Recent Developments in Personal Care and Other Home and Community-Based Services in Medicaid and Medicare

(March 23, 2020): Until recently, personal care services, such as home health aides, were not covered under the Medicare program unless they were part of a skilled service where the beneficiary was homebound. However, beginning with calendar year 2019, the Medicare program has expanded the ability of plans that participate in the Medicare Advantage program ("MA Plans") to offer these services as a separate supplemental service at their option. Additionally, as part of the Bipartisan Budget Act of 2018,[2] Congress expanded the supplemental benefits that MA Plans could offer to encompass certain benefits that were not primarily health related for certain chronically ill patients beginning with calendar year 2020. This paper will discuss those changes, some of the major compliance issues that providers of personal care services face, and how the Medicaid program addresses these services.

I. The Medicare Advantage ("MA") Changes to Cover Additional Supplemental Benefits:

A. The 2019 MA Changes to Cover Personal and Other Home and Community Based Type Services

MA Plans are permitted to cover certain benefits that are not included in the fee for service Medicare program ("Original Medicare"). Generally, these have taken the form of benefits such as dental and vision services. However, to be covered as supplemental benefits, the items and services have been required to be "primarily health related." [3]

Prior to calendar year 2019, the Centers for Medicare and Medicaid Services ("CMS") has considered an item or service to be "primarily health related" only if the primary purpose is to "prevent, cure, or diminish an illness or injury."[4] However, CMS had not considered a service to fit within this definition if the primary purpose is daily maintenance.

In the 2019 Final Call Letter, CMS announced that it would change the definition of that term to cover services under certain conditions "even if a significant purpose of the item is daily maintenance."[5] Thus, under the new interpretation, "in order to be 'primarily health related' … [an item or service] must diagnose, prevent, or treat an illness or injury, compensate for physical

impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and health care utilization."

The intent of the change was to provide plans the flexibility to offer supplemental benefits that enhance the quality of life and improve outcomes. The service, however, also must be medically appropriate, recommended by a licensed provider as part of a plan of care, and cannot include items or services that are solely to induce enrollment.

A letter from CMS to MA Plans dated April 27, 2018 provided further guidance on the new interpretation of "primary health related."[6] The letter listed a number of examples of benefits that MA Plans could provide beginning in 2019 under the revised definition including *in-home support services*, adult day care services, home-based palliative care, support for caregivers enrollees, medically-approved non-opioid pain management, stand-alone memory fitness benefit, home and bathroom safety devices and modifications, transportation, and over-the-counter benefits. The letter further described in-home support benefits as:

> ***"in-home services to assist individuals with disabilities and/or medical conditions in performing ADLs and IADLs within the home to compensate for physical impairments, ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization. Services must be provided by individuals licensed by the state to provide personal care services, or in a manner that is otherwise consistent with state requirements."*** **(Emphasis added.)**

Finally, in a speech at the Medicare Prescription Drug Plan Spring Conference, Seema Verma, Administrator, CMS, stated that "[t]his means that now Medicare Advantage beneficiaries will be provided adult day care services, respite care for caregivers, and *in-home assistance with activities like bathing and managing medications*." (Emphasis added.)[7]

B. The 2020 MA Changes to Cover Benefits that are Not Primarily Health Related for Certain Chronically Ill Patients

The Balanced Budget Act of 2018 further expanded the benefits that MA Plans could offer as supplemental benefits to include certain benefits that are not primarily health related for chronically ill beneficiaries if they chose, beginning in 2020. In the 2020 Final Call Letter, CMS refers to these benefits as Special Supplemental Benefits for the Chronically Ill ("SSBCI").[8]

Unlike other supplemental benefits, MA Plans are able to offer SSBCI in a non-uniform manner.

Thus, MA Plans will be allowed to vary or target SSBCI to an individual's particular medical needs.[9] However, the 2020 Final Call Letter also states that while MA Plans have broad discretion with respect to both non-uniformity and the form of the benefit, itself, the items or services provided must have a reasonable expectation of improving or maintaining the health or overall function of an individual as it relates to the chronic condition or illness.[10]

For the purpose of SSDI, a chronically ill enrollee is one who: " 1) has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee; 2) has a high risk of hospitalization or other adverse health outcomes; and 3) requires intensive care coordination."[11] Currently, CMS will consider any individual with a condition identified as chronic in the list at section 20.1.2 of Chapter 16b of the Medicare Managed Care Manual to meet this criteria. However, the 2020 Final Call Letter also states that CMS will convene a technical advisory panel to periodically update the list of conditions that satisfy the necessary criteria.[12]

