on each program separately.

CMS officials told us the agency is not currently taking additional steps to harmonize requirements—within the limits of the various statutes—in

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<sup>45</sup>GAO, *Standards for Internal Control*.

<sup>46</sup>International Organization for Standardization, *Risk Management – Principles and Guidelines*, ISO 31000:2009(E) (Nov. 15, 2009).

<sup>47</sup>Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2402(a), 124 Stat. 119, 301-302 (2010).

<sup>48</sup>GAO, *Medicaid: States' Plans to Pursue New and Revised Options for Home- and Community-Based Services*, [GAO-12-649](#) (Washington, D.C.: June 13, 2012).

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response to the Patient Protection and Affordable Care Act, but may make federal guidance more similar in the future.<sup>49</sup> First, officials said that they want to provide states with flexibility to implement programs that meet each state's needs. Second, CMS officials said that the statutes authorizing the programs are different. CMS officials also stated that in the future, where the statute and regulations are similar across programs, they will work on making federal policy the same or similar. In addition, officials stated that when CMS identifies a good oversight policy or practice being used by a state for one type of PCS program, CMS can discuss best practices that may be applicable to other authorities, but CMS cannot suggest that such best practices are required.<sup>50</sup>

In addition to creating complexities for states and others in understanding federal requirements governing different types of HCBS programs, including PCS, the differing federal requirements across the different types of PCS programs may result in significant differences in beneficiary safeguards and fiscal oversight:

- Beneficiaries may experience different health and welfare safeguards depending on the program in which they are enrolled. For example, in one state we reviewed, the state requires quarterly or biannual monitoring of beneficiaries for most of its PCS programs. For a State Plan PCS program, the state requires only annual monitoring contacts. Officials told us that the reason for this difference was due to the lack of a requirement that states provide assurances to CMS that they will safeguard beneficiaries' health and welfare. CMS may also have fewer assurances that similar beneficiaries' safety is protected. Three of the four states we reviewed—Maryland, Oregon, and Texas—transitioned coverage of PCS for beneficiaries who need an institutional level of care from PCS programs with relatively more stringent federal beneficiary safety requirements to programs with relatively less stringent requirements. Specifically, the states transitioned PCS from HCBS Waiver programs to Community First

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<sup>49</sup>PCS programs have different statutory requirements that CMS lacks authority to alter. However, harmonization does not entail complete consistency but "a more consistent administration of policies and procedures across programs in relation to the provision of such services." See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2402(a), 124 Stat. 119, 301-302 (2010).

<sup>50</sup>CMS officials also said that as of August 2016, the agency was in the process of developing guidance for the Community First Choice program, and they plan to include guidance on how states can operate HCBS Waiver and Community First Choice programs together.

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Choice programs.<sup>51</sup> In doing so, state officials in the three states reported that the state chose to apply the same quality assurance measures to services received under both the HCBS Waiver program and the Community First Choice program. Officials in two of the states said that maintaining the processes was the best way to ensure safety for beneficiaries. The states were not required to apply the same quality measures across programs, and CMS has no assurance that states that transition PCS from HCBS Waivers to Community First Choice in the future will make the same decisions.

- States can use different processes for each PCS program to ensure that billed services are actually provided, and some programs may not be subject to federal PCS requirements explicitly in this regard. For example, in one state we reviewed, steps taken to ensure billed services are provided under some types of PCS programs are not required in another of the state's programs. The state reported that it used its quality assurance process in some of its PCS programs to meet with and verify service delivery with the beneficiary in an effort to ensure that billed services are provided. For example, in one PCS program, a supervisor must visit the beneficiary and document whether the attendant is delivering the authorized PCS tasks. In training materials, CMS recommended states take such an approach to detect fraud in PCS programs.<sup>52</sup> The state did not apply the same process to a State Plan PCS program, and federal requirements for State Plan PCS do not include requirements that states help ensure that PCS billed services are provided specifically.

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## Conclusions

Over the years, federal laws have given states a number of different options and incentives to provide Medicaid home- and community-based services. PCS are important to beneficiaries and amount to billions of dollars and expected rising costs to the federal government and states. As the federal government continues to encourage states to offer Medicaid services in community settings and as demand for such services continues to grow, CMS could do more to obtain and use

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<sup>51</sup>Eligibility for both of these PCS programs is limited to beneficiaries whose needs require an institutional level of care. Officials in two states told us that the state adopted Community First Choice programs in part because of a 6 percentage point increase in their federal matching rate for expenditures, an incentive that encourages more states to provide more home- and community-based services to beneficiaries.

