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**INDEPENDENT STATE AUDITOR'S REPORT ON
CERTAIN ACTIVITIES OF THE OFFICE OF
MEDICAID AS ADMINISTERED BY MASSHEALTH
IN THE PAYMENT OF CERTAIN CLAIMS FOR
PERSONAL CARE SERVICES
JULY 1, 2004 TO JULY 31, 2008**

**OFFICIAL AUDIT
REPORT
OCTOBER 14, 2009**

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INTRODUCTION

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The Office of the State Auditor (OSA) conducted an expanded scope audit on the MassHealth Personal Care Attendant (PCA) program following the release of OSA's audit report¹ issued in October 2008 that was prepared in partnership with the United States Department of Health and Human Services Office of the Inspector General (HHS/OIG). The October 2008 report indicated that MassHealth's internal controls and procedures are inadequate to prevent or discover the overpayment of claims for Personal Care Attendant services performed while consumers² are residents of nursing facilities or other inpatient facilities and therefore not reimbursable under both state³ and federal⁴ regulations. Because of inadequate internal controls and procedures over personal care services (PCS) and a high exception rate in the previous audit, the OSA expanded its audit scope and audit period for this report to further review the overpayments and related issues.

In accordance with Chapter 118E of the Massachusetts General Laws, MassHealth, within the Executive Office of Health and Human Services (EOHHS), administers the Medicaid program, which provides access to health care services for more than one million low- and moderate-income individuals, couples, and families in Massachusetts. MassHealth annually pays in excess of \$6.5 billion on approximately 56 million claims to 30,000 providers, of which 50% is federally funded. The Medicaid program represents approximately 30% of the Commonwealth's annual budget. In the program, Medicaid provides reimbursement for PCS to 16,000 MassHealth members through its PCA program. This program helps people with permanent or chronic disabilities keep their independence, stay in the community, and manage their own personal care by providing funds to hire PCAs. PCS include PCA services, personal care management (PCM) services⁵, and fiscal intermediary (FI) services.⁶ In fiscal year 2004, MassHealth paid over \$224 million on approximately 678,000 claims related to PCS. This amount increased to over \$331 million paid on approximately 1,058,000 claims in fiscal year 2008.

Once in the PCA program, the consumer or surrogate⁷ is trained by the PCM agency on his or her responsibilities under the program and how to employ and manage a PCA. The PCM agency also educates them about the tools available to promote PCA services that are safe, such as the availability of Criminal Offender Record Information (CORI), Disabled Persons Protection Commission (DPPC), the sex offender registry (SOR), and the Elder Services hotline. To provide PCM services, the PCM agency must select a MassHealth-approved FI.

¹ Report No. 2008-1374-3S2, Independent State Auditor's Report on Certain Activities of the Office of Medicaid As Administered by MassHealth in the Payment of Certain Claims For Personal Care Services, October 1, 2004 to September 30, 2005.

² MassHealth members in the PCA program are known as "consumers."

³ 130 CMR 422.412 (D).

⁴ Section 1905(a)(24) of the Social Security Act.

⁵ A public or private agency or entity under contract with EOHHS to provide PCM services in accordance with 130 CMR 422.000 and the PCM services contract, or a public or private agency or entity that has been approved by EOHHS to provide transitional living services covered under 130 CMR 422.431 to 422.441.

⁶ An entity contracting with EOHHS to perform employer-required tasks and related administrative tasks including, but not limited to, tasks described in 130 CMR 422.419(B).

⁷ The consumer's legal guardian, a family member, or other person as identified in the service agreement, who is responsible for performing certain PCA management tasks that the member is unable to perform.

The PCM agency educates the consumer on the role of the FI, who performs numerous administrative tasks, including processing all claims for PCA services and verifying the mathematical accuracy of PCA activity forms, which for each two-week pay period identifies who provided the PCA services and the hours and dates during which the PCA services were provided. Moreover, as an intermediary, the FI accepts reimbursement from MassHealth for payments made to PCAs for services provided to the consumer. The consumer or surrogate is the sole party responsible to ensure that information submitted to the FI on the activity forms is true.⁸ The FIs and PCM agencies have recordkeeping requirements that include documenting their activities, maintaining the consumers' personal and medical data, and pertinent information regarding the PCAs.

The PCA is not a provider to MassHealth, but an unlicensed person employed by the consumer. As such, the PCA is not regulated by MassHealth or EOHHS. Massachusetts' PCA hiring is unregulated, with no requirements for background checks, training, age, supervision, health, literacy, or education. The HHS/OIG reported that Massachusetts is the only state in the nation with a single program through which Medicaid consumers receive PCS that does not have established requirements for PCAs.⁹ All states other than Massachusetts had at least one program that required background checks; in excess of 80% of the states had programs with requirements pertaining to training, age, and supervision; and more than 60% of the states had health and literacy/education requirements (see Appendix A). PCAs are continually in unsupervised contact with vulnerable elderly and disabled consumers in the privacy of the consumers' homes, yet the PCAs are not held to the same standards as employees of nursing homes, rest homes, home health agencies, homemaker agencies, and hospice programs. Massachusetts' nursing homes, rest homes, home health agencies, homemaker agencies, and hospice programs are required by regulation¹⁰ to conduct a CORI check on employee applicants whose services may entail the potential for unsupervised client contact. "It is the policy of EOHHS and the Department (Department of Public Health) that convictions of certain crimes presumptively pose an unacceptable risk to the vulnerable populations served by the Department and its vendor agencies."¹¹

In accordance with Chapter 11, Section 12, of the Massachusetts General Laws, the OSA conducted an audit of claims paid for PCA services allegedly provided on behalf of 30 consumers who were identified in our previous audit as having claims paid for PCA services while they were residents of nursing facilities or other inpatient facilities, and therefore did not qualify for reimbursement under both state¹² and federal¹³ regulations. We determined whether there was a recurrence of claims paid for non-covered PCA services during the period of July 1, 2004 through July 31, 2008. Our audit included a review of documentation pertinent to the claims as maintained by MassHealth, the PCM agencies, and the FIs; a calculation of the quantity of hours and amount of the overpayments; and a review of MassHealth's policies and procedures for effectiveness. We provided certain information to

⁸ 130 CMR 422.420 (A) (3) & (4).

⁹ The U.S. Department of Health and Human Services Office of the Inspector General (HHS/OIG) report issued December 2006, "States' Requirements for Medicaid-Funded Personal Care Service Attendants."

¹⁰ 105 CMR 950.000.

¹¹ 105 CMR 950.002.

¹² 130 CMR 422.412 (D).

¹³ Section 1905(a)(24) of the Social Security Act.

the OSA's Bureau of Special Investigations (BSI)¹⁴ for them to conduct background checks for the consumers, PCAs, and surrogates and, in addition, we researched the Department of Public Health's Nurses Aid Registry, the SOR, and the HHS/OIG List of Excluded Individuals/Entities¹⁵ to determine whether the PCAs were registered. The objective of the audit was to determine the extent, cause, and effect of the overpayments; to determine whether the well-being of the consumers and their assets were at risk; and to make recommendations in the improvement of MassHealth's internal controls and procedures in the PCA program.

AUDIT RESULTS

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INADEQUATE POLICIES, PROCEDURES, REGULATIONS, AND INTERNAL CONTROLS OVER MASSACHUSETTS PERSONAL CARE ATTENDANT PROGRAM

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Inadequate internal controls and procedures over MassHealth's Personal Care Attendant Program have resulted in a) repeated overpayments on potentially fraudulent claims; b) unregulated and unsupervised felons with multiple crimes of violence, theft, and drugs providing services to the elderly and disabled; and c) providers missing critical documentation relative to the PCA program, as follows:

a. Repeated Overpayments on Potentially Fraudulent Claims

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Our audit disclosed that 27 (90%) of the 30 consumers we reviewed had recurrences of claims paid for PCA services allegedly performed while they were residents of nursing facilities or other inpatient facilities during the period July 1, 2004 through July 31, 2008; therefore, charges for PCA services by these consumers are not reimbursable under both state and federal regulations. It is improbable that these services could have been provided while the consumers were residents of nursing facilities or other inpatient facilities and not in their homes. The activity forms were signed under pain and penalty of perjury to their trueness by the consumers or surrogates and the PCAs. Based on our audit, we conclude that there is a high probability that these claims are potentially fraudulent.

Our prior audit disclosed that overpayments of claims paid attributable to services allegedly received by these 30 consumers was \$22,516 during the period of service audited for federal fiscal year 2005¹⁶. This expanded audit found an additional \$207,283 in overpayments for non-covered PCA services allegedly performed for the 30 consumers. As a result, the original overpayments increased more than tenfold to \$229,799 for 18,980 hours billed and paid during the period July 2004 through July 2008.

In the previous OSA and HHS/OIG partnership audit, the HHS/OIG extrapolated the results and estimated that \$610,333 was overpaid by MassHealth for non-covered PCA services during the 2005 federal fiscal year. While we cannot project that there has been a tenfold increase in that amount as well, it is probable that there have been substantial

¹⁴ The OSA's Bureau of Special Investigations is charged with the responsibility of investigating fraud within the Commonwealth's public assistance programs.

¹⁵ The HHS/OIG List of Excluded Individuals/Entities database provides information to the health care industry, patients, and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all Federal health care programs.

¹⁶ October 1, 2004 through September 30, 2005

overpayments for PCA services allegedly performed while the consumers were residents of nursing facilities or other inpatient facilities. The potentially fraudulent filing of claims is ongoing, and will continue, unless remedial action is taken by MassHealth. Our audit indicated that MassHealth's internal controls and procedures are inadequate to prevent, detect, or deter the payment of these potentially fraudulent claims, resulting in overpayments as defined by applicable laws, rules, and regulations.

MassHealth responded by stating that they will ensure that consumers, surrogates, and PCAs are aware of the serious nature of making a false claim by amending its existing PCA forms to include language pertaining to the potential penalties for committing fraud. MassHealth noted that the responsibilities of PCM agencies and FIs are delineated in their respective contracts and do not include the responsibility of overseeing or supervising PCAs or performing associated compliance verifications. That is the primary responsibility of the consumer or surrogate, as is typical in consumer-directed programs. MassHealth is continuing to evaluate methods by which the agency could implement enhanced program oversight activities. Additionally, MassHealth commented that the high error rate in our sample of consumers could not be used to describe the level of fraud in the program, as our sample was not a randomly selected statistical sample.

We are pleased that MassHealth is undertaking efforts to enhance the PCA program's oversight. Our audit methodology is delineated in the Audit Scope, Objectives, and Methodology section of this report. It explains the source from which we selected those to be audited, what we intended to determine, and how we would perform our procedures. We did not select our audit subjects from a statistical sample and no extrapolation to the entire PCA program was made. Our Audit Results are what we discovered in overpayments for services provided to those consumers that were subject to our audit. MassHealth should conduct a broader analysis to gain a full understanding of the nature, extent and magnitude of the safety issue raised in the report.

b. Individuals with Multiple Felony Crimes of Violence, Theft, and Drugs Providing Services to the Elderly and Disabled

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The Bureau of Special Investigations (BSI) conducted background checks for the consumers, PCAs, and surrogates in our sample and found that 14 (47%) of the 30 consumers had employed PCAs who had been convicted, or for whom the courts found sufficient evidence to find guilty, of a felony. During our audit period, the 30 consumers employed a combined total of 82 PCAs. Of these, 18 (22%) were either convicted or the courts had sufficient evidence to find them guilty of a major felony, seven (9%) had been committed to prison, four (5%) had outstanding warrants, 12 (15%) were involved in violent crimes, nine (11%) had been convicted of drug offenses, and 10 (12%) perpetrated crimes of theft. Most of the PCAs guilty of felonies had multiple offenses. There were 41 crimes of violence, including manslaughter, assault and battery with a dangerous weapon, threatening murder, assault and battery on a child with injury, family abuse, and malicious destruction of property. There were 29 crimes of theft, including larceny and breaking and entering during the daytime. There were 26 drug crimes, including distributing heroin, possession of hypodermic needles or syringes, and trafficking cocaine in a school zone. The gravity of the circumstances in 35 of the crimes caused the perpetrator to be committed to prison. Nine (11%) of the PCAs had a total of 13 restraining orders issued on them to refrain from abuse. Five of the restraining

orders were to protect children. Although 47% of the consumers had employed PCAs who were felons, these consumers represented 64% of the overpayments. Five (17%) consumers had a history of serious crimes¹⁷ and of these, four hired PCAs with a similar past.