CMS followed up the 2020 Final Call Letter with additional sub-regulatory guidance in the form of a letter to Medicare Advantage Organizations.[13] That letter listed as examples of permitted benefits, the following: meals beyond a limited basis; food and produce; transportation for non-medical needs; pest control; indoor air quality equipment and services; social needs benefits; complimentary therapies; services supporting self-direction; structural home modifications; and general supports for living.[14]

C. Status of Implementation by MA Plans

Anecdotal information indicates that plans were experimenting with the types and scope of benefits to cover under the reinterpretation of "primarily health related" during the 2019 calendar year. This was, in part, due to the fact that the 2019 Final Call Letter was not issued until April 2018, just two months before plan bids were due. Thus, there was a limit on the time within which MA Plans had to determine how to utilize this new flexibility. Also, the nature of the benefit, coupled with the competition from traditional supplemental benefits such as dental and vision care, almost dictated a need for experimentation and slow implementation.

Nevertheless, two studies by Milliman attempted to encapsulate the manner in which MA Plans had implemented that flexibility in the initial plan year that they were available.[15] And a more recent Milliman study that was published in November 2019 appears to indicate that a significantly greater number of plans are offering new types of supplemental benefits for the 2020 calendar year.[16]

II. Compliance Issues in Personal Care:

Personal care services have become extremely popular as other government programs attempt to rebalance services for the elderly and disabled from those that are provided in institutions to those provided in the home. Additionally, many individuals who otherwise do not qualify for government

sponsored long term care under the traditional benefit package also prefer to use personal care aides to enable them to remain in their homes.

However, from a compliance standpoint, personal care provides a number of challenges. First, aides are frequently low paid, and thus struggle to make a living wage. Additionally, the work can be difficult. From an agency perspective, government rates generally are low, thus furthering the need to retain workers at low wage levels and the needs of elderly and disabled clients can be extremely challenging. Adding to these difficulties is the fact that because the work takes place in the home, it is more challenging to monitor than care provided in the institutional setting.

Over the past years, there have been a number of investigations and prosecutions of home and personal care aides and agencies. The issues involved in these cases have taken a number of forms but generally arise under several categories. Thus, conduct that has been prosecuted can range from aides colluding with clients who otherwise would not be eligible for services, falsification of time sheets by aides and clients, operation of an agency by an excluded individual, and theft from elderly clients.

As an example, in 2014 the Federal Bureau of Investigation had a “takedown” of more than twenty individuals and agencies for Medicaid fraud in the District of Columbia. Allegations involved aides falsifying time sheets for visits that never occurred, sometimes to clients who falsified their eligibility for services, and splitting the Medicaid payments between aides and clients for services that were never provided. In one instance, an agency owner who had been excluded in Virginia under her maiden name, operated an agency in the District under a different name and allegedly received more than $70 million from the District Medicaid program before being busted. There were even allegations that one or more aides involved in the conduct transported a patient who had been out of state when services were allegedly delivered, back to the District because they had determined that the company would be making an internal compliance verification visit to check on the delivery of services.[17] These actions resulted in the Director of the District’s Medicaid program estimating that he lost approximately 70% of his providers and temporarily establishing a government operated personal care agency to provide care while the Medicaid program rebuilt its provider pool.

In another example, twelve people, including home care aides and the owners of a home care agency, were indicted for an $87 million Medicaid fraud in Pennsylvania. The allegations included making false Medicaid claims, creating fake employees, misusing customers’ personal information and falsifying documents, and submitting claims for “customers” who were in the hospital, jail, or dead. [18]

As yet another set of examples, two more home care workers were recently sentenced to prison for paying kickbacks to beneficiaries and submitting timesheets to different home care agencies for services that they did not provide, and one for billing for services that she claimed to provide while traveling outside of the United States. This case also highlights the difficulty of monitoring the service because the aides were alleged to have perpetrated the fraud to the District of Columbia

Medicaid program from 2014 through 2018 at eighteen different agencies, despite the major District takedown in 2014.[19]

The Office of the Inspector General at the United States Department of Health and Human Services has issued several reports with recommendations in the area.[20] The most significant would require states to either enroll personal care attendants as providers or require those attendants to register with state Medicaid agencies, assigning each a unique identifier.

Finally, as part of the 20th Century Cures Act, beginning January 1, 2020, all State Medicaid Agencies must require an electronic visit verification ("EVV") system for Medicaid-funded personal care services to verify that the visits actually occur.[21] States that fail to implement this requirement on a timely basis are subject to an incremental reduction in their Federal Medical Assistance Percentage for these services which ultimately reaches 1%. CMS is authorized to provide an exception to states to delay implementation for up to one year if they can demonstrate making a good faith effort to comply but have encountered unavoidable delays. However, the State must apply for, and be granted, the waiver by CMS.[22]

While this provision only applies to personal care services provided under the Medicaid program, these trackers may be at least a partial solution for those agencies that choose to provide these services for MA Plans. This is especially so since agencies that also participate in Medicaid will already be required to implement EVV for those services, and MA Plans almost certainly will have their own compliance plan requirements as well.