<sup>52</sup>Centers for Medicare & Medicaid Services, *Increasing Fiscal Protections for Personal Care Services*, webinar (2016), accessed October 24, 2016, <https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-increasing-fiscal-protections-v6.pdf>.

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information from states about their programs. CMS has not collected information states are required to prepare on two PCS programs that would inform the agency of the effects that certain PCS programs are having on beneficiaries' well-being. Although these programs have not yet been widely adopted by states, it is likely these will grow in prevalence given incentives for states to adopt certain programs and provide more home- and community- based services. Without the required information, CMS is missing opportunities to monitor states' programs to ensure that potentially vulnerable beneficiaries are receiving quality care.

Although the various options for providing PCS have helped facilitate and encourage states to provide care for more beneficiaries in their homes, they have also resulted in a patchwork of federal requirements among programs, resulting in varying levels of beneficiary safeguards and requirements to ensure that billed services are actually provided. As a result, beneficiaries with similar needs could be receiving services in programs with significantly different safeguards in place depending on the program. Similarly, the type of fiscal controls required to prevent improper payments for these services can vary based on the type of program.

Congress and others have called on HHS to take steps to improve the coordination and administration of home- and community-based services. HHS could do more towards this end by, within limits of existing law, harmonizing the patchwork of federal program requirements. A more consistent administration of policies and procedures across programs could ease some of the differences and provide some comparable approaches to safeguards and assurances and help the federal government and states better manage risks to beneficiaries and to protect the integrity of the program.

CMS has taken some needed steps to harmonize requirements across the program authorities; however, significant differences remain in the federal program requirements that serve as the basis for state oversight policies and protections for their different PCS programs.

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## Recommendations for Executive Action

To achieve a better understanding of the effect of certain PCS services on beneficiaries and a more consistent administration of policies and procedures across PCS programs, we recommend the Acting Administrator of CMS take the following two actions:

- collect and analyze states' required information on the impact of the Participant-Directed Option and Community First Choice programs on

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the health and welfare of beneficiaries as well as the state quality measures for the Participant-Directed Option and Community First Choice programs; and

- take steps to harmonize requirements, as appropriate, across PCS programs in a way that accounts for common risks faced by beneficiaries and to better ensure that billed services are provided.

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## Agency Comments and Our Evaluation

We provided a draft of this report to HHS for comment. HHS concurred with our recommendations and noted efforts to address them. HHS stated that it plans to issue guidance for states to submit information on Community First Choice programs and is exploring the value of collecting information from states on Participant-Directed Option programs. HHS stated it will continue to take steps to assess areas to harmonize program requirements across PCS programs, including soliciting information from states, stakeholders, and the public on ideas for doing so. On November 9, 2016, CMS published in the Federal Register a request for information on numerous topics related to Medicaid home and community-based services, including input on how to ensure beneficiary health and safety and program integrity across different types of PCS programs. Input received could lead to harmonizing some program requirements. HHS also provided technical comments, which we incorporated as appropriate. HHS's comments are reprinted in appendix II.

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As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, relevant state agencies, and interested congressional committees. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or [iritanik@gao.gov](mailto:iritanik@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last

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page of this report. GAO staff who made key contributions to this report are listed in appendix III.

A handwritten signature in black ink that reads "Katherine Iritani". The signature is written in a cursive style with a large, prominent initial "K".

Katherine M. Iritani  
Director, Health Care

# Appendix I: Description of Selected States' Fee-for-Service Personal Care Services Programs

## California

California provides personal care services (PCS) to Medicaid beneficiaries under the following programs: State Plan PCS, Participant-Directed Option (paired with the State Plan PCS program), and Community First Choice (see table 9).<sup>1</sup> California operates these three programs together in a program called In-Home Supportive Services. The California Department of Social Services oversees In-Home Supportive Services, which is generally administered by staff in each county.

**Table 9: Number of Beneficiaries and Personal Care Attendants (Attendant) in California Personal Care Services (PCS) Programs, Calendar Year 2015**

	State Plan PCS	Participant-Directed Option	Community First Choice
Beneficiaries who received at least one PCS service <sup>a</sup>	177,611	7,982	133,908
Number of attendants who billed for the provision of PCS <sup>b</sup>	220,200	9,919	166,241

Source: State of California | GAO-17-28

<sup>a</sup>We also excluded PCS that were administered as part of a Medicaid demonstration project integrating services for beneficiaries eligible for both Medicare and Medicaid. California also provides PCS through State Plan HCBS and through HCBS Waivers, but we excluded these programs from our review because officials told us the two programs provide a minimal amount of PCS in beneficiaries' homes beyond In-Home Supportive Services.