Based on these results and also recognizing that there was a small sub sample of claims that indicated payment problems, we have serious concerns that MassHealth's internal controls, procedures, and regulations are inadequate to prevent, detect, or deter the employment by consumers of persons with criminal backgrounds, resulting in unwarranted risks to the consumers' personal safety and the security of their assets.

We strongly recommend that improvements be made to make Criminal Offender Record Information (CORI) more readily available to consumers. Also, the information should be made available in a user-friendly manner so that it is understandable and should be provided at no cost to the consumer.

Further, with the understanding that the MassHealth program is a consumer driven model, with consumers making their own choice of PCAs, MassHealth and its PCM agencies should encourage the utilization of CORI reports in the consumer decision-making process, and provide any necessary support needed by consumers in the hiring process.

MassHealth responded that in accordance with the current administration's CORI reform initiative, EOHHS has revised CORI regulations in a manner that will continue to assure client safety for EOHHS programs and standardize employer decision making about worker suitability for direct care roles. CORI reform is intended to maximize client safety while assuring that rehabilitated offenders can be employed and reintegrated successfully into the community. MassHealth stated that the new CORI regulations do not extend to the MassHealth PCA program. However, the next phase of CORI reform efforts will address assuring access to CORI information for consumers in the PCA program. MassHealth further commented that the data, as is currently presented, suggests a much higher degree of concern than can reasonably and reliably be inferred from the sampling method used. The results cannot, therefore, be used to describe the relative level of risk in the program.

We are pleased that the next phase of CORI reform will address assuring access to CORI information for consumers in the MassHealth PCA program and the pragmatic challenges the consumers will face in performing meaningful background checks. In our opinion, any risks to the consumers' safety and security should be mitigated by all reasonable means available. MassHealth should conduct a broader analysis to gain a full understanding of the nature, extent and magnitude of the safety issue raised in the report. Our audit methodology is delineated in the Audit Scope, Objectives, and Methodology section of this report. The audit sample of consumers was not selected from a statistical sample and no extrapolation to the entire PCA program was made. Our audit results are what we discovered in background checks of the PCAs providing services to those consumers that were subject to our audit.

¹⁷ These five consumers had been convicted or the courts had sufficient evidence to find guilty of five crimes of violence, 14 drug offenses, and 23 crimes of theft.

c. Providers Missing Critical Documentation	30
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Both the PCM agencies and the FIs have specific recordkeeping requirements that, by regulation¹⁸ and contractual obligation, they are to maintain. Our audit disclosed that the PCM agencies were missing documentation for 19 (63%) of the 30 consumers and that the FIs were missing documentation for 19 (63%) of the 30 consumers. The PCM agencies were missing several documents critical to the consumers' care. For example, some PCM agencies were missing evaluation reports, and MassHealth's prior authorization for PCA services.

The FIs in many instances were missing forms indicating whether the PCA is authorized to work in the U.S. Additionally, the providers were missing contact information for the consumer's primary medical physician and PCAs. Those providers missing documentation are neither in compliance with regulations nor their contractual obligations. Our audit indicated that MassHealth's internal controls and procedures are inadequate to prevent or detect noncompliance with the recordkeeping requirements of both the PCM agencies and the FIs.

MassHealth responded that it conducts site visits to PCM agencies as part of its contract performance evaluation process. During site visits, MassHealth reviews a sample of consumer records to ensure PCM agencies are in compliance with PCM documentation requirements. MassHealth requested that the OSA list the documentation missing for the consumers, FIs, and PCM agencies in detail.

We will share the detail of the missing documentation with MassHealth and identify the respective consumers, FIs, and PCM agencies.

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¹⁸ 130 CMR 422.446

INTRODUCTION

Background

The Office of the State Auditor (OSA) conducted an expanded scope audit on the MassHealth Personal Care Attendant (PCA) program following the release of OSA's audit report¹⁹ issued in October 2008 that was prepared in partnership with the United States Department of Health and Human Services Office of the Inspector General (HHS/OIG). The OSA and HHS/OIG partnership audit indicated that MassHealth's internal controls and procedures are inadequate to prevent or discover the overpayment of claims for Personal Care Attendant (PCA) services performed while consumers²⁰ are residents of nursing facilities or other inpatient facilities and therefore not reimbursable under both state²¹ and federal²² regulations. Because of inadequate internal controls and procedures over personal care services (PCS) and a high exception rate in the previous audit, the OSA expanded its audit scope and period for this report.

In accordance with Chapter 118E of the Massachusetts General Laws, MassHealth, within the Executive Office of Health and Human Services (EOHHS), administers the Medicaid program, which provides access to health care services for more than one million low- and moderate-income individuals, couples, and families in Massachusetts. MassHealth annually pays in excess of \$6.5 billion on approximately 56 million claims to 30,000 providers, of which 50% is federally funded. The Medicaid program represents approximately 30% of the Commonwealth's annual budget. In the program, Medicaid provides reimbursement for PCS to 16,000 MassHealth members through its PCA program. This program helps people with permanent or chronic disabilities keep their independence, stay in the community, and manage their own personal care by providing funds to hire PCAs. PCS include PCA services, personal care management (PCM) services²³, and fiscal intermediary (FI) services.²⁴

¹⁹ Report No. 2008-1374-3S2, Independent State Auditor's Report on Certain Activities of the Office of Medicaid As Administered by MassHealth in the Payment of Certain Claims For Personal Care Services, October 1, 2004 to September 30, 2005.

²⁰ MassHealth members in the PCA program are known as "consumers."

²¹ 130 CMR 422.412 (D).

²² Section 1905(a)(24) of the Social Security Act.

²³ A public or private agency or entity under contract with EOHHS to provide PCM services in accordance with 130 CMR 422.000 and the PCM services contract, or a public or private agency or entity that has been approved by EOHHS to provide transitional living services covered under 130 CMR 422.431 to 422.441.

²⁴ An entity contracting with EOHHS to perform employer-required tasks and related administrative tasks including, but not limited to, tasks described in 130 CMR 422.419(B).

Personal Care Attendant Program

PCAs assist people (known in the program as “consumers”) with activities of daily living (ADLs) (e.g., taking medications, bathing, dressing, eating, using the toilet) and instrumental activities of daily living (IADLs) (e.g., preparing meals, doing housework, shopping, traveling to medical providers). The consumers are the employers of the PCAs, and are fully responsible for recruiting, hiring, scheduling, training, and, if necessary, firing PCAs. PCS include PCA services, personal care management (PCM) services, and fiscal intermediary (FI) services.²⁵ In fiscal year 2004, MassHealth paid over \$224 million on approximately 678,000 claims related to PCS. This amount increased to over \$331 million paid on approximately 1,058,000 claims in fiscal year 2008, as follows:

Payee for PCS	SFY* 2004		SFY 2008	
	Amount Paid	Number of Paid Claims	Amount Paid	Number of Paid Claims
PCA**	\$209,890,398	392,197	\$311,410,153	677,349
PCM Agencies	7,859,461	148,700	11,319,273	205,315
Fiscal Intermediaries	<u>7,128,361</u>	<u>137,226</u>	<u>9,136,698</u>	<u>175,801</u>
	<u>\$224,878,220</u>	<u>678,123</u>	<u>\$331,866,124</u>	<u>1,058,465</u>

Source of Data: Medicaid Management Information System Data Warehouse

*State fiscal year.

**Approximately 12% of the PCA class rate²⁶ amount is the statutorily required Employer Expense Component, which is the portion designated as reimbursement to members for their mandated employers' share of social security, federal and state unemployment taxes, Medicare, and worker's compensation insurance premiums.

MassHealth members are eligible for PCA services if they have: a) approval from their doctor for PCA services, b) a chronic or permanent disability that prevents them from performing their own personal care, and c) a need for hands-on assistance in certain daily activities. When the member obtains an order for PCA services from their physician, the member's physician or nurse practitioner will refer the member to a PCM agency who will file a prior authorization request for PCA services with MassHealth. When authorization is granted for the services requested, the PCM agency will evaluate the consumer. Part of the evaluation is the PCM agency's determination of whether the consumer can manage the PCA program independently. If the PCM agency determines that the consumer requires the assistance of a surrogate (a person who substitutes for consumers who are

²⁵ 130 CMR 422.402.

²⁶ Includes both the Employer Expense Component and the PCAs' compensation.

physically or cognitively unable to perform certain tasks), the consumer will appoint a surrogate who meets certain criteria.

The PCM agency is a public or private agency or entity under contract with EOHHS to provide personal care management (PCM) services in accordance with MassHealth regulations and the PCM services contract, or a public or private agency or entity that has been approved by EOHHS to provide transitional living services.²⁷ The PCM agency must provide PCM services in accordance with regulations²⁸ and its contract with EOHHS/MassHealth, including, but not limited to: (1) maintaining a communication system that is accessible to members on a 24-hour basis; (2) responding to member inquiries about MassHealth's prior-authorization decisions; (3) maintaining records; (4) conducting a formal, written assessment of the member's ability to manage the PCA program independently; (5) performing evaluations and reevaluations of members who are eligible for PCS; (6) submitting to MassHealth all requests for prior authorization for PCA services; (7) developing in conjunction with the member and the member's surrogate, if any, a formal, written service agreement for the member; (8) providing intake and orientation services to determine a member's initial eligibility for PCA services, and to instruct the member in the rules, policies, and regulations of the PCA program; (9) providing functional skills training to instruct the member and the surrogate, if necessary, in the basic requisites of an effective program of PCS; (10) maintaining policies and procedures for the receipt and timely resolution of member complaints; (11) providing written information to members in a language and format that is understandable to them; (12) providing PCM services that are culturally sensitive; (13) seeking out and including member input and feedback into the PCM services provided by the PCM agency; (14) educating members and surrogates about the tools available to promote PCA services that are safe, such as the availability of Criminal Offender Record Information (CORI), Disabled Persons Protection Commission (DPPC), the sex offender registry (SOR), and the Elder Services hotline; (15) working with the member to establish a list of PCAs who can be contacted when an unforeseen event occurs that prevents the member's regularly scheduled PCA from providing services; (16) developing creative methods to assist members in the recruitment of PCAs; (17) establishing a cooperative working relationship between the FI and the consumer; (18) reporting suspicion of fraud to MassHealth and cooperating with any subsequent investigation; (19) if MassHealth reassigns a PCM agency to a new FI, cooperating with MassHealth, the new FI, and the current FI to ensure a smooth transition to the

²⁷ 130 CMR 422.431 to 422.441.

²⁸ 130 CMR 422.000.

new FI; and (20) notifying MassHealth if, in the opinion of the PCM agency, the member's surrogate is not managing PCA tasks for the member in accordance with MassHealth regulations. The PCM agency has specific recordkeeping requirements²⁹ pertaining to its activities, the consumers' personal and medical data, consumer assessments and evaluations, contact information for the consumer, his or her surrogate and physician, and the employment eligibility status of the PCAs. To provide PCM services, the PCM agency must select a MassHealth-approved FI.

The PCM agencies are paid \$97.37 per member, per month, for a maximum of three consecutive months for services provided to a member who does not yet have prior authorization for PCA services. These services include screening to determine the appropriateness of a member's participation in a specified program, project, or treatment protocol. The PCM agencies receive \$214.00 for the initial medical disability examination and evaluation of a member. After the member receives authorization for PCA services, the PCM agencies are paid \$123.00 per session for follow-up examinations and re-evaluations, and a monthly fee of \$45.85 per member for case management.