III. Personal Care and Home and Community Based Services in Medicaid:

Unlike the Medicare program, states have been able to provide home and community-based services, including personal care services, under Medicaid for many years. While states will vary on how and when they will provide these services to beneficiaries, virtually every state covers personal care services under either its State Plan or one of several waiver authorities.[23]

States are able to provide personal care services under the following authorities taken from a table in a recent Kaiser Family Foundation report[24]:

1. **Home Health Services (required State Plan service):**
   - Part-time or intermittent nursing services, home health aide services, and medical supplies, equipment and appliances suitable for use in the home
   - At state option-physical therapy, occupational therapy, and speech pathology and audiology services
2. **Personal Care Services (optional State Plan service)**
   - Assistance with self-care (e.g. bathing, dressing) and household activities (e.g. preparing meals)
3. **Community First Choice (optional):**

- Attendant services and supports for beneficiaries who would otherwise require institutional care
- Income up to 150% FPL or eligible for benefit package that includes nursing home services; state option to expand financial eligibility to those eligible for HCBS waiver

4. **Section 1915(i) (optional):**
    - Case management, homemaker/home health aide/personal care services, adult day health, habilitation, respite, day treatment/partial hospitalization, psychosocial rehabilitation, chronic mental health clinic services, and/or other services approved by the Secretary
    - Beneficiaries must be at risk of institutional care
    - Population targeting permitted
5. **Section 1915(c) waiver (optional):**
    - Same services as available under Section 1915(i)
    - Beneficiaries must otherwise require institutional care
    - Secretary can waive regular program income and asset limits
    - Cost neutrality required (average per enrollee cost of HCBS cannot exceed average per enrollee cost of institutional care)
    - Enrollment caps permitted
    - Population targeting permitted
6. **Section 1115 waiver (optional):**
    - Secretary can waive certain Medicaid requirements and allow states to use Medicaid funds in ways that are not otherwise allowable under federal rules for experimental, pilot, or demonstration projects that are likely to assist in promoting program objectives
    - Federal budget neutrality required
    - HCBS enrollment caps permitted"

These services can be targeted at a variety of beneficiary populations including such groups as seniors, seniors and adults with physical disabilities, individuals with developmental disabilities, individuals with HIV/AIDS, medical fragile technology dependent children, mental health, and TBI and spinal cord injuries.[25] What is clear is that state Medicaid programs are attempting to rebalance and focus their spending on long term care towards services in the home and community as opposed to institutional care, and that personal care services play an important role in Medicaid.

For a comprehensive understanding of the services and populations that each State is covering under home and community-based services, readers are referred to the Kaiser Family Foundation reports referenced in note 23.

IV. Conclusion:

The provision of personal care services and other services that address the social determinants of health in the public programs and under private health insurance is evolving and expanding. What

is clear is that there is now a growing understanding at both the state and federal government levels and in the private health insurance market that these services can play a vital role in reducing costs and improving health. The expansion of the definition of optional supplemental benefits in the MA program, discussed, above, present significant potential opportunities in this area. However, issues of compliance that have occurred in the past also make it critical that providers seeking to participate in this area understand both the potential benefits and pitfalls in the manner of any participation.

For more on this please check the presentation here given on this topic at the AHLA LTC conference March 2020

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[2] Pub. L. 115-123 amending section 1852(a) of the Social Security Act

[3] Medicare Managed Care Manual, Chapter 4, section 30.1

[4] Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (April 2, 2018) ("2019 Final Call Letter"), p. 207 https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf

[5] *Id.* at 207-8

[6] Letter from Kathryn Coleman to Medicare Advantage Organizations and Section 1876 Cost Contract Plans, "Reinterpretation of 'Primarily Health Related' for Supplemental Benefits," dated April 27, 2018 https://www.nahc.org/wp-content/uploads/2018/05/HPMS-Memo-Primarily-Health-

Related-4-27-18.pdf

[7]https://www.cms.gov/newsroom/fact-sheets/speech-remarks-cms-administrator-seema-verma-medicare-advantage-and-prescription-drug-plan-spring. While this guidance has been included only in sub-regulatory guidance to date, CMS recently published a proposed rule that, if adopted, will codify this re-interpretation into its regulations. *See* 85 Fed. Reg. 9002, 9210 (February 18, 2020)

[8] Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (April 1, 2019) ("2020 Final Call Letter"), p. 187 https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf

[9] *Id.* at p. 190

[10] *Id. See also* 83 Fed. Reg. 16440, 16481-2 (April 16, 2018)

[11] *See* 2020 Final Call Letter at p. 188

[12] Additionally, a recently published proposed rule for Medicare Advantage Contract Year 2021 and 2022, if adopted, would allow plans to target additional chronic conditions. *See* 85 Fed. Reg. 9002, 9012.