<sup>b</sup>The counts of attendants include both participant-directed and provider agency delivery models. California officials were also unable to determine if the attendants included in the counts are PCS providers for the demonstration project integrating services for beneficiaries eligible for both Medicare and Medicaid.

In-Home Supportive Services operates almost entirely under a participant-directed delivery model. Many beneficiaries choose a relative or friend to be their attendant: 69 percent of attendants in In-Home Supportive Services were a friend or family member of the beneficiary; and 58 percent of attendants live with the beneficiary. Other beneficiaries seek an attendant through county-maintained registries of attendants who are seeking positions.

In 2011, California became the first state to adopt a Community First Choice program. At the time, some beneficiaries previously served

<sup>1</sup>California also provides PCS through State Plan HCBS and through HCBS Waivers, but we excluded these programs from our review because they provide a minimal amount of PCS in beneficiaries' homes beyond In-Home Supportive Services. We also excluded PCS that were administered as part of a demonstration project integrating services for beneficiaries eligible for both Medicare and Medicaid.

through In-Home Supportive Services under State Plan PCS were transitioned into Community First Choice. Officials told us that the Community First Choice program provides an opportunity for California to enhance the state's PCS services, and gain the enhanced federal matching rate.

**Maryland**

Maryland provides PCS to Medicaid beneficiaries under both State Plan PCS and Community First Choice (see table 10). Maryland operates these two programs (called Community Personal Assistance Services and Community First Choice) under the Maryland Department of Health and Mental Hygiene. Generally, county-based agencies assess Medicaid eligible beneficiaries for their PCS needs, and case managers and nurses monitor beneficiaries.

**Table 10: Number of Beneficiaries and Personal Care Attendants (Attendant) in Maryland Personal Care Services (PCS) Programs, Calendar Year 2015**

	<b>State Plan PCS</b>	<b>Community First Choice</b>
Beneficiaries who received at least one PCS service	3,115	5,937
Number of attendants who billed for the provision of PCS	108	2502

Source: State of Maryland | GAO-17-28

In 2015, Maryland implemented changes to its two PCS programs to make all PCS delivered through provider agencies.<sup>2</sup> However, beneficiaries may still choose a relative or friend to be their attendant. To do so, officials told us that case managers direct friends and relatives to PCS provider agencies that may hire them as attendants. Officials estimated that before the change, about one-third of beneficiaries received services through the participant-directed model.

Before its Community First Choice program was approved in 2014, Maryland provided PCS under HCBS Waiver and State Plan PCS.

<sup>2</sup>Officials told us that Maryland made the decision to change to a provider agency-directed model in anticipation of new federal regulations that require employers to pay overtime to staff who work more than 40 hours per week. Under a participant-directed model, officials told us that Maryland was considered a joint employer, and therefore responsible for paying overtime under the new regulations. By changing to an agency-directed model, the provider agency is the employer is responsible for paying overtime.

**Appendix I: Description of Selected States' Fee-for-Service Personal Care Services Programs**

Maryland continues to provide certain services, such as case management, to some beneficiaries under an HCBS Waiver, but provides PCS through Community First Choice. Officials told us that, when transitioning to Community First Choice, close to 90 percent of State Plan PCS beneficiaries were found to need an institutional level of care. These beneficiaries now receive PCS through Community First Choice, while beneficiaries who do not require an institutional level of care receive services through State Plan PCS.

**Oregon**

Oregon provides PCS to Medicaid beneficiaries under State Plan PCS, Participant-Directed Option (paired with an HCBS Waiver), and Community First Choice (see table 11).<sup>3</sup> Two departments implement the programs: Aging and People with Disabilities generally serves seniors and people with physical disabilities through all three programs; and the Office of Developmental Disability Services serves people with intellectual or developmental disabilities, through State Plan PCS and Community First Choice programs.<sup>4</sup>

**Table 11: Number of Beneficiaries and Personal Care Attendants (Attendant) in Oregon Personal Care Services (PCS) Programs, 2015**

	State Plan PCS	Participant-Directed Option	Community First Choice
Beneficiaries who received at least one PCS service <sup>a</sup>	2852	483	30,419
Number of attendants who billed for the provision of PCS <sup>b</sup>	2558	485	35,282

Source: State of Oregon | GAO-17-28

<sup>a</sup>We excluded from our study PCS delivered through provider agencies because the program accounted for less than 1 percent of the attendants that serve beneficiaries.