Paid to PCM Agencies	SFY 2004		SFY 2008	
	Amount Paid	Number of Paid Claims	Amount Paid	Number of Paid Claims
Case Management	\$5,861,717	125,207	\$8,475,918	177,469
Medical Disability Exam/Evaluation	1,462,672	12,115	2,116,210	16,476
Initial Screening Exam/Evaluation	<u>535,072</u>	<u>11,378</u>	<u>727,145</u>	<u>11,370</u>
Totals	<u>\$7,859,461</u>	<u>148,700</u>	<u>\$11,319,273</u>	<u>205,315</u>

Source of Data: Medicaid Management Information System Data Warehouse

When a member is accepted into the PCA program as a consumer, he or she becomes the employer of his or her own PCA. The consumer (or surrogate) is responsible for finding, hiring, training, and firing (if needed) his or her PCA. The consumer employs the PCA to assist him or her with ADLs and with IADLs. The PCA is paid based on the number of 15-minute segments (units) that are performed providing ADLs and IADLs. The claims OSA audited were paid at a rate of \$2.91 per unit for those occurring prior to January 2, 2005; \$3.00 per unit from then until July 3, 2005; and \$3.07 per unit thereafter. The premium rate for overtime and holidays is 150% of the base rate.

²⁹ 130 CMR 422.446.

The consumer must follow specific rules to make sure his or her PCA gets paid on time. The PCM agency informs the consumer on how to get help with these duties, and the consumer or surrogate is responsible for complying with all applicable MassHealth regulations.³⁰ It is the consumer's responsibility to complete and sign activity forms and submit them to the FI. The activity form is essentially a timesheet for a two-week pay period. It details the hours worked by the PCA providing services to the consumer. The billing and payment for the PCA services for the two-week pay period is considered one claim. The consumer or surrogate is the sole party responsible for ensuring that information submitted on the activity forms for each pay period correctly identifies who provided the PCA services and the correct hours and dates during which the PCA services were provided.³¹ The consumer or surrogate signs the form certifying that, "under pain and penalty of perjury that I have received MassHealth PCA services during the times described on this activity form." The PCA also signs, similarly certifying under pain and penalty of perjury, that he or she has provided the services as described. The activity form is submitted to the FI for processing.

The FI performs numerous administrative tasks, including processing all claims for PCA services and verifying the mathematical accuracy of PCA activity forms. Moreover, as an intermediary, the FI accepts reimbursement from MassHealth for payments made to PCAs for services provided to the consumer. Among other services performed by the FI are: (a) establishing a member services unit with staff trained to answer member telephone calls about activity forms, tax forms, and the functions of the FI; (b) establishing, in conjunction with the PCM agency, systems to resolve member and PCA complaints in a timely fashion; (c) developing, using, and distributing standardized activity forms and schedules to document the use of PCAs and to meet the requirements for reimbursement; (d) issuing checks for PCAs with appropriate taxes withheld; and (e) reporting suspicion of fraud to MassHealth and cooperating with any subsequent investigation.³² The FI has specific recordkeeping requirements³³ pertaining to the services it provides. The FIs are currently paid \$1.72 per member per day (\$53.32 for a 31-day month). There are three FIs in the Commonwealth; combined, they were paid in excess of \$9 million in fiscal year 2008 for services provided.

³⁰ 130 CMR 422.420: PCA Program: Member Responsibilities.

³¹ 130 CMR 422.420 (A) (3) & (4).

³² 130 CMR 422.419 (B).

³³ 130 CMR 422.446.

The PCA is not a provider to MassHealth, but a person employed by the consumer. As such, the PCA is not regulated by MassHealth regulations, but is managed by the consumer or surrogate. The criteria set by MassHealth regulations are that services must be performed by a PCA who is: (a) not the spouse of the member, the parent of a minor member, including an adoptive parent, or any legally responsible relative; (b) not the member's surrogate; (c) not the member's foster parent; (d) legally authorized to work in the United States; (e) able to understand and carry out directions given by the member or the member's surrogate; (f) willing to receive training and supervision in all PCA services from the member or the member's surrogate; and (g) not receiving compensation from any other entity during time spent performing PCA services except where such entity is nonprofit, does not receive funds from any state agency other than MassHealth, and has a Board of Directors consisting of at least 51% members, family members, and/or siblings of members.³⁴ The current PCA total class rate is \$12.32 per hour, which includes the PCA gross wage component of \$10.84 and the employer expense component³⁵ of \$1.44. In fiscal year 2008, PCA total class rate fees paid was \$294 million on 465,000 claims.

Consumer Safety

The PCA program delivers services to some of the most vulnerable MassHealth members in the privacy of their own home. While there are no federal requirements for PCAs other than the criteria set by MassHealth regulations, the State Medicaid Manual³⁶ suggests that states develop qualifications or requirements for providers of PCS and establish mechanisms for monitoring the quality of care.

States may wish to employ several methods to ensure that recipients are receiving high quality personal care services. For example, states may opt to a criminal background check or screen personal care attendants before they are employed. States can also establish basic minimal requirements related to age, health status, and/or education and allow the recipient to be the judge of the provider(s) competency through an initial screening. States can provide training to personal care providers. States also may require agency providers to train their employees. States can also utilize case managers to monitor the competency of personal care providers. State level oversight of overall program compliance, standards, case level oversight, attendant training and screening, and recipient complaint and grievance mechanisms are ways in which states can monitor the quality of their personal care programs. In this way, states can best

³⁴ 130 CMR 422.411 (A) (1).

³⁵ The portion of the PCA class rate designated as reimbursement to members for their mandated employers' share of social security, federal and state unemployment taxes, Medicare, and worker's compensation insurance premiums.

³⁶ An official medium by which the U.S. Department of Health & Human Services, Health Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.

*address the needs of their target populations and develop unique provider qualifications and quality assurance mechanisms.*³⁷

Massachusetts is the only state in the nation with a single program through which Medicaid recipients receive PCS that did not have established requirements for PCAs, according to the HHS/OIG (see Appendix A). The HHS/OIG issued a report in December 2006, “States’ Requirements for Medicaid-Funded Personal Care Service Attendants,” with the objective to determine (1) the requirements that states have established for Medicaid personal care service attendants and (2) state policies for oversight of those requirements. To determine what requirements states had established for PCAs, the HHS/OIG consulted with state staff in all 50 states and the District of Columbia (hereinafter referred to as states) about established requirements and the oversight thereof. The HHS/OIG also reviewed state policies and guidelines to verify the requirements. The six most commonly established requirements for PCAs included background checks, training, supervision, age, health, and education/literacy. All states, other than Massachusetts, had at least one program that required background checks; in excess of 80% of the states had programs with requirements pertaining to training, age, and supervision; and more than 60% of the states had health and literacy/education requirements. The HHS/OIG reported that background check requirements included not only varying degrees of criminal background checks, but also checks of abuse or neglect registries to identify previous offenses and checks of federal or state exclusions lists for previous fraudulent or abusive activities. Some background check requirements also required contacting personal references or verifying previous employment.

On June 7, 2007, the U.S. Senate introduced the Patient Safety and Abuse Prevention Act (S.1577), and on July 18, 2007, the U.S. House of Representatives introduced an identical bill (H.R. 3078), both of which, if passed, will coordinate abuse and neglect registries with state law enforcement registries. The bill also adds a federal component to the background check process by screening applicants against the FBI’s national database of criminal history records. On September 22, 2008, the Senate bill was placed on the Senate’s legislative calendar. The House bill is currently in the house Judiciary Committee. The bills make the following findings:

(1) Frail elders are a highly vulnerable population who often lack the ability to give consent or defend themselves. Since the best predictor of future behavior is past behavior, individuals with histories of abuse pose a definite risk to patients and residents of long-term care facilities.

³⁷ The State Medicaid Manual, Chapter 4, Section 4480, Paragraph E.

(2) Every month, there are stories in the media of health care employees who commit criminal misconduct on the job and are later found, through a background check conducted after the fact, to have a history of convictions for similar crimes.

(3) A 2006 study³⁸ conducted by the Department of Health and Human Services determined that:

(A) criminal background checks are a valuable tool for employers during the hiring process;

(B) the use of criminal background checks during the hiring process does not limit the pool of potential job applicants;

(C) a correlation exists between criminal history and incidences of abuse; and

(D) the long-term care industry supports the practice of conducting background checks on potential employees in order to reduce the likelihood of hiring someone who has potential to harm residents.

(4) In 2005, the Michigan Attorney General found that 10 percent of employees who were then providing services to frail elders had criminal backgrounds.

(5) In 2004, the staffs of State Adult Protective Services agencies received more than 500,000 reports of elder and vulnerable adult abuse, and an ombudsman report concluded that more than 15,000 nursing home complaints involved abuse, including nearly 4,000 complaints of physical abuse, more than 800 complaints of sexual abuse, and nearly 1,000 complaints of financial exploitation;

(6) The Department of Health and Human Services has determined that while 41 States now require criminal background checks on certified nurse aides prior to employment, only half of those (22) require criminal background checks at the Federal level.

The purposes of the Act are to:

(1) create a coordinated, nationwide system of State criminal background checks that would greatly enhance the chances of identifying individuals with problematic backgrounds who move across State lines;

(2) stop individuals who have a record of substantiated abuse, or a serious criminal record, from preying on helpless elders and individuals with disabilities; and

(3) provide assurance to long-term care employers and the residents they care for that potentially abusive workers will not be hired into positions of providing services to the extremely vulnerable residents of our Nation's long-term care facilities.

MassHealth regulations require that the PCM agencies educate members and surrogates about the tools available to promote PCA services that are safe, such as the availability of CORI reports, the Department of Public Health (DPH) registry, the DPPC, the sex offender registry, and the Elder Services hotline. Contact information for these organizations is listed in the PCA Handbook that is

³⁸ U.S. Department of Health and Human Services, Ensuring a Qualified Long-Term Care Workforce: From Pre-Employment Screens to On-the-Job Monitoring, prepared by The Lewin Group, May 2006.

provided to the consumer. It is not required that these tools are utilized nor do the providers inquire of the consumer whether they were used. Massachusetts' nursing homes, rest homes, home health agencies, homemaker agencies, and hospice programs are required by regulation³⁹ to conduct a CORI check on employee applicants whose services may entail the potential for unsupervised client contact. "It is the policy of EOHHS and the Department that convictions of certain crimes presumptively pose an unacceptable risk to the vulnerable populations served by the Department and its vendor agencies."⁴⁰ PCAs are continually in unsupervised contact with vulnerable elderly and disabled clients, but it is not a requirement in Massachusetts that a CORI check be conducted on them.

Currently, to receive a CORI report, individuals must submit an application to, and be approved by, the Criminal History Systems Board (CHSB). CORI reports are printed in codes⁴¹ (see Appendix B) and The Master Crime List⁴² contains over 1,900 criminal offenses. A CORI report is limited to criminal history in Massachusetts and does not provide any information for crimes that were committed out-of-state. To obtain a CORI report on another person in Massachusetts, one has to make a request for a publicly accessible CORI report with a non-refundable processing fee of \$30 to the CHSB⁴³. A publicly accessible CORI report is a record of individuals that have been convicted of a crime punishable by five years or more, or, at the time of the request, were convicted and sentenced to a term of incarceration for a felony within the last two years or misdemeanor within the last year. A publicly accessible CORI report only reflects convictions. The directions on the form, Request for Publicly Accessible Massachusetts CORI, are as follows:

It is lawful to request this agency to provide a copy of another person's publicly accessible adult conviction record. For the adult conviction record to be "publicly accessible" the person whose record is requested must have been convicted of a crime punishable by a sentence of five years or more, or has been convicted of any crime and sentenced to any term of imprisonment, and at the time of the request:

- 1. is serving a sentence of probation or incarceration, or is under the custody of the parole board; or*

³⁹ 105 CMR 950.000.

