Applied Self-Direction

Fraud in Self-Directed Personal Care Services:

What Does the Data Tell Us?

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Introduction

There is a pervasive and long-standing narrative that personal care services, and self-direction programs in particular, are highly susceptible to fraud. However, research and experience working with states across the country demonstrate the opposite to be true. That is, fraud is rare in self-direction and does not occur at greater rates than in traditional home and community-based services (HCBS).[1]

The longstanding misperception that self-direction is especially vulnerable to fraud can present a significant barrier to the expansion of this model, which offers people access to high-quality HCBS on their own terms. Additionally, robust self-direction programs have many protections in place to prevent and detect fraud, including the recent addition of electronic visit verification (EVV) as a standard feature of self-directed personal care. Amid a pandemic *and* an acute shortage of direct care workers, the option to access self-direction and recruit, hire, and manage staff of one's own choosing is more important than ever before.

This is not to say that fraud is nonexistent or inconsequential. Robust fraud prevention and mitigation strategies are an essential component of healthy self-direction programs. Even when all appropriate precautions are taken, fraud can occur. However, analysis of recent data from the Office of Inspector General (OIG) confirms past research and experiential findings that fraud occurs at exceedingly low rates within personal care services, and by extension, self-direction.

In this brief, we will analyze quantitative fraud data from OIG to clarify the extent to which fraud occurs in personal care, acknowledge current limitations on the available data, and provide recommendations for collaboration and future study.

Overview of Personal Care Services and Self-Direction

Personal care programs serve an important and ever-growing part of Medicaid-funded HCBS. These programs allow older adults and people with disabilities to remain in their own homes and communities.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955336/pdf/hesr0042-0446.pdf

Personal care programs have taken on added importance in the era of COVID, in which the especially rapid spread of the virus in congregate settings has caused hundreds of thousands of severe illnesses and deaths. States continue to "rebalance" long-term care toward options that allow older adults and people with disabilities to live in their own homes with support—particularly those offered via Medicaid personal care. Not only do people overwhelmingly prefer the option to stay in their own home, but their health and safety can be maintained at a far lower per-person median cost.[2]

Medicaid personal care programs generally follow two models. In a traditional model, agencies hire workers and deploy them into beneficiaries' homes. In a self-directed model, Medicaid beneficiaries can select, hire, and manage their own personal care workers, who are often beneficiaries' family members or friends.[3] This latter model has expanded rapidly in recent years, particularly amidst the COVID pandemic, since many beneficiaries did not want to receive services from agency workers that typically visit multiple homes per week.

Self-direction is a well-established, evidence-based model which has operated successfully across the country for decades.[4] However, for those unfamiliar with the robust literature on self-direction, this model can raise undue concerns. In the Medicaid system, quality is often equated with formal credentialing, licensing, and training. Some people are biased to assume non-traditional caregivers, including family members and friends, are uniquely inclined to commit fraud, without understanding there are numerous safeguards in place.

Critics of self-direction often overlook or minimize the role of Financial Management Services (FMS) entities, which play a crucial role in preventing and detecting fraud in self-direction programs. While a detailed description of FMS entities is beyond the scope of this brief, they are best known for their payroll services. However, FMS entities also verify worker qualifications to ensure they meet program criteria prior to hire, review time records to ensure hours worked and

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[2] https://www.aarp.org/ppi/info-2021/paying-family-caregivers-to-provide-care-during-the-pandemic.html
[3] https://www.medicaid.gov/medicaid/long-term-services-supports/self-directed-services/index.html
[4] https://appliedselfdirection.com/resources/2019-national-inventory-self-direction-programs

services provided were authorized and perform regular audits to ensure all dollars paid out meet program requirements[5] — all functions that are vital to fraud prevention.

Analyzing OIG Personal Care Fraud Data in Context

Allegations of fraud in personal care usually involve some variation of personal care workers billing Medicaid for hours not worked. This includes scenarios in which workers collude with Medicaid beneficiaries to overstate actual hours worked. In other cases, personal care workers or agencies set up elaborate schemes of false identities or aliases to bill for non-existent hours. OIG works to fight against such instances of waste, fraud, and abuse and to improve the efficiency of Medicare, Medicaid, and other Department of Health & Human Services (HHS) programs.[6] OIG oversees a network of Medicaid Fraud Control Units (MFCUs) that operate in all 50 states to investigate and prosecute Medicaid fraud.[7]

Over the years, OIG has consistently reported "significantly more convictions for fraud involving personal care services attendants and agencies than any other provider type."[8] For example, the MFCUs' Fiscal Year 2020 Annual Report cites 360 convictions involving personal care attendants and agencies out of 774 total MFCU cases resulting in fraud convictions for that year nationwide, representing 47% of the total convictions.[9]

Given the higher rate of personal care fraud compared to other provider types across its diverse portfolio, it is certainly prudent that the OIG approach personal care with proportionate scrutiny. It is important to clarify that while personal care fraud may make up the largest share of OIG convictions, that does not mean fraud is prevalent within the personal care industry. The myth that personal care is fraught with fraud likely stems from this misunderstanding. We argue that further examination is needed to understand the extent to which fraud pervades personal care, which subsequently informs the scale and scope of prevention and detection efforts.