<sup>b</sup>Oregon's count of PCAs did not account for duplication. It is possible that some attendants bill for the provision of PCS in more than one PCS programs.

<sup>3</sup>Officials told us that Oregon also provides PCS through State Plan HCBS, but we excluded this program from our review because the PCS is incidental to their other services, such as working with beneficiaries to maintain or improve skills.

<sup>4</sup>A small number of beneficiaries also receive PCS through the Oregon Health Authority.

Oregon’s PCS programs operate almost entirely under a participant-directed model.<sup>5</sup> Officials told us that many beneficiaries select either a family member or friend to serve as their attendant. Oregon maintains a registry of attendants, called the Registry and Referral System. Officials told us that all attendants must enroll in the registry, including family members and friends who serve as attendants. The state agency that oversees the registry, the Oregon Home Care Commission, also provides an orientation to new attendants and offers ongoing training. The Commission also serves as the employer of record for purposes of collective bargaining.

In 2013, Oregon became the second state to adopt the Community First Choice program. The state transitioned all PCS out of its HCBS Waiver into Community First Choice, although Oregon provides some other services—such as case management—under an HCBS Waiver to some Community First Choice beneficiaries. In transitioning to Community First Choice from an HCBS Waiver, Oregon officials chose to maintain some of the same quality assurance processes of previous HCBS Waiver programs; 15 of the HCBS Waiver quality assurance measures were incorporated into Community First Choice. Officials told us that Community First Choice also has additional quality assurance measures that were not part of the previous HCBS Waivers. Community First Choice provides PCS to those who need an institutional level of care, while officials told us that State Plan PCS provides PCS to those who have do not require an institutional level of care.

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## Texas

Texas provides PCS to Medicaid beneficiaries under four types of programs and, in some cases, administers separate programs within the same type.<sup>6</sup> Texas operates: two State Plan PCS programs (one is for participants under age 21 and one is for participants age 21 or older); Participant-Directed Option (paired with State Plan PCS); and Community First Choice.<sup>7</sup> Texas also operates an additional PCS program that is unique to Texas. Authorized by Section 1929(b) of the Social Security

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<sup>5</sup>We exclude services provided by agencies that employ attendants because these attendants made up less than 1 percent of all attendants.

<sup>6</sup>Texas did not provide data on the number of beneficiaries and attendants in each PCS program as of August 2016.

<sup>7</sup>We excluded one group of Community First Choice beneficiaries from our study because the state is transitioning the program to a managed care delivery model in the fall of 2016.

Act, Texas uses the Community Attendant Services program to provide PCS to beneficiaries who have incomes that are too high to qualify for other Medicaid services, according to officials. Texas is the only state that has adopted such a program. The programs are operated within different departments of the Texas's Health and Human Services Commission, which operates one of two State Plan PCS programs, while one of its operating departments, the Department of Aging and Disability Services, operates another State Plan PCS program, Community First Choice, and the 1929(b) program.

Texas's PCS programs deliver PCS both through provider agencies and through a participant-directed model. Participants in each PCS program who wish to exercise more control over their services may operate under a set of requirements known as the consumer-directed services option. According to officials, many of the PCS services in Texas are now being provided by a managed care company (We excluded this type of arrangement from our study).

Texas is the most recent state to adopt the Community First Choice program, as of April 2016. The state transitioned all PCS out of five of its HCBS Waivers into Community First Choice. In so doing, Texas maintained certain features of four of the five programs, including retaining the same service providers, such as attendants.<sup>8</sup> For example, Texas transitioned the PCS in its HCBS Waiver program called the Community Living Assistance and Support Services into Community First Choice. This HCBS Waiver had served beneficiaries who have developmental disabilities. After the transition to Community First Choice, beneficiaries receive generally the same services through the same providers, and the claims for the services are attributed to Community First Choice.

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<sup>8</sup>The fifth HCBS Waiver program, Community Based Alternatives, was discontinued.

# Appendix II: Comments from the Department of Health & Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

NOV 03 2016

Katherine M. Iritani  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Ms. Iritani:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicaid Personal Care Services: CMS Could Do More to Harmonize Requirements Across Programs*" (GAO-17-28).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID PERSONAL CARE SERVICES: CMS COULD DO MORE TO HARMONIZE REQUIREMENTS ACROSS PROGRAMS (GAO-17-28)**

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) report on Medicaid Personal Care Services (PCS). CMS takes the oversight of state personal care service programs seriously and the health and well-being of Medicaid beneficiaries, particularly the most vulnerable, are a top CMS priority.