⁴⁰ 105 CMR 950.002.

⁴¹

[http://www.mass.gov/?pageID=eopsterminal&L=5&L0=Home&L1=Crime+Prevention+%26+Personal+Safety&L2=Background+Check&L3=Criminal+Offender+Record+Information+\(CORI\)&L4=How+to+Read+a+Criminal+Record&sid=Eeops&b=terminalcontent&f=chsb_disposition_codes&csid=Eeops](http://www.mass.gov/?pageID=eopsterminal&L=5&L0=Home&L1=Crime+Prevention+%26+Personal+Safety&L2=Background+Check&L3=Criminal+Offender+Record+Information+(CORI)&L4=How+to+Read+a+Criminal+Record&sid=Eeops&b=terminalcontent&f=chsb_disposition_codes&csid=Eeops)

⁴² http://www.mass.gov/Eeops/docs/chsb/cori_master_crime_list.pdf

⁴³ MassHealth does not cover the cost of a CORI report. According to the General Counsel for CHSB: The consumer would be able to complete an affidavit of indigence. If the consumer qualifies, the fee would be waived.

2. *having been convicted of a misdemeanor, has been released from all custody or supervision not more than one year; or*
3. *having been convicted felony, has been released from all custody or supervision for not more than two years; or*
4. *having been sentenced to the custody of the department of correction, has finally been discharged therefrom, either having been denied release on parole or having been returned to penal custody for violating parole for not more than three years.*

Directions: Please fill this request form out as completely as possible. The more information you are able to provide, the more easily this agency will be able to process your request. A non-refundable processing fee of \$30.00 is charged for each record requested and must be included with your request(s). There will be no exceptions made to this rule. Only checks or money orders made payable to the Commonwealth of Massachusetts will be accepted. A self-addressed, stamped envelope must also be enclosed with your request(s). Walk in requests or faxed requests will not be accepted. Requests will be processed in the order in which they are received. Mail all requests to: the Criminal History System Board, 200 Arlington Street, Suite 2200, Chelsea, MA 02150, ATTN: CORI Unit.

All requests must be typed.⁴⁴ Requests containing any illegible identifying information will be returned. If you are making more than one request, please copy this form and fill in the requested identifying information accordingly.

In accordance with Chapter 6, Section 167, of the General Laws,

Criminal offender record information, records and data in any communicable form compiled by a criminal justice agency which concern an identifiable individual and relate to the nature or disposition of a criminal charge, an arrest, a pre-trial proceeding, other judicial proceedings, sentencing, incarceration, rehabilitation, or release. Such information shall be restricted to that recorded as the result of the initiation of criminal proceedings or any consequent proceedings related thereto. Criminal offender record information shall not include evaluative information, statistical and analytical reports and files in which individuals are not directly or indirectly identifiable, or intelligence information. Criminal offender record information shall be limited to information concerning persons who have attained the age of seventeen and shall not include any information concerning criminal offenses or acts of delinquency committed by any person before he attained the age of seventeen; provided, however, that if a person under the age of seventeen is adjudicated as an adult, information relating to such criminal offense shall be criminal offender record information. Criminal offender record information shall not include information concerning any offenses, which are not punishable by incarceration.

State and federal statutes mandate the Department of Public Health (DPH) Division of Health Care Quality (DHCQ) to license and certify approximately 6,000 health facilities to ensure the delivery of quality health care services. Facilities include hospitals, nursing homes, rest homes, chronic renal dialysis units, home health agencies, hospices, ambulatory surgical centers, clinical laboratories, blood banks, clinics, rehabilitative services, and state schools. In addition, the DHCQ investigates

⁴⁴ According to the General Counsel for CHSB: Submissions to the CHSB must be legible and are not required to be typewritten.

complaints against health care facilities and provides the mechanism by which criminal action may be taken by the Office of the Attorney General. The DHCQ also investigates all complaints of patient abuse and neglect in long-term care facilities. In the DHCQ is the Nurse Aide Registry Program (NARP), instituted under the provision of the Omnibus Reconciliation Acts of 1987, 1989, and 1990 (OBRA), 42 U.S.C. 1396r, which calls for the establishment of training and competency evaluation programs and the maintenance of a long-term care NARP by coordinating certain activities, including the operation of a Nurse Aide Registry (NAR). The NAR contains information about individuals qualified to function as nurse aides in long-term care facilities, and substantiated findings of resident abuse, neglect, or misappropriation of resident property. The NAR registers (1) all certified nursing assistants, home health aides, hospice home health aides, and homemakers who have a finding or adjudicated finding of patient abuse, neglect, mistreatment, or misappropriation; or (2) individuals certified as nurse aides pursuant to federal long-term care facility regulations.⁴⁵ All nursing homes, rest homes, home health agencies, homemaker agencies, and hospice programs must contact the NAR before hiring individuals. The DPH mandates that:

No nursing home, rest home, home health agency, homemaker agency or hospice program shall hire or employ an individual whose name appears in the registry with a finding or adjudicated finding of patient or resident abuse, neglect, mistreatment or misappropriation of patient or resident property, or if a sanction was imposed upon that individual, such individual may not be hired or employed until the terms of such sanction have been fulfilled, except in circumstances where the individual is working under a probationary sanction where the individual's performance is closely monitored by the employer. Furthermore, no nursing home, rest home, home health agency, homemaker agency or hospice program shall hire or employ an individual if such individual has been found guilty of, or pleaded guilty or nolo contendere to or admitted to sufficient facts to support a guilty finding of patient or resident abuse, neglect, mistreatment or misappropriation of patient or resident property in a court of law.⁴⁶

There is no similar provision for the registration of PCAs with the NAR.

The CHSB has authorized the EOHHS agencies and their vendor agencies to receive criminal record information regarding present or prospective employees in any program funded or operated by such agencies. The DPH regulations seek to protect consumers and their property by mandating CORI checks on a large population of health care personnel and employees of homemaking agencies (PCAs are not included), as follows:

⁴⁵ 42 USC s.1396r.

⁴⁶

http://www.mass.gov/?pageID=eohhs2terminal&L=6&L0=Home&L1=Provider&L2=Certification%2c+Licensure%2c+and+Registration&L3=Occupational+and+Professional&L4=Nurse+Aides&L5=Accessing+the+Nurse+Aide+Registry&sid=Eeohhs2&b=terminalcontent&f=dph_quality_healthcare_p_na_response_system_overview&csid=Eeohhs2

In order to ensure that employees or other persons regularly providing client or support services with the potential for unsupervised contact⁴⁷ in any program or facility of the Department or in vendor agency programs funded by the Department are appropriate for serving in their positions, a Criminal Offender Record Information (CORI) check shall be performed on candidates for positions in such programs or facilities, as provided in 105 CMR⁴⁸ 950.000. It is the policy of EOHHS and the Department that convictions of certain crimes presumptively pose an unacceptable risk to the vulnerable populations served by the Department and its vendor agencies. 105 CMR 950.000 sets forth minimum standards. Stricter standards may be set by CMR or agencies.⁴⁹

105 CMR 950.000 applies to candidates seeking employment or regular trainee or volunteer positions, which entail the potential for unsupervised client contact in the Department and/or Department funded vendor agency programs. At the discretion of the hiring authority, the scope of 105 CMR 950.000 may be expanded to include potential employees, including volunteers, interns, students or other persons regularly offering support to any program or facility in either a paid or unpaid capacity, whose services do not entail the potential for unsupervised client contact, upon appropriate certification by the CHSB.⁵⁰

Non-PCA applicants are required to disclose their criminal record.

All applicants for a position in DPH or a vendor agency program shall complete an application form that contains a section requiring the applicant to disclose whether or not he or she has a criminal record and what crimes, if any, he or she has been convicted of, consistent with the requirements of M.G.L. c. 151B, §4 (9).... The application shall not require an applicant to disclose: (i) an arrest, detention, or disposition regarding any violation of law in which no conviction resulted, or (ii) a first conviction for any of the following misdemeanors: drunkenness, simple assault, speeding, minor traffic violations, affray, or disturbance of the peace, or (iii) any conviction of a misdemeanor where the date of such conviction or the completion of any period of incarceration resulting therefrom, whichever date is later, occurred five or more years prior to the date of such application for employment or such request for information, unless such person has been convicted of any offense within five years immediately preceding the date of such application for employment or such request for information. No application for employment shall be considered complete unless the applicant completes this section.⁵¹

Information on Level 2 and Level 3 sex offenders may be obtained upon written request to the SOR and will be provided free of charge.

A person may request sex offender information from the Board. Requests must be made on a form approved by the Board. The Board will provide a report identifying whether the person is a sex offender with an obligation to register, the offenses for which he/she was convicted or adjudicated and the dates of such convictions or adjudications. The Board will only disseminate information on offenders who have been finally classified as a Level 2 (moderate risk) or Level 3 (high risk) offender. The law prohibits the dissemination of information unless and until the

⁴⁷ Potential for contact with a person who is receiving or applying for services in a Department or vendor agency program when no other CORI-cleared employee is present.

⁴⁸ 105 CMR: Department of Public Health.

⁴⁹ 105 CMR 950.002.

⁵⁰ 105 CMR 950.003.

⁵¹ 105 CMR 950.100: Applicant Disclosure of Criminal Record Information.

*offender is finally classified as a Level 2 or a Level 3 offender. The law strictly prohibits the dissemination of information on Level 1 (low risk) offenders.*⁵²

The SOR's web site⁵³ lists only the most dangerous Level 3 sex offenders:

Pursuant to M.G.L. c. 6, Sections 178C - 178P, the individuals who appear on the following notifications have been designated Level 3 Sex Offenders by the Sex Offender Registry Board. The Board has determined that these individuals have a high risk to reoffend and that the degree of dangerousness posed to the public is such that a substantial public safety interest is served by active community notification.

The DPPC was created as an independent state agency responsible for the investigation and remediation of instances of abuse committed against persons with disabilities in the Commonwealth.⁵⁴ Pursuant to its enabling statute M.G.L. c. 19C, the jurisdiction of DPPC includes adults with disabilities between the ages of 18 and 59 who are within the Commonwealth, whether in state care or in a private setting, and who suffer serious physical and/or emotional injury through the act and/or omission of their caregivers. The DPPC's enabling statute fills the gap between the Department of Children and Families (DCF) (through the age of 17) and the Executive Office of Elder Affairs (EOEA) (age 60 and over) statutes. The role of the DPPC is to: (a) receive and screen reports of suspected abuse, neglect, and deaths through a 24-hour Hotline; (b) conduct investigations; (c) oversee investigations conducted on DPPC's behalf by other state agencies [Department of Mental Retardation (DMR), Department of Mental Health (DMH), and the Massachusetts Rehabilitation Commission (MRC)]; (d) ensure that the appropriate protective services are provided when abuse has been substantiated or risk is determined; (e) provide training and education for service providers, law enforcement personnel, and the public; and (f) provide assistance to the public in clarifying the presence of abuse and neglect.

Recordkeeping Requirements

FIs have specific recordkeeping requirements⁵⁵ pertaining to the services they provide. The OSA requested the following documents from the FIs, which they are required to maintain by regulation and contract:

a. PCA Personnel Information

⁵² M.G.L. c. 6, Section 178.

⁵³ <http://sorb.chs.state.ma.us/>

⁵⁴

http://www.mass.gov/?pageID=dppcterminal&L=2&L0=Home&L1>About+DPPC&sid=Idppc&b=terminalcontent&f=about_overview&csid=Idppc

⁵⁵ 130 CMR 422.446.

