Home and Community-Based Services: Understanding Your Role as a Provider

Medicaid Home Health Services

The Centers for Medicare & Medicaid Services (CMS) continues to implement activities focused on reducing payment errors along with fraud, waste, and abuse (FWA) in the Medicaid program. Through analysis of data produced by the Payment Error Rate Measurement (PERM) program, CMS identified payment errors for Home and Community-Based Services (HCBS). CMS developed educational materials for beneficiaries and providers to address the major causes of error.

Medicaid home health services are a mandatory benefit under the State plan for patients eligible for nursing facility care. They also may be provided to populations with specific needs through a waiver program. Home health services include part-time nursing, home health aides, medical supplies, medical equipment, and appliances suitable for use in the home.

The Medicaid benefit for home health services is often a source of payment errors. Some of the common causes of payment errors in home health services include:

- The number of units billed for a procedure code differs from the number of units documented
- The units are not calculated correctly for the procedure code, such as billing for units of service in 15-minute increments when the procedure code specifies 1-hour increments
- Service logs are missing the provider's name, dates of service, time spent, and activities performed. Logs were not signed by the provider or validated by the beneficiary.

Some promising practices to avoid improper payments involve establishing quality control processes for services provided, records, and claims processing. A compliance officer can help ensure policies are current with Federal and State regulations.

For further information about how to strengthen the integrity of the Medicaid program and reduce making improper payments, review the toolkits available at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS Medicaid Program Integrity Education (MPIE) website.

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HCBS Waiver Programs

The Centers for Medicare & Medicaid Services (CMS) continues to implement activities focused on reducing payment errors along with fraud, waste, and abuse (FWA) in the Medicaid program. Through analysis of data produced by the Payment Error Rate Measurement (PERM) program, CMS identified payment errors for Home and Community-Based Services (HCBS). CMS developed educational materials for beneficiaries and providers to address the major causes of error.

HCBS waiver programs provide the opportunity for Medicaid-eligible individuals to receive services in their home and community. Waiver programs vary by State and are designed to meet the specific needs of their respective populations, including individuals with physical, mental, and intellectual disabilities, the aged, or people with chronic conditions.

The Medicaid benefit for HCBS waiver services is a common source of payment errors. The most common errors were found in documenting person-centered plans of care, ensuring sufficient documentation to support claims, and properly documenting the number of billing units when applicable. Examples of common causes of payment errors in waiver programs include:

- Person-centered plans of care were not present, were incomplete, or were outdated
- Service logs were missing the care provider's name, dates of service, time spent, and activities performed. In addition, the logs were not signed by the personal care aide, the beneficiary, or both, as required.
- For services provided in another venue such as adult day care or assisted living, there were no records submitted to show that the beneficiary was present to receive the services
- Documentation provided did not support the number of units billed

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Home and Community Based Personal Support Services and Person-Centered Plans of Care – Part I

The Centers for Medicare & Medicaid Services (CMS) continues to implement activities focused on reducing payment errors along with fraud, waste, and abuse (FWA) in the Medicaid program. Through analysis of data produced by the Payment Error Rate Measurement (PERM) program, CMS identified payment errors for Home and Community-Based Services (HCBS). CMS developed educational materials for beneficiaries and providers to address the major causes of error.

Medicaid personal support services are defined as providing assistance that most often relates to performing activities of daily living and instrumental activities of daily living. They include personal care services, adult companion services, attendant care, and consumer directed attendant services. Personal support services can be provided as an optional benefit under a State Medicaid plan or as part of an HCBS waiver program. Personal support services must be provided in accordance with a person-centered plan of care authorized by a State Medicaid agency. They may also be offered under a self-directed care model.

States can use waiver authority to design programs for a specific group of residents with specific needs. Personal support services must be:

- Recommended by a beneficiary's treating physician in a person-centered plan or in accordance with a service plan approved by the State
- Provided by an approved provider
- Provided in an individual's home or other location as authorized by the State

Some promising practices to avoid improper payments involve establishing quality control processes for services provided, records, and claims processing. A compliance officer can help ensure policies are current with Federal and State regulations.