Medicaid PCS are services provided to eligible beneficiaries that allow them to stay in their own homes and communities rather than live in institutional settings, such as nursing facilities. These services may be provided by an independent or agency-based personal care attendant (PCA). States can choose to furnish PCS through 1905 (a), 1915 (i), or 1915 (k) authorities, or through a home and community-based services waiver. As a result of these different statutory authorities that states may choose, PCS can vary greatly by state and within states, depending on the Medicaid authority used. However, states must request and receive approval from HHS to operate the programs and specify the services to be delivered. HHS has taken a number of steps to improve program coordination by issuing additional guidance, providing technical assistance to states and modernizing federal databases.

In January 2014, HHS promulgated final rules that harmonized many requirements for home and community-based services (HCBS), including PCS. These regulations addressed beneficiary assessments and plans of care provisions for certain programs that provide PCS. The final rule also provided states with the option to combine coverage for multiple target populations into one waiver to facilitate streamlined administration of HCBS waivers. It also allowed states to use a five-year renewal cycle to align concurrent waivers that serve individuals eligible for both Medicaid and Medicare.

More recently, HHS published guidance for providers summarizing PCS and personal care attendant (PCA) requirements, a brief explanation of differences between PCS and home health services, an overview of common causes of improper payments, and guidance on how to avoid them. HHS also recently issued an Informational Bulletin to states providing several options states could implement to secure a robust and qualified workforce to deliver home care services, including personal care services. Options included the implementation of a registry to reflect individuals meeting the state's provider qualifications (or in the case of self-directed programs, meeting the beneficiary's qualifications) and the offering of basic training to workers without usurping beneficiary decisions on what skills are most appropriate for their homecare workers. In February 2016, HHS provided training for monitoring fraud, waste, and abuse in home and community-based settings for PCS.

HHS believes that maintaining state flexibility for this service, in terms of provider qualifications and oversight, is important. HHS plans to take additional steps to help develop policies for home and community-based services, including ways to advance program integrity while taking into account issues affecting beneficiary access. CMS has also incorporated a process to offer additional guidance to states for improving program integrity in the delivery of personal care services and how they can help protect beneficiaries and taxpayers.

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID PERSONAL CARE SERVICES: CMS COULD DO MORE TO HARMONIZE REQUIREMENTS ACROSS PROGRAMS (GAO-17-28)**

GAO's recommendations and HHS' responses are below.

**GAO Recommendation**

Collect and analyze states' required information on the impact of the Participant-Directed Option and Community First Choice programs on the health and welfare of beneficiaries as well as the state quality measures for the Participant-Directed Option and Community First Choice Program.

**HHS Response**

HHS concurs with GAO's recommendation. HHS plans to issue guidance on the Community First Choice Program to assist states in submitting information to HHS on the health and welfare of beneficiaries. Once the guidance is published, HHS will assess the benefit of requiring states to report on the optional quality measures. With regard to the Participant-Directed Option, given the limited number of states currently operating under this authority, HHS will continue to explore the value of collecting this information.

**GAO Recommendation**

Take steps to harmonize requirements, as appropriate, across PCS programs in a way that accounts for common risks faced by beneficiaries requiring the same level of care and to better ensure that billed services are provided.

**HHS Response**

HHS concurs with GAO's recommendation. As mentioned above, HHS has promulgated regulations and guidance summarizing and harmonizing, where appropriate, the various requirements of the different delivery models, and continues to provide training on monitoring fraud, waste and abuse in home- and community-based settings, including PCS. To this end, HHS will continue, as appropriate given the differences in program authorities, to take steps to assess areas to harmonize federal program requirements across PCS programs. These steps include issuing a Request for Information to solicit additional thoughts on how to better align programs across the various authorities, and issuing guidance on PCS.

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# Appendix III: GAO Contact and Staff Acknowledgments

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## GAO Contact

Katherine M. Iritani, Director, (202) 512-7114 or [iritanik@gao.gov](mailto:iritanik@gao.gov)

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## Staff Acknowledgments

In addition to the contact name above, Tim Bushfield, Assistant Director; Anna Bonelli, Analyst-in-Charge; Christine Davis; Barbara Hansen; Laurie Pachter; Vikki Porter; Bryant Torres; and Jennifer Whitworth also made key contributions to this report.

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