- b. I-9 for PCA⁵⁶
- c. Employment Package, all inclusive with PCA and Surrogate Information, Relation of Surrogate to Consumer
- d. Prior Authorization and Modifications
- e. Consumer Agreement
- f. Consumer Information
- g. Consumer Complaints During Year of Claim Dates
- h. Name and Address of the Consumer's Primary Physician or Medical Clinic

The PCM agencies have specific recordkeeping requirements⁵⁷ pertaining to their activities, the consumers' personal and medical data, consumer assessments and evaluations, contact information for the consumer, his or her surrogate and physician, and the employment eligibility status of the PCAs. The OSA requested the following documents from the PCM agencies, which they are required to maintain by regulation and contract:

- a. Consumer Assessment
- b. Contract for Personal Care Management Services (PCMS) with EOHHS
- c. Service Agreement (previously known as the Personal Care Services Plan)
- d. MassHealth Application for PCA Services Form
- e. PCA Prior Authorization Adjustment Form
- f. EOHHS/MassHealth Notice of Approval
- g. If Applicable: Authorization from the MassHealth Agency For Premium Pay For Overtime
- h. Written Assessment of the Member's Capacity to Manage PCA Services Independently
- i. If Applicable: Name, Address, and Phone Number of the Member's Surrogate and Relation to Consumer
- j. Evaluation to Initiate PCA Services
- k. Re-evaluations
- l. Written Service Agreement with Any Subsequent Modifications
- m. Name and Address of the Member's Primary Physician or Medical Clinic
- n. Record of Functional Skills Training
- o. If Applicable: Night PCA Services Authorization
- p. Name, Address, and Phone Number of PCA

⁵⁶ The purpose of this form is to document that each new employee (both citizen and non-citizen) hired after November 6, 1986 is authorized to work in the United States.

⁵⁷ 130 CMR 422.446.

- q. Suspicion of Fraud Reports to MassHealth/EOHHS
- r. Record of Consumer Complaints
- s. Copies of Any Notice of Default Sent to EOHHS During the Period 2004-2008
- t. If Any, List Sanctions Imposed on the Provider During the Period 2004-2008
- u. Quality Management Report

Audit Scope, Objectives, and Methodology

In accordance with Chapter 11, Section 12, of the Massachusetts General Laws, the Office of the State Auditor conducted an audit of claims paid for PCA services allegedly provided on behalf of 30 consumers who were among those identified in our partnership audit⁵⁸ with HHS/OIG as having claims paid for PCA services during the period October 1, 2004 to September 30, 2005 while they were residents of nursing facilities or other inpatient facilities, and therefore did not qualify for reimbursement under both state⁵⁹ and federal⁶⁰ regulations. Our audit was conducted in accordance with applicable generally accepted government auditing standards. The objectives of the audit were to determine whether there was a recurrence of claims paid for non-covered PCA services for the same reasons during the period of July 1, 2004 through July 31, 2008, to determine the cause and effect of the overpayments, to determine whether the security of the consumers or their assets was at risk, and to make recommendations in the improvement of MassHealth's internal controls and procedures in the PCA program. Our audit included a review of documentation pertinent to the claims as maintained by MassHealth, the PCM agencies, and the FIs; a calculation of the quantity of hours and amount of the overpayments; a review of MassHealth's policies and procedures for effectiveness; and the Bureau of Special Investigations (BSI)⁶¹ performed background checks for the consumers, PCAs, and surrogates. The OSA researched all PCAs in the NAR, the SOR and the HHS/OIG List of Excluded Individuals and Entities⁶² to determine whether they were listed.

⁵⁸ Report No. 2008-1374-3S2, Independent State Auditor's Report on Certain Activities of the Office of Medicaid As Administered by MassHealth in the Payment of Certain Claims For Personal Care Services, October 1, 2004 to September 30, 2005.

⁵⁹ 130 CMR 422.412 (D).

⁶⁰ Section 1905(a)(24) of the Social Security Act.

⁶¹ The OSA's Bureau of Special Investigations is charged with the responsibility of investigating fraud within the Commonwealth's public assistance programs.

⁶² The HHS/OIG List of Excluded Individuals/Entities database provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all Federal health care programs.

The OSA collected from the FIs and the PCM agencies documentation they are required to maintain according to regulations and their contract. We reviewed the documentation for its content, completeness, and conformance with regulations and contractual obligations. We visited the FIs at their place of business during our prior audit and interviewed management.

Utilizing the Medicaid Management Information System (MMIS) and the data warehouse, we matched dates of PCA services that corresponded with the same days during which the consumers were residents of a nursing facility or other inpatient facility (dates of admission and discharge were excluded). We then quantified the number of hours and the amount paid on the claims inappropriately paid. The OSA conducted meetings with various management and personnel of MassHealth and EOHHS, and reviewed applicable state and federal laws, rules, and regulations, as well as applicable MassHealth and EOHHS policies and procedures.

AUDIT RESULTS

INADEQUATE POLICIES, PROCEDURES, REGULATIONS, AND INTERNAL CONTROLS OVER MASSACHUSETTS PERSONAL CARE ATTENDANT PROGRAM

Inadequate internal controls and procedures over MassHealth's Personal Care Attendant Services have resulted in a) repeated overpayments on potentially fraudulent claims; b) unregulated and unsupervised felons with multiple crimes of violence, theft, and drugs providing services to the elderly and disabled; and c) providers missing critical documentation relative to the Personal Care Attendant (PCA) program, as follows:

a. Repeated Overpayments on Potentially Fraudulent Claims

We audited the claims paid for Personal Care Services (PCS) provided to 30 consumers during the period July 2004 through July 2008. Our audit indicated that 27 (90%) of the 30 consumers had recurrences of claims paid for PCA services allegedly performed while the consumers were residents of nursing facilities or other inpatient facilities during the period July 1, 2004 through July 31, 2008; therefore, charges for Personal Care Attendant (PCA) services by these consumers are not reimbursable under both state⁶³ and federal⁶⁴ regulations. These questioned claims were improperly paid according to the 130 Code of Massachusetts Regulations (CMR) 422.412, Non-Covered Services, which states, in part:

MassHealth does not cover any of the following as part of the PCA program or the transitional living program: ... (D) PCA services provided to a member while the member is a resident of a nursing facility or other inpatient facility;

It is improbable that these services could have been provided while the consumers were residents of nursing facilities or other inpatient facilities and not in their homes. The consumers or surrogates and the PCAs signed the activity forms under pain and penalty of perjury to their truthfulness. Consequently, the OSA concludes that there is a high probability that these claims may be fraudulent, defined as follows:

Fraud is defined as making false statements or representations of material facts in order to obtain some benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person's own benefit or for the benefit of some other party. In order to prove that fraud has been committed against the Government, it is

⁶³ 130 CMR 422.412 (D).

⁶⁴ Section 1905(a)(24) of the Social Security Act.

*necessary to prove that fraudulent acts were performed knowingly, willfully, and intentionally.*⁶⁵

In our audit report released in October 2008,⁶⁶ MassHealth and Executive Office of Health and Human Services (EOHHS) management agreed that the claims were for non-covered services and consequently were overpaid. They also stated that they were unaware that payments had been made for PCA services while consumers were residents of nursing facilities or other inpatient facilities. The only internal control over payments for services resides in MassHealth's trust in consumers' and surrogates' veracity. Consumers and their surrogates are the sole parties responsible for ensuring that the information submitted to the fiscal intermediary (FI) on the activity forms for each two-week pay period correctly identifies who provided the PCA services and the correct hours and dates that the PCA services were provided. The 130 CMR 422.420, PCA Program Member Responsibilities, states, in part:

As a condition of receiving MassHealth PCA services, the member must:

- (3) complete and sign activity forms and submit them to the fiscal intermediary in accordance with the instructions provided and time frame specified by the fiscal intermediary;*
- (4) ensure that information submitted on the activity forms for each pay period correctly identifies who provided the PCA services, and the correct hours and dates that the PCA services were provided; ...*
- (12) notify the personal care agency when there is a change in the member's medical condition or living situation that may require an adjustment in the number of day/evening hours per week or night hours per night authorized by the MassHealth agency; ...*
- (20) comply with all applicable MassHealth regulations.*

We researched, in the Massachusetts Medicaid Management Information System (MMIS) and its data warehouse, all claims paid for hospital and nursing facility residency provided to the 30 consumers during the period July 2004 through July 2008. We reviewed all of the activity forms detailing PCA services allegedly performed for consumers during their residency in hospitals or nursing facilities (excluding day or admission and discharge). The activity forms are faxed to the FIs and therefore are not original documents. Several of the forms appeared to have been copies

⁶⁵ Medicare General Information, Eligibility, and Entitlement, Chapter 1 - General Overview, 20.3.1 - Definition and Examples of Fraud - (Rev. 1, 09-11-02).

⁶⁶ Report No. 2008-1374-3S2, Independent State Auditor's Report on Certain Activities of the Office of Medicaid As Administered by MassHealth in the Payment of Certain Claims For Personal Care Services, October 1, 2004 to September 30, 2005.

of older forms with the hours worked and dates altered. We confirmed in MMIS that the claims for PCA services allegedly performed as indicated on the activity forms were paid. Additionally, we researched in MMIS and its data warehouse all claims paid for services provided to the consumers during the applicable period of service (POS) for hospital and nursing facilities and found that PCA services were allegedly performed for consumers when they were either hospital inpatients or residents of a nursing facility.

As shown in the table that follows, our previous audit disclosed that overpayments of claims paid attributable to services allegedly received by the 30 consumers totaled \$22,516 during the periods of service audited for federal fiscal year 2005. Our expanded scope audit found an additional \$207,283 in overpayments for non-covered PCA services allegedly performed for the 30 consumers. As a result, the original overpayments increased more than tenfold to \$229,799 for 18,980 hours billed and paid during the period July 2004 through July 2008. There were 295 activity forms inappropriately filed during 167 occurrences⁶⁷ when the consumers were residents of nursing facilities or other inpatient facilities.

⁶⁷ Each time the consumer becomes a hospital inpatient or a resident of a nursing facility.

OVERPAYMENTS

Consumer	First Audit Overpayment	Expanded Scope Audit Overpayment	Total Overpayments	Hours Billed (Rounded)	Occurrences*	Number of Improper Activity Reports (Timesheets)**	Consumer or Surrogate Felon***	PCA Felon***
1	\$ 624.00	\$ 6,927.26	\$ 7,551.26	619	13	17	No	Yes
2	442.32	3,377.48	3,819.80	321	6	9	Yes	Yes
3	2,467.68	3,305.76	5,773.44	496	3	5	No	Yes
4	378.30	2,758.68	3,136.98	270	3	6	No	Yes
5	355.02	-	355.02	31	1	1	No	No
6	1,032.00	360.84	1,392.84	117	3	3	No	Yes
7	407.40	22,433.48	22,840.88	1,876	11	23	Yes	Yes
8	402.00	206.61	608.61	51	2	2	No	No
9	1,478.28	4,972.44	6,450.72	548	4	7	No	No
10	1,104.00	237.64	1,341.64	112	3	3	No	No
11	447.00	12,694.45	13,141.45	1,071	14	17	No	No
12	660.00	911.40	1,571.40	130	3	3	No	No
13	828.00	785.92	1,613.92	133	3	3	No	No
14	564.00	2,948.18	3,512.18	290	10	10	No	Yes
15	792.00	4,017.64	4,809.64	397	4	6	No	Yes
16	826.44	11,953.47	12,779.91	1,084	6	11	Yes	Yes
17	1,041.78	32,487.80	33,529.58	2,769	13	23	No	Yes
18	420.00	2,574.80	2,994.80	247	3	12	Yes	Yes
19	312.00	5,420.76	5,732.76	468	7	14	Yes	No
20	931.20	17,398.10	18,329.30	1,510	21	30	No	Yes
21	500.52	2,836.68	3,337.20	274	5	8	Yes	Yes
22	616.92	174.60	791.52	68	2	2	No	No
23	500.52	4,020.00	4,520.52	387	3	9	No	No
24	1,547.28	35,253.36	36,800.64 ⁶⁸	2,997	2	25	No	No
25	1,252.56	21,183.32	22,435.88	1,840	4	21	No	Yes
26	648.00	72.00	720.00	60	2	2	No	No
27	444.00	1,591.18	2,035.18	171	5	6	No	No
28	372.00	-	372.00	31	1	1	No	No
29	510.00	-	510.00	43	1	1	No	No
30	<u>610.93</u>	<u>6,379.46</u>	<u>6,990.39</u>	<u>569</u>	<u>9</u>	<u>15</u>	No	No
Totals	<u>\$22,516.15</u>	<u>\$207,283.31</u>	<u>\$229,799.46</u>	<u>18,980</u>	<u>167</u>	<u>295</u>	6	14
Percent	9.8%	90.2%	100.0%				20%	47%

Note: 47% of the consumers employed felons and these consumers represent 64% of the overpayments.