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[5] https://appliedselfdirection.com/sites/default/files/Participant%20Direction%20Handbook.pdf (see p.153)

[6] https://oig.hhs.gov/about-oig/

[7] https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/

[8] https://oig.hhs.gov/oei/reports/OEI-09-21-00120.pdf (see p.5)

[9] https://oig.hhs.gov/oei/reports/OEI-09-21-00120.pdf

In January 2021, OIG provided Applied Self-Direction with state-by-state personal care fraud data from FY2020 as reported by each state's MFCU via a Freedom of Information Act (FOIA) request. While this dataset does not delineate which fraud cases specifically involved self-direction, OIG was able to distinguish data involving individual personal care attendants versus personal care agencies. Based on feedback from OIG representatives, we assume that any cases that involve self-direction would be included as a subset of the data on personal care workers.

From our research conducted in partnership with AARP, we know there were over 1.2 million people self-directing nationwide as of 2019.[10] Based on our longstanding review of care recipient to worker ratios, we estimate there were over 1.8 million personal care workers working in self-direction in 2019. We believe this number is a conservative estimate of the total number of Medicaid recipients receiving self-directed personal care from individual workers.[11]

The results are telling. Three hundred and sixty personal care attendant convictions out of 1.8 million workers in self-direction (a percentage rate of .02%) simply does not constitute a high prevalence rate of personal care fraud.[12] Across the vast number of people who self-direct personal care services and their workers, the number of fraud convictions is very low.

Reviewing state-by-state conviction rates provides an equally compelling context. The highest conviction rate (number of convictions divided by the estimated number of personal care workers) is Ohio with 46 personal care services attendant convictions out of approximately 3,735 self-direction workers or 1.23%. Louisiana (.55%), the District of Columbia (.42%), and Pennsylvania (.31%) are the runners up for highest conviction rates. All the other states have rates below .14% including 21 states with no convictions in FY2020.

While personal care represents the largest share of fraud cases across the OIG's portfolio, based on OIG's own data sources, the prevalence of fraud nationwide within personal care is very low.

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[10] https://appliedselfdirection.com/resources/2019-national-inventory-self-direction-programs

[11] Estimate assumes 1.5 workers per every person self-directing. In many cases, people hire more workers. Further research is needed to better understand the composition of the self-direction workforce.

[12] Note that the 360 personal care attendant convictions include traditional and self-directed personal care cases. Therefore, the percentage rate of convictions for self-directed workers is presumably even lower than .02%.

Implications for Electronic Visit Verification

The use of EVV systems has been required for all Medicaid-funded personal care services since January 1, 2020 as per the 21st Century Cures Act, however the vast majority of states were given a good faith exemption until January 1, 2021.[13] From January 1, 2021 onwards, all states are at risk for a reduction in their Federal Medical Assistance Percentage (FMAP) if they have not implemented EVV. EVV requirements were put in place based on the belief that fraud is pervasive across personal care services.

In FY2020, the Congressional Budget Office estimated that EVV would save taxpayers $21 million (and significantly more for every year thereafter).[14] However, OIG reported a total of $6,065,610 in fraud recoveries for cases involving personal care workers in FY2020. It is not yet publicly documented how much each state has spent to implement and maintain EVV systems, but anecdotal reports suggest implementation costs are in at least the tens, if not hundreds, of millions of dollars across all states. While far more states will have implemented EVV systems in FY2021, it appears unlikely that EVV will result in significant cost savings given that personal care fraud was already rare. Further research will be needed to understand the financial impact of new EVV requirements.

Limitations

It is important to acknowledge the limitations of OIG's dataset. In some cases, reported convictions may cross multiple calendar years, given the lag time between the start of investigations and actual convictions. Meanwhile, some states have large numbers of personal care workers and yet show no convictions (e.g., New Jersey at approximately 27,839 self-directed workers and New York at approximately 125,552 self-directed workers). It is not clear whether the MFCUs in those states simply do not prioritize personal care fraud, whether those states have extraordinary pre- and post-payment controls, or some other mechanism. Also, there

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[13] https://www.medicaid.gov/medicaid/home-community-based-services/guidance/electronic-visit-verification-evv/index.html

[14] Estimates for EVV/Sectional 12006 are available on p.2, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr34amendment5.pdf

is no publicly available source that documents what degree of fraud was remediated at the Medicaid agency program integrity level without rising to the level of criminal prosecution.

We recognize that OIG data does not capture the full extent of fraud. Each state Medicaid agency has program integrity personnel investigating provider payment irregularities. Since the bandwidth of MFCUs is often limited, MFCUs may prioritize prosecuting high-profile cases, while agency integrity efforts may focus on smaller amounts of fraud or first-time offenders.

Importantly, OIG does not track which fraud cases involve self-direction as a subcategory of personal care fraud. Therefore, it is difficult to rely fully on this data to understand the extent to which fraud is pervasive in traditional personal care versus self-direction.