[13] Letter from Kathryn Coleman to Medicare Advantage Organizations, "Implementing Supplemental Benefits for Chronically Ill Enrollees," dated April 27, 2019

[14] https://www.cms.gov/Medicare/HealthPlans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf. As with the guidance on the new interpretation of primarily health related, the guidance on SSBCI has been sub-regulatory to date. However, the proposed rule cited at note 7, if adopted, would codify much of this guidance into regulations. *See* 85 Fed. Reg. 9002, 9213

[15] LTSS Services in Medicare Advantage Plans – The 2019 Market Landscape and the Challenges Ahead http://www.qa.milliman.com/insight/2019/LTSS-services-in-Medicare-Advantage-Plans/; Review of contract Year 2019 Medicare Advantage Supplemental Health Benefit Offerings https://www.bettermedicarealliance.org/sites/default/files/2018-12/20181207%20Milliman%20%20MA%202019%20Supplemental%20Benefits%20-%20Final.pdf

[16] Review of Contract Year 2020 Medicare Advantage Supplemental Healthcare Benefit

Offerings
https://www.bettermedicarealliance.org/sites/default/files/2019-11/Review_of_Contract_Year_2020_Medicare_Advantage_Supplemental_Healthcare_Benefit_Offerings.pdf

[17] *See* FBI Press Release, "More Thank 20 People Arrested Following Investigation Into Widespread Health Care Fraud in D.C. Medicaid Program," February 20, 2014 https://archives.fbi.gov/archives/washingtondc/press-releases/2014/more-than-20-people-arrested-following-investigations-into-widespread-health-care-fraud-in-d.c.-medicaid-program

[18] *See* "12 Home Health Workers Indicted for $87 Million Medicaid Fraud," Home Health Care News, November 27, 2018 https://homehealthcarenews.com/2018/11/12-home-health-workers-indicted-for-87-million-medicaid-fraud/); *see also* US Department of Justice Press Release, "Two More Defendants Plead Guilty in Multi-Million Dollar Home Health Care Fraud Conspiracy," January 21, 2020 https://www.justice.gov/usao-wdpa/pr/two-more-defendants-plead-guilty-multi-million-dollar-home-health-care-fraud-conspiracy

[19] *See* US Attorneys Office for the District of Columbia Press Release, "Two former Personal Care Aides Sentenced to Prison for Defrauding Medicaid," February 14, 2020 https://www.justice.gov/usao-dc/pr/two-former-personal-care-aides-sentenced-prison-defrauding-medicaid; *see also* US Attorneys Office for the District of Columbia Press Release, "Former Personal Care Aide Pleads Guilty to Health Care Fraud," November 22, 2019 https://www.justice.gov/usao-dc/pr/former-personal-care-aide-pleads-guilty-health-care-fraud-1

[20] *See* "Medicaid Fraud Control Units: Investigation and Prosecution of Fraud and Beneficiary Abuse in Medicaid Personal Care Services," HHS OIG Brief, OEI-12-16-00500 (December 2017) https://oig.hhs.gov/oei/reports/oei-12-16-00500.pdf; "Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs: OIG's Top Recommendations (July 2019) https://oig.hhs.gov/reports-and-publications/compendium/files/compendium2019.pdf; "OIG Calls for Additional Oversight of Home Health, Personal Care Service Providers," Home Health Care News (July 25, 2019) https://homehealthcarenews.com/2019/07/oig-calls-for-additional-oversight-of-home-health-personal-care-service-providers/

[21] Section 12006(a) of the Cures Act (2016)

[22] *See* CMCS Information Bulletin from Calder Lynch, "Additional EVV Guidance," dated August 8, 2019

[23] *See* "Key State Policy Choices About Medicaid Home and Community-Based Services," M. Musumeci, M. O'Malley Watts, and P. Chidambaram, Kaiser Family Foundation (February 2020)
https://www.kff.org/report-section/key-state-policy-choices-about-medicaid-home-and-community-

based-services-issue-brief/; "Medicaid Home and Community-Based Services Enrollment Spending, M. O'Malley Watts, M. Musumeci, and P. Chidambaram, Kaiser Family foundation (February 2020) https://www.kff.org/medicaid/issue-brief/medicaid-home-and-community-based-services-enrollment-and-spending/

[24] *See* note 23, "Medicaid Home and Community-Based Services," *supra*, Table 1 at p.4

[25] *Id.* at pp. 8-9