*Each time the consumer becomes a hospital inpatient or a resident of a nursing facility.

**Filed every two weeks during occurrence.

***See Audit Result (b)

The United States Department of Health and Human Services Office of the Inspector General (HHS/OIG) extrapolated the results of the previous audit and estimated that \$610,333 was overpaid by MassHealth for non-covered PCA services for the 2005 federal fiscal year. While we

⁶⁸ Consumer was in a nursing home for 11 consecutive months during which time PCA services were paid at the rate of \$1,547.28 every two weeks.

cannot project that there has been a tenfold increase in that amount as well, it is probable that there have been substantial overpayments for PCA services allegedly performed while the consumers were residents of nursing facilities or other inpatient facilities. The potentially fraudulent filing of claims is ongoing, and will continue, unless MassHealth takes remedial action. Our audit indicated that MassHealth's internal controls and procedures are inadequate to prevent, detect, or deter the payment of these claims, resulting in overpayments as defined by applicable laws, rules, and regulations.

Recommendation

Based on the results of our audit, MassHealth should strengthen its procedures, internal controls, and oversight over payments for PCA services to ensure that it is not paying potentially fraudulent claims for non-covered services, including those provided while consumers are residents of nursing facilities or other inpatient facilities. We recommend that:

1. Consumers, surrogates, and PCAs be held accountable for fraudulent actions. Those associated with the overpayments should be investigated and, if MassHealth suspects that fraud was involved, those cases should be referred to the OSA's Bureau of Special Investigations (BSI) and the Medicaid Fraud Control Unit within the Office of the Attorney General.
2. If it is determined that a PCA is guilty of fraud, discontinue his or her association in the PCA program and report that individual to the HHS/OIG List of Excluded Individuals/Entities.⁶⁹
3. MassHealth should determine if it is feasible to recover the overpayments. If it appears unlikely that a cash recovery can be made because these parties do not have sufficient funds, MassHealth should determine whether liens or attachments could be put on other existing assets.
4. Notify all consumers, surrogates, and PCAs by letter of the serious nature of making a false claim and the potential penalty to be borne by the offending party.
5. The personal care management (PCM) agencies and FIs are assigned the task of overseeing that the PCAs are actually performing the services as reported on the activity forms. The oversight should have, as its goal, the detection and deterrence of fraudulent reporting. The procedure should be frequent and evident in order to have a sentinel effect on the consumers, surrogates, and PCAs.

⁶⁹ The HHS/OIG List of Excluded Individuals/Entities database provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all Federal health care programs.

6. MassHealth has a contractual arrangement with the PCAs to provide services to the consumer. The contract should stipulate that PCAs disclose any criminal background to the consumers or surrogates, the PCM agencies, and the FIs prior to, and during, their employment as PCAs.
7. A high degree of surveillance should be placed on the PCAs that have disclosed criminal backgrounds or those whose history was discovered as a result of background checks.
8. Edits be developed within MMIS that will suspend payment for PCA services when there is any evidence that the consumer is a resident of a nursing facility or other inpatient facility. These edits should include all non-covered services as indicated in 130 CMR 422.412. This will not prevent the initial or early overpayments, but will stop payments for PCA services when the consumer is a resident of nursing facilities or other inpatient facilities for an extended period.
9. A requirement that the original activity forms be mailed to the FI, in addition to the faxed form. This may deter the alteration and reuse of old signed forms. The FI should be required to review these forms for authenticity.
10. Determine whether the fees paid to the FIs and PCM agencies during the periods when the consumers were residents of nursing or other inpatient facilities are proper. If the fees were improperly paid, they should be recovered.
11. Establish regular audits of PCS by MassHealth's internal audit department with the intent to detect, prevent, and deter fraud and abuse. Conduct an audit of all payments for PCA services during state fiscal years 2005 through 2008 and identify overpayments for non-covered services. All audits should be conducted in accordance with applicable generally accepted government auditing standards.

Auditee's Response

Recommendation 1: MassHealth has, and will continue to, refer any suspicion of fraud, including evidence that PCAs were paid during times when a consumer was in an inpatient or nursing facility to BSI... MassHealth follows up with PCA Consumers upon receipt of documentation from BSI that supports the allegation of fraud, and terminates Consumers or PCAs, as appropriate, from further participation in the program.

Recommendation 2: Upon determination by BSI that a PCA has committed fraud, MassHealth will submit a report to HHS.

Recommendation 3: MassHealth has been reviewing the feasibility of recovering overpayments.

Recommendation 4: MassHealth will ensure that Consumers, surrogates and PCAs are aware of the serious nature of making a false claim by amending its existing PCA forms to include language pertaining to the potential penalties for committing fraud. MassHealth is amending the Service Agreement form, including the surrogate signature pages (signed by surrogate and Consumer), the Consumer Agreement form (signed by the Consumer), and the PCA Signature Form (signed by the PCA).

Recommendation 5: The responsibilities of PCM Agencies and FIs are delineated in their respective MassHealth contracts and do not include the responsibility of overseeing or supervising PCAs or performing associated compliance verifications. Such verification and validation is the primary responsibility of the consumer or surrogate, as is typical in consumer-directed programs... MassHealth is taking steps to reinforce with Consumers, surrogates, and PCAs what their roles and responsibilities are, including the requirements of the program regarding covered services. Additionally, MassHealth is continuing to evaluate the roles and responsibilities of its contractors to determine what additional actions PCM Agencies and FIs could take to ensure that the services provided by PCAs are meeting the needs of consumers and are performed in accordance with the Service Agreement. Finally, MassHealth is continuing to evaluate methods by which we could implement enhanced program oversight activities.

Recommendation 6: MassHealth will work with the PCA Workforce Council, Consumers, and advocates to discuss, design, and develop mechanisms by which we can enhance our support of Consumers as employers of PCAs.

Recommendation 7: MassHealth will work with the PCA Workforce Council, consumers, and advocates to discuss, design, and develop mechanisms by which we can enhance our support of Consumers as employers of PCAs.

Recommendation 8: As stated in MassHealth's response dated August 18, 2008 (Audit report No. 2008-1374-3S2), it would not be effective to implement edits that suspend PCA claims as PCA claims are generally received and paid well in advance of claims for facility and other services. MassHealth has developed new reporting algorithms to monitor this issue, and is developing a schedule of post-payment reviews... MassHealth will take appropriate action to follow up on any overlaps in service identified in the post-payment review including referral to BSI for further investigation as appropriate.

Recommendation 9: All activity forms require the signature of the Consumer and the PCA to be considered valid. Whether the signed activity form is faxed or mailed to the FI, it is considered to be an authentic activity form if all documentation is entered as instructed by the FI. MassHealth believes it would be a costly administrative burden to require that original forms be mailed and reviewed, and that the additional burden would have little impact on our ability to detect fraud and abuse. FIs review each activity form and contact the consumer if the activity form is not complete or is inaccurate. Additionally, if FIs identify any suspect activity based on visual assessment of activity forms, they can and do refer the cases to MassHealth.

Recommendation 10: MassHealth regulations allow administrative payments to PCM Agencies and FIs while a consumer is in an inpatient facility, providing all other payment conditions described in the PCA regulations and the PCM and FI contracts are met. MassHealth conducts and will continue to conduct, on a regular basis, reviews of claims paid to FIs and PCM Agencies to determine if claims paid meet regulatory and contractual requirements.

Recommendation 11: MassHealth's Program Integrity (PI) unit has established a schedule for periodic and regular reviews of PCA services. The results of such reviews will be handled accordingly, including referrals to BSI, when necessary, and take appropriate action upon the results of BSI's investigations.

Note: The auditee has also responded to Audit Result (a) in its cover letter that is included in the following section (b).

Auditor's Reply

We commend MassHealth for taking action and evaluating methods that will implement enhanced oversight of the PCA program. Notifying consumers and PCAs of the serious nature of making false claims and amending the language of existing PCA program forms and agreements should provide a deterrent to fraudulent behavior. Also, algorithms and post-payment reviews, if done efficiently and frequently, are beneficial. We understand that verification and validation of PCA activities and reporting is the primary responsibility of the consumer or surrogate. However, we continue to recommend that oversight of the consumers' performance in this area also be enhanced. MassHealth reports cases to BSI for investigation as standard operating procedure. However, when it is clear that a PCA claim was improperly paid because the consumer was inpatient, MassHealth's systems can verify that for the agency. Therefore, we suggest that MassHealth may take action based on its own investigation and without the assistance of BSI. Finally, while reviews by the Program Integrity unit can be effective, they are not a substitute for an internal audit conducted in accordance with generally accepted government auditing standards.

b. Individuals with Multiple Felony Crimes of Violence, Theft, and Drugs Providing Services to the Elderly and Disabled

In Massachusetts, PCA hiring is unregulated, with no requirements for background checks, training, age, supervision, health, literacy, or education. PCAs are continually in unsupervised contact with vulnerable elderly and disabled clients in the privacy of the consumers' homes, yet the PCAs are not held to the same standards as employees of nursing homes, rest homes, home health agencies, homemaker agencies, and hospice programs. Our audit disclosed that MassHealth's internal controls and procedures are inadequate to prevent, detect, or deter the employment by consumers of persons with criminal backgrounds, resulting in unwarranted risks to the consumers' personal safety and the security of their assets.

BSI conducted background checks for the consumers, PCAs, and surrogates in our sample and found that 14 (47%) of the 30 consumers had employed PCAs who had been convicted, or for whom the courts found sufficient evidence to find guilty, of a felony. During our audit period, the 30 consumers employed a combined total of 82 PCAs. Of these, 18 (22%) were either convicted,

or the courts had sufficient evidence to find them guilty of, a major felony, seven (9%) had been committed to prison, four (5%) had outstanding warrants, 12 (15%) were involved in violent crimes, nine (11%) had been convicted of drug offenses, and 10 (12%) perpetrated crimes of theft. Most of the PCAs guilty of felonies had multiple offenses. There were 41 crimes of violence, including manslaughter, assault and battery with a dangerous weapon, threatening murder, assault and battery on a child with injury, family abuse, and malicious destruction of property. There were 29 crimes of theft, including larceny and breaking and entering during the daytime. There were 26 drug crimes, including distributing heroin, possession of hypodermic needles or syringes, and trafficking cocaine in a school zone. The gravity of the circumstances in 35 of the crimes caused the perpetrator to be committed to prison. Nine (11%) of the PCAs had a total of 13 restraining orders issued on them to refrain from abuse. Five of the restraining orders were to protect children. Although 47% of the consumers had employed PCAs who were felons, these consumers represented 64% of the overpayments. Five (17%) consumers had a criminal history of serious crimes and of these, four hired PCAs with a similar past.

Most authoritative sources recognize the vulnerability of elderly and disabled consumers, and, as a result, have established measures to protect their safety and the security of their assets. The United States Senate, the United States House of Representatives, the United States Department of Health and Human Services, and the Massachusetts Department of Public Health have all developed policies and procedures to shield vulnerable elderly and disabled consumers from harm.

The United States House of Representatives Patient Safety and Abuse Prevention Act (H.R. 3078) is currently in a House subcommittee. The bill makes the following findings:

(1) Frail elders are a highly vulnerable population who often lack the ability to give consent or defend themselves. Since the best predictor of future behavior is past behavior, individuals with histories of abuse pose a definite risk to patients and residents of long-term care facilities.