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Home and Community-Based Services: Understanding Your Role as a Provider

Home and Community Based Personal Support Services and Person-Centered Plans of Care – Part II

The Centers for Medicare & Medicaid Services (CMS) continues to implement activities focused on reducing payment errors along with fraud, waste, and abuse (FWA) in the Medicaid program. Through analysis of data produced by the Payment Error Rate Measurement (PERM) program, CMS identified payment errors for Home and Community-Based Services (HCBS). CMS developed educational materials for beneficiaries and providers to address the major causes of error.

Medicaid personal support services provided as part of an HCBS waiver program may be provided by state "sister" agencies such as the Department of Aging or Department of Disabilities and monitored by a State-agency-specified professional who is usually a case manager or care coordinator. Claims for services provided may be submitted to and paid by a state "sister" agency or the State Medicaid agency. Regardless of who pays, the rules for both agencies must be followed. For example, expenditures for HCBS are included in the Medicaid PERM universe, and documentation (including the person-centered plan) must be provided to support those payments.

Medicaid personal support service claims are often identified as a source of payment errors. Common causes of payment error include:

- The person-centered plans were not signed by the case manager or other State-designated professional, did not include specific goals, and did not show necessity for the services provided
- Service logs were missing the personal care aide's name, dates of service, time spent, and activities performed. In addition, the logs were not signed by the personal care aide, the beneficiary, or both, as required.
- The units of service were not calculated correctly for the procedure code, such as billing for units of service in 1-hour increments when the procedure code specifies per diem increments

Some promising practices to avoid improper payments involve establishing quality control processes for services provided, records, and claims processing. A compliance officer can help ensure policies are current with Federal and State regulations.

For further information about how to strengthen the integrity of the Medicaid program and reduce making improper payments, review the toolkits available at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS Medicaid Program Integrity Education (MPIE) website.

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Home and Community-Based Services: Understanding Your Role as a Provider

Home and Community Based Personal Support Services and Person-Centered Plans of Care – Part III

The Centers for Medicare & Medicaid Services (CMS) continues to implement activities focused on reducing payment errors along with fraud, waste, and abuse (FWA) in the Medicaid program. Through analysis of data produced by the Payment Error Rate Measurement (PERM) program, CMS identified payment errors for Home and Community-Based Services (HCBS). CMS developed educational materials for beneficiaries and providers to address the major causes of error.

Medicaid requires that documentation support all services billed and the accuracy of this documentation is critical. Federal regulations require a written person-centered plan for HCBS, whether services are provided through the State Medicaid Plan or through a waiver program. Using Federal funds is not allowed for HCBS waiver services that are provided without a person-centered plan. A beneficiary's plan of care must:

- Indicate their diagnosis
- Describe their service needs related to their diagnosis
- Include their expectations and goals
- Indicate the type and frequency of the services needed (for example, bathing assistance 30 minutes per day, 3 days per week)
- Indicate the level of assistance they need (for example, hands-on assistance, cueing, or supervision)
- Be reviewed by their treating physician or State-agency-specified professional at least once per year, or when their circumstances change
- Be authorized with the signature of a physician or State-agency-specified professional when changes are made

Additional State requirements may apply. Check with your State Medicaid agency or state "sister" agency for further information.

Some promising practices to avoid improper payments involve establishing quality control processes for services provided, records, and claims processing. A compliance officer can help ensure policies are current with Federal and State regulations.

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Durable Medical Equipment

The Centers for Medicare & Medicaid Services (CMS) continues to implement activities focused on reducing payment errors along with fraud, waste, and abuse (FWA) in the Medicaid program. Through analysis of data produced by the Payment Error Rate Measurement (PERM) program, CMS identified payment errors for Home and Community-Based Services (HCBS). CMS developed educational materials for beneficiaries and providers to address the major causes of error.

When medically necessary, reasonable, and cost effective, Medicaid will purchase or rent durable medical equipment (DME) and medical supplies for beneficiaries living in a community setting, including those provided by a qualified home health provider as part of home health services.

The Medicaid benefit for DME is often a source of payment errors. Common causes of payment errors include:

- Claims for DME were submitted to Medicaid instead of Medicare or other primary insurance. (Medicaid is considered the payer of last resort; therefore, payment should be sought from other insurance first.)
- Dates on the documentation provided do not match the dates of service or date of delivery on the claim
- The number of units billed does not match the number of units received by the beneficiary as identified in the documentation

Some promising practices to avoid improper payments involve establishing quality control processes for services provided, records, and claims processing. A compliance officer can help ensure policies are current with Federal and State regulations.

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