Further research is needed to better understand why certain states have personal care attendant fraud cases involving huge sums of recoveries (see Figure 1).[15] These cases provoke questions on how such high dollar amounts could have been fraudulently amassed by individual workers without being detected by the usual pre- and post-payment controls. In some cases, it may simply be a data coding error (for example, a fraud case is coded by a MFCU as involving an individual personal care worker but was actually a personal care agency scheme). In the absence of data specific to self-direction, it is unclear whether any high dollar amount cases are even attributable to self-direction. A better understanding of these large recovery cases in personal care is needed to spot trends and to better understand methods used by perpetrators to avoid detection.

Figure 1

State/District	Personal Care Attendant Criminal Convictions	Recoveries
District of Columbia	4	$1,710,639.83
Connecticut	2	$30,688.72
Michigan	3	$45,233.30
Missouri	11	$220,313.36
Vermont	4	$54,834.37

[15] Convictions reported to the OIG in FY2020 might cross over multiple years and recovery amounts accordingly do not always track to specific fiscal periods.

State/District	Personal Care Attendant Criminal Convictions	Recoveries
Virginia	25	$816,007.43

In our analysis, Applied Self-Direction does not intend to minimize the risks of personal care fraud or to downplay the necessary vigilance of MFCUs and OIG in investigating and prosecuting personal care fraud. We only argue that personal care fraud data be seen in nuanced context and not result in unnecessary restrictions in the use of personal care or burdensome and unwarranted requirements.

Recommendations

Demand for self-directed services is greater than ever before in the post-COVID era. States are currently enacting plans to expand their HCBS with enhanced funding from the American Rescue Plan, including significant planned investments to grow self-direction programs. In anticipation of the forthcoming growth of self-direction, it is a critical time to correct the misleading narrative that personal care, or self-direction specifically, is uniquely vulnerable to fraud. We have identified the following recommendations to further strengthen program integrity within a self-direction context:

1. On a state-by-state level, closer collaboration between MFCUs, Medicaid Integrity Directors, Self-Direction State Program Administrators, FMS entities, and where applicable, managed care organizations (MCOs). Each of these entities plays a critical role in fraud prevention in self-direction, but may not be aware of each other's work and findings. While some states have already developed close collaborative relationships among these entities, not all states have reached this point.
    - MFCUs have critical information regarding the most serious cases of personal care fraud. Understanding the details of these cases will better enable FMS entities and state administrators to implement further protections to prevent known methods of fraud. In future publications, OIG should compel MFCUs to provide case summaries of high-profile personal care fraud cases, particularly where high dollar fraudulent amounts are attributed to individual personal care workers.

- As the first line of defense against fraud in self-direction, FMS entities fulfill a myriad of duties to ensure programs operate with integrity and regulatory compliance. Fraud detection and prevention functions fulfilled by FMS entities include extensive pre-payment controls, post-payment reporting, and education to participants and service providers. FMS entities routinely flag suspicious time entry (e.g., time records that purport a worker was providing services to two people in two different places at the same time), signature irregularities, and other indicators of fraud. Leveraging FMS capabilities can strengthen states' program integrity efforts.
- Both Medicaid program integrity personnel and MFCUs have access to reported cases of fraud that do not rise to the level of conviction. It is critically important to better understand the trends and themes across reported cases to better inform fraud prevention and detection strategies. OIG should commence a dialogue with the National Association of Medicaid Directors (NAMD) and individual state Medicaid agencies to help analyze these trends.

2. OIG should require MFCUs to specifically track and report on personal care fraud cases that involve self-direction programs.
    - More detailed data may help identify specific patterns, trends, or vulnerabilities unique to self-direction. States and FMS entities need to learn from the rare high-profile cases of fraud in self-direction to illuminate what steps of detection may have been missed.
3. State Medicaid programs should assure adequate screening and vetting of personal care workers, including criminal background checks. Workers should be made aware of the consequences of committing fraud. States should assure identifiable markers for each personal care worker that can be tracked directly to the client they serve. States should periodically audit personal care cases and have payment edits that reveal billing practices that exceed authorized hours in a client's plan of care. Periodic surveys of client satisfaction are critical.
4. OIG should consider their findings on rates of personal care fraud in the broader context. While personal care may continue to represent the largest share of fraud cases in the OIG portfolio, this does not equate to a high rate of fraud across the vast field of personal care

workers or self-direction workers specifically. Future reports should make note of this distinction.

Conclusion

Documented rates of Medicaid personal care fraud, based on data OIG collects annually from state MFCUs, are exceedingly low across the United States. Nonetheless, continued vigilance at all levels is essential. External reviews of personal care programs, particularly as they relate to Medicaid fraud, should be measured and proportionate, placing data in the full context of the actual numbers of people who self-direct and the workers who serve them. Data gathered to document fraud should contain additional detail about the type of program it represents so it can be constructively used to improve program performance. Personal care programs, including self-directed programs, are growing rapidly and are an integral component of Medicaid-funded HCBS. Receiving personal care at home is a cost-effective and widely preferred alternative to institutional placement, particularly now that institutional settings face new health and safety challenges in the era of COVID.