(2) Every month, there are stories in the media of health care employees who commit criminal misconduct on the job and are later found, through a background check conducted after the fact, to have a history of convictions for similar crimes.

(3) A 2006 study⁷⁰ conducted by the Department of Health and Human Services determined that:

⁷⁰ United States Department of Health and Human Services, Ensuring a Qualified Long-Term Care Workforce: From Pre-Employment Screens to On-the-Job Monitoring, prepared by The Lewin Group, May 2006.

(A) criminal background checks are a valuable tool for employers during the hiring process;

(B) the use of criminal background checks during the hiring process does not limit the pool of potential job applicants;

(C) a correlation exists between criminal history and incidences of abuse; and

(D) the long-term care industry supports the practice of conducting background checks on potential employees in order to reduce the likelihood of hiring someone who has potential to harm residents.

The EOHHS, which administers the PCA program for MassHealth, contains in its regulations the following:

It is the policy of EOHHS and the Department that convictions of certain crimes presumptively pose an unacceptable risk to the vulnerable populations served by the Department and its vendor agencies. 105 CMR 950.000 sets forth minimum standards. Stricter standards may be set by CMR or agencies.⁷¹

Yet, Massachusetts is the only state in the nation with a single program through which Medicaid consumers receive PCS that does not have established hiring requirements for PCAs.⁷² All states other than Massachusetts had at least one program that required background checks; in excess of 80% of the states had programs that had requirements pertaining to training, age, and supervision; and more than 60% of the states had health and literacy/education requirements (See Appendix A). Massachusetts' nursing homes, rest homes, home health agencies, homemaker agencies, and hospice programs are required by regulation⁷³ to conduct a Criminal Offender Record Information (CORI) check, and to verify that certain applicants are not registered in the Department of Public Health's Nurse Aide Registry for those employees whose services may entail the potential for unsupervised client contact.

The consumers are educated by the PCM agency about the tools available to promote PCA services that are safe, such as the availability of Criminal Offender Record Information (CORI), Disabled Persons Protection Commission (DPPC), the sex offender registry (SOR), and the Elder Services hotline. To obtain information from these sources can be time-consuming, costly, and the interpretation of data difficult. In some cases the process may require computer access and literacy. Elderly and disabled consumers or their surrogates within the PCA program may not have

⁷¹ 105 CMR 950.002.

⁷² The U.S. Department of Health and Human Services Office of the Inspector General (HHS/OIG) report issued December 2006, "States' Requirements for Medicaid-Funded Personal Care Service Attendants"

⁷³ 105 CMR 950.000.

the resources to properly utilize these tools. A sample CORI report is shown in Appendix B exemplifying the difficulty a consumer might have with its interpretation.

Recommendation

Based on the results of our audit, MassHealth should acknowledge that not all of the elderly and disabled consumers or surrogates within the PCA program can be expected to properly perform all of the oversight necessary to ensure that a PCA applicant has the qualifications, requirements, and background necessary to effectively and safely provide PCA services. Further, MassHealth should take steps necessary to provide adequate support to improve consumer decision-making and help ensure the personal safety and security of assets of consumers participating in the PCA program. We recommend that:

1. MassHealth work with state agencies and the state Legislature to assure access to CORI information for consumers in the PCA program. Consolidated information from multiple services such as DPPC, SOR, and federal sources should be included.
2. Such information should be made available in an easy-to-understand format.
3. Such information should be made available free to the consumer.
4. MassHealth consider developing specific requirements for PCAs concerning training, age, supervision, health, literacy, and education.
5. Require all applicants for PCA positions to complete an application that contains a section requiring disclosure of any record of physical abuse and/or criminal behavior.
6. Establish formal provisions for screening individuals functioning as surrogates for PCA program consumers.
7. Consider conducting written surveys of all PCAs currently serving consumers in the program to determine whether or not he or she has a criminal record and for what crimes.

Auditee's Response

Thank you for the opportunity to comment on the draft Office of the State Auditor ("OSA") "Report on Certain Activities of the Office of Medicaid as Administered by MassHealth in the Payment of Certain Claims for Personal Care Services July 1, 2004 to July 31, 2008". This response addresses three critical areas raised by the draft report: key Patrick Administration policies and priorities; concern about sampling methodology; and, the importance of Consumer engagement in discussions regarding enhancements to the MassHealth Personal Care Attendant (PCA) program.

The Patrick Administration's Community First long-term care policy represents a commitment to supporting elders and people with disabilities of all ages to live with dignity and independence in the community. The growth that we have seen in the PCA program is

a reflection of our overall Community First policy, and our commitment to providing people with disabilities with choices as to how they can receive necessary and very personal services. Demographic projections regarding expanding numbers of Commonwealth residents likely to be in need of long-term supports highlight the importance of this policy commitment.

Consumer-direction features prominently in our program design for a reason. Consumers, or their Surrogates if necessary, are in the best position to make determinations as to when, how, and by whom services should be provided. They have been doing so successfully in the MassHealth PCA program for more than thirty years.

Massachusetts is not alone in its approach. Consumer-directed programs are expanding in public programs across the country, and data from the CMS Cash and Counseling Demonstration projects supports the conclusion that there is no increased risk of injury to consumers under consumer-directed models of care, compared to agency provided care.⁷⁴ Additionally, other reputable national evaluations of consumer-directed programs have convinced many policymakers, including those within the Centers for Medicare and Medicaid Services, that such programs are safe and cost-effective...

In response to the Governor's CORI reform initiative, EOHHS has revised CORI regulations in a manner that will continue to assure client safety for EOHHS programs and standardize employer decision-making about worker suitability for direct care roles. CORI reform is intended to maximize client safety while assuring that rehabilitated offenders can be employed and reintegrate successfully into the community. The new CORI regulations do not extend to the MassHealth PCA program. The next phase of our CORI reform efforts will address assuring access to CORI information for Consumers in our PCA program.

As we have previously communicated to your office, we continue to be concerned about the research methodology and data that underlies your findings, and results in misrepresentation of the level of risk for financial and physical abuse faced by consumers in the MassHealth PCA program.

The audit sample that the Office chose in the first PCA Claims Overlap Audit (No. 2008-1374-3S2) was not randomly selected, but was based on a subset of claims identified as having a high probability of overlap. The high error rate found in that sample could not, therefore, be appropriately used to describe the level of fraud in the program. As an example, the HHS-OIG extrapolation of potential overlaps from that audit amounted to about 0.36% of total PCA program expenditures.

We are similarly concerned about the use and arraying of percentages in this expanded scope audit report. The sample used in this audit was drawn from a subset of Consumers that had been previously determined to have overlapping claims; it was neither random nor drawn from the general population of consumers or all paid claims. The data, as is currently presented, suggests a much higher degree of concern than can reasonably and reliably be inferred from the sampling method used. The findings cannot, therefore, be used to describe the relative level of risk in the program.

We believe that the Office's "Draft on Certain Activities of the Commonwealth's Personal Care Attendant Program July 1, 2005 – June 30, 2007" attempts to provide a more appropriate perspective for considering the issues of risk in the program, acknowledging the

⁷⁴ U.S. Department of Health and Human Services, Addressing Liability Issues in Consumer-Directed Personal Assistance Services (January, 2004).

importance of PCAs to Consumers seeking to live independently in the community, and consumer direction as a critical feature of the program. The referenced report also acknowledges the variety of consumer-directed delivery systems models across the country, and concludes that such models are preferred by Consumers, efficient, and "just as safe" as other models. The report additionally provides perspective regarding background checks, concluding that "the level of risk associated with PCA abuse and fraud is relatively low".

We would like to acknowledge that both of the draft reports appropriately focus concern on the pragmatic challenges Consumers face in acquiring, paying for, and adequately understanding CORI information, all issues we intend to address in the planned next phase of our CORI reform effort.

Consistent with our ongoing commitment to supporting individuals to be employers, make decisions about who they hire, and direct the services they buy, MassHealth will work with the PCA Workforce Council, Consumers, and advocates to discuss, design, and develop mechanisms by which we can enhance our support of Consumers performing background checks of their potential employees. Specifically, we intend for those conversations to focus on how best to reinforce the value of meaningful background checks, and minimize the financial impact of CORI checks on Consumers. As stated previously, however, mechanisms developed will be consistent with the Patrick Administration's commitment to ensuring that rehabilitated individuals with criminal backgrounds receive a fair opportunity to be employed.

As you know from our previous responses to the OSA's audits of the PCA program, we acknowledge the complexity and value of the program, as well as OSA's advice and counsel regarding what more we can do [to] improve our administration of the program. Management controls that ensure program integrity and Consumer safety are essential for all MassHealth services, and we appreciate the collaborative work we have done with the OSA to enhance these controls. It is essential, however, that our priority policy initiatives guide our decision-making regarding program design and controls. We do not believe that these are conflicting principles.

Auditor's Reply

Our audit methodology is delineated in the Audit Scope, Objectives, and Methodology section of this report. It explains the source from which we selected those to be audited, what we intended to determine, and how we would perform our procedures. We did not select our audit subjects from a statistical sample and no extrapolation to the entire PCA program was made. Our Audit Results are what we discovered in overpayments, PCAs' criminal backgrounds, and claims documentation. MassHealth should conduct a broader analysis to gain a full understanding of the nature, extent and magnitude of the safety issue raised in the report.

The U.S. Department of Health and Human Services (HHS) report⁷⁵ referenced in your response addresses the legal liability issues that may arise in government-sponsored consumer-directed

⁷⁵ U.S. Department of Health and Human Services, Addressing Liability Issues in Consumer-Directed Personal Assistance Services: The National Cash and Counseling Demonstration and selected Other Models (January 2004)

personal assistance programs. The purpose of the HHS report is twofold: first to identify the circumstances in which negligence or other misconduct could result in liability and what persons or entities are likely to be liable; and second to identify steps that can reduce exposure to such liability. One of the options the report gave to reduce exposure was that the states offer worker background checks to the consumers. The report indicated that preliminary data from a study⁷⁶ indicates that there is “no increase in risk of injury to consumers under the consumer-directed model of care, compared to agency-provided care.” As we disclosed in our audit, background checks are performed for workers in agency-provided home health care to MassHealth members, but not in the PCA program. We did not reference the HHS report in our audit, as our focus is on the risks to the consumers’ personal safety and the security of their assets, without concern for who is liable. In our opinion, any risks to the consumers’ safety and security should be mitigated by all reasonable means available. We are pleased that the next phase of CORI reform will address assuring access to CORI information for consumers in the MassHealth PCA program and the pragmatic challenges the consumers will face in performing meaningful background checks.

We agree that MassHealth’s consumer-directed PCA program supports elders and people with disabilities of all ages to live with dignity and independence in the community. It is a valuable program that can cost-effectively fulfill a growing need for the citizens of the Commonwealth. Like you, we look forward to continuing the collaborative work we have done with MassHealth to make certain its programs have adequate internal controls that ensure the programs’ integrity.

c. Providers Missing Critical Documentation

Both the PCM agencies and the FIs have specific recordkeeping requirements that, by regulation and contractual obligation, they are to maintain. Our audit disclosed that the PCM agencies were missing documentation for 19 (63%) of the 30 consumers and that the FIs were missing documentation for 19 (63%) of the 30 consumers.

In one instance, a PCM agency had misplaced the consumer’s entire file and had no information regarding the consumer and his or her care requirements. For another consumer, the agency was missing all documentation, other than progress notes. The agencies did not have contact information for the PCAs servicing eight (27%) consumers. The PCM agencies were missing

⁷⁶ U.S. Department of Health and Human Services, Does Consumer Direction Affect the Quality of Medicaid Personal Assistance in Arkansas? (March 2003).

several other important documents critical to the consumers' care. The FIs were missing the name and contact information of the consumers' primary physicians for 18 (60%) of the consumers. FIs were also missing I-9s⁷⁷ for the PCAs employed by nine (30%) of the consumers; therefore, it is unknown whether these PCAs are authorized to work in the United States.

The following table lists the missing documentation:

Consumer	PCM Agency Recordkeeping	FI Recordkeeping
1	Misplaced File, no documentation submitted	Name and contact information of Consumer's primary physician missing
2	Quality Management Report missing	Name and contact information of Consumer's primary physician missing
3	Missing all documentation, other than Progress Notes	Name and contact information of Consumer's primary physician missing - I-9 missing for PCA
4	Missing Consumer Service Agreement - Name, address, and phone number of PCA missing	Name and contact information of Consumer's primary physician missing - I-9 missing for PCA
5	Re-evaluations missing - Name, address, and phone number of PCA missing	Name and contact information of Consumer's primary physician missing
6	Complete	Name and contact information of Consumer's primary physician missing - I-9 missing for PCA
7	Complete	Name and contact information of Consumer's primary physician missing
8	Complete	Complete
9	Missing Consumer Service Agreement; Name, address, and phone number of PCA missing	Complete
10	Quality Management Report missing	Complete
11	Evaluation to Initiate Services missing	Complete
12	Name, address, and phone number of PCA missing	Complete
13	Evaluation to Initiate Services; Re-evaluations missing; Name and Address of consumer's primary care physician missing	Complete
14	Service Agreement with PCM is missing; Initial Application for PCA Services missing; Evaluations missing; Record of Functional Skills Training missing; Quality Management Report missing; Name, address, and phone number of PCA missing	Complete

⁷⁷ The purpose of this form is to document that each new employee (both citizen and non-citizen) hired after November 6, 1986 is authorized to work in the United States.

Consumer	PCM Agency Recordkeeping	FI Recordkeeping
15	Evaluation to Initiate Services missing; Quality Management Report missing	Name and contact information of Consumer's primary physician missing - I-9 missing for PCA
16	Quality Management Report missing; Name, Address for PCA missing	Name and contact information of Consumer's primary physician missing
17	Complete	Name and contact information of Consumer's primary physician missing
18	Complete	Name and contact information of Consumer's primary physician missing
19	Complete	Name and contact information of Consumer's primary physician missing
20	Complete	Complete
21	Complete	I9 Forms missing for PCAs
22	Complete	Name and contact information of Consumer's primary physician missing; I-9 for PCA missing
23	Complete	Complete
24	Written capacity of member to manage program independently missing; Evaluations to Initiate Services missing; Quality Management Report missing; Name and Address of PCA missing	Complete
25	Contract for Personal Care Management Services missing; EOHHS/MassHealth Notice of Approval missing; Name, Address, and Phone Number of PCA missing	Name and contact information of Consumer's primary physician missing
26	Complete	Name and contact information of Consumer's primary physician missing; I-9 for PCA missing
27	Consumer Assessment missing; Service Agreement missing; Record of Functional Skills Training missing; Quality Management Report missing	Complete
28	Quality Management Report missing	Name and contact information of Consumer's primary physician missing; I-9 for PCA missing
29	Quality Management Report missing	Name and contact information of Consumer's primary physician missing
30	Contract for Personal Care Management Services missing; Evaluation to Initiate PCA Services missing; Name, Address, and Phone Number of PCA missing	I-9 and W-4 for PCA missing; Name and contact information of Consumer's primary physician missing

The providers who are missing documentation are neither in compliance with regulations nor their contractual obligations. Our audit disclosed that MassHealth's internal controls and procedures are

inadequate to prevent or detect noncompliance with the recordkeeping requirements of both the PCM agencies and the FIs.

Recommendation

MassHealth should strengthen its procedures, internal controls, and oversight to maintain that providers are in compliance with regulations and their contractual obligations pertaining to recordkeeping requirements. We recommend that MassHealth:

1. Complete regularly scheduled desk audits for compliance with recordkeeping requirements utilizing randomly sampled consumers from each FI and PCM agency.
2. Notify all FIs and PCM agencies of the desk audit policy.
3. Review with the FIs and PCM agencies the deficiencies discovered by the OSA.

Auditee's Response

MassHealth conducts site visits to PCM Agencies as part of its contract performance evaluation process. During site visits, MassHealth reviews a sample of Consumer records to ensure PCM Agencies are in compliance with PCM contract documentation requirements. In cases where documentation is missing or incomplete, the PCM Agency is required to develop a corrective action plan to address the deficiency, and MassHealth follows up with the PCM Agency to ensure the plan is implemented. MassHealth plans to continue this practice with, potentially, the addition of desk audits, when appropriate.

MassHealth would appreciate the Office of the State Auditor sharing its work papers or identifying the specific records and agencies that were lacking information so that we can [...] share the deficiencies identified with our contractors.

Auditor's Reply

We will share the detail of the missing documentation with MassHealth and identify the respective consumers, FIs, and PCM agencies.

APPENDIX A

PCA Requirements By State

State	Programs ⁷⁸	Requirement Sets ⁷⁹	Number of Requirement Sets Including Each Requirement ⁸⁰						
			Background	Training	Age	Supervision	Health	Literacy/ Education	Other
AK	1	2	2	2	2	2	1	0	0
AL	6	6	6	6	2	6	6	6	1
AR	5	5	2	3	2	4	3	5	2
AZ	1	1	1	1	0	1	0	0	0
CA	5	5	3	0	5	2	2	1	2
CO	8	7	3	7	0	4	0	0	2
CT	4	6	4	4	6	4	2	2	2
DC	3	3	3	3	3	3	3	3	3
DE	2	2	2	2	0	2	2	2	0
FL	13	13	13	10	7	9	6	7	5
GA	5	5	5	5	0	5	5	0	0
HI	4	8	4	4	4	4	4	4	8
IA	6	12	6	0	12	0	0	0	12
ID	3	3	3	0	3	3	3	0	1
IL	5	9	8	5	4	0	6	4	3
IN	6	6	6	6	6	0	6	4	1
KS	4	8	2	1	8	0	4	0	2
KY	2	2	2	2	1	2	2	2	0
LA	3	4	4	4	4	3	0	3	3
MA	1	0	0	0	0	0	0	0	0
MD	4	5	5	3	4	4	2	4	2
ME	4	5	5	4	2	5	0	0	1
MI	2	2	1	1	1	2	0	0	0
MN	9	9	9	9	9	9	9	0	0
MO	8	14	14	10	10	11	3	4	0
MS	3	3	1	3	3	2	3	3	2
MT	4	6	2	4	6	4	0	4	2
NC	7	7	7	6	3	7	6	0	0
ND	3	3	3	1	2	1	2	0	2
NE	1	1	1	0	1	0	1	0	0
NH	5	5	5	5	4	4	4	0	3
NJ	7	7	6	6	1	7	6	0	6
NM	2	3	3	2	3	1	3	1	1
NV	2	2	2	2	0	2	2	2	0

⁷⁸ Number of Medicaid-funded programs offering PCA services.

⁷⁹ Any combination of background checks, training, supervision, age, health, literacy, or education, or any other requirements established for personal care assistants in a program.

⁸⁰ Source: The U.S. Department of Health and Human Services Office of Inspector General (HHS/OIG) report issued December 2006, "States' Requirements for Medicaid-Funded Personal Care Service Attendants, Appendix C.

State	Programs ⁷⁸	Requirement Sets ⁷⁹	Number of Requirement Sets Including Each Requirement ⁸⁰						
			Background	Training	Age	Supervision	Health	Literacy/ Education	Other
NY	2	3	3	2	0	2	3	3	3
OH	6	10	10	8	9	8	0	1	4
OK	2	2	1	2	2	2	2	0	0
OR	7	9	9	4	9	7	6	2	5
PA	7	9	9	9	9	4	5	9	1
RI	5	4	4	4	0	4	0	0	4
SC	7	12	1	12	12	12	11	12	7
SD	3	3	1	3	1	0	1	1	1
TN	6	6	6	6	4	6	6	5	4
TX	9	13	13	13	13	10	4	2	1
UT	4	5	5	5	5	5	1	4	0
VA	5	9	8	5	7	8	8	8	4
VT	2	4	3	1	3	2	0	2	0
WA	7	14	14	14	14	0	14	14	14
WI	13	13	9	13	9	13	4	0	13
WV	1	1	1	1	0	1	0	0	0
WY	<u>4</u>	<u>5</u>	<u>5</u>	<u>4</u>	<u>4</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>1</u>
Total	<u>238</u>	<u>301</u>	<u>245</u>	<u>227</u>	<u>219</u>	<u>198</u>	<u>162</u>	<u>125</u>	<u>128</u>

APPENDIX B

Sample Criminal Offender Record Information Report (CORI)⁸¹

NAME: DOE, JOHN PCF: 00001960484 DOB: 07/04/1956 Page: 01

***** WARNING *****

THIS INFORMATION MAY CONTAIN CORI. IT IS NOT SUPPORTED BY FINGERPRINTS. PLEASE
CHECK THAT THE NAME REFERENCED BELOW MATCHES THE NAME AND DATE OF BIRTH OF THE PERSON.

COMMONWEALTH OF MASSACHUSETTS

CRIMINAL HISTORY SYSTEMS BOARD

*** PERSONS COURT SUMMARY ***

NAME:

DOE, JOHN

FORMAL NAME: JOHN

PCF: 00001960484

DOB: 07/04/1956

SEX: M

RACE: W

POB:
CAMBRIDGE MA

SSN: 002345678

ADDRESS: 1234 ANYWHERE STREET, ANY CITY MA

ALIAS:

NAME: JOHN DOE

FORMAL NAME: DOE

DOB: 07/04/56

SEX: M

RACE: W

*** ADULT APPEARANCES ***

ARRAIGNMENT

⁸¹ Source: Official Website of the Executive Office of Public Safety and Security (EOPSS), Criminal History Systems Board (CHSB) website:
[http://www.mass.gov/?pageID=eopsterminal&L=5&L0=Home&L1=Crime+Prevention+%26+Personal+Safety&L2=Background+Check&L3=Criminal+Offender+Record+Information+\(CORI\)&L4=How+to+Read+a+Criminal+Record&sid=Eeops&b=terminalcontent&f=chsb_cori_bop_sample&csid=Eeops](http://www.mass.gov/?pageID=eopsterminal&L=5&L0=Home&L1=Crime+Prevention+%26+Personal+Safety&L2=Background+Check&L3=Criminal+Offender+Record+Information+(CORI)&L4=How+to+Read+a+Criminal+Record&sid=Eeops&b=terminalcontent&f=chsb_cori_bop_sample&csid=Eeops)

ARG DATE: 11/12/1985 **PD:** BOS **COURT:** WEST ROXBURY DISTRICT **DKT#:** 2006CR12

OFF: A&B ON POLICE OFFICER

DISP: C 01/07/1986 5 YR SS 3 YR DF 07/20/1989 **STATUS:** W
D/R C 08/16/1989 VOP WPD: WRD

PROB 08/16/1992 DF WAR

ARRAIGNMENT: (This is a Pending Case)

ARG DATE: 01/22/1984 PD: WAL COURT: WALTHAM DISTRICT DKT#: 893CR1234A

OFF: DISORDERLY PERSON DIS PER

DISP: C 02/01/1984 STATUS: O WPD:

ARRAIGNMENT:

ARG DATE: 01/24/1979 PD: BOS COURT: BOSTON DISTRICT DKT#: 8619CR4321B

OFF: LIQUOR LAW VIOLATION LIQ LAW

DISP: C 01/29/1979 G PROB 01/29/1980 VWF CMNTY SRV TERM STATUS: O WPD:

ARRAIGNMENT:

ARG DATE: 12/21/1976 PD: WEY COURT: QUINCY DISTRICT DKT#: 781CR9767ZZ

OFF: OPERATING AFTER SUSPEND REG 114C-SUS

DISP: DISM STATUS: C WPD:

END OF ADULT ARRAIGNMENTS

REQUESTED BY: CHSB
COMPLETED BY: ##CORI-SHM 0066-SMH