

Overview of Home and Community-Based Services

The Centers for Medicare & Medicaid Services (CMS) and the States are increasing educational outreach about Home and Community-Based Services (HCBS) to enhance awareness of and engage providers and beneficiaries in efforts to reduce payment errors and fraud, waste, and abuse in the Medicaid program.

The Medicaid Integrity Program, established under the Deficit Reduction Act of 2005, and the President's November 2009 Executive Order 13520 Reducing Improper Payments and Eliminating Waste in Federal Programs are two comprehensive strategies that protect the integrity of the Medicaid program.

As part of these programs, CMS has analyzed data produced by the Payment Error Rate Measurement (PERM) program to identify areas that may be at high risk for improper payments and to target root causes for errors. Due to these PERM-identified payment errors, CMS implemented a supplemental measure to further assess HCBS. Through its analysis, CMS identified multiple payment errors and root causes.

This fact sheet has been developed to educate beneficiaries and providers about the major causes of payment errors and to maintain program integrity.

These are the key terms used in this document:

- **Beneficiary:** includes the person receiving Medicaid HCBS and their legal guardian, family member, or other support;
- **Provider:** includes physician; nurse practitioner; registered nurse; licensed practical nurse; aide; private or not-for-profit agency; case manager; State Medicaid agency or State sister agency; Medicaid durable medical equipment (DME), supplies, and devices supplier; home modification business; or other providers of HCBS; and
- **Person-centered plan:** synonymous with plan of care, care plan, individual service plan (ISP), individual education plan (IEP), or other terms used to describe a written individual plan that includes HCBS.

This fact sheet summarizes the Medicaid HCBS programs. After reading this fact sheet, providers should be able to describe:

- The basic home and community-based services;
- The eligibility for services;
- The provider's documentation requirements;
- The provider's role in participating in program integrity and reducing improper payments; and
- Where to go for additional resources about HCBS and program integrity.

Overview of Medicaid HCBS Programs

The Medicaid Program pays for long-term care services through many programs. The services can be provided in different settings, such as residential centers (assisted living, group home, residential rehabilitation program), foster care, adult day care, or the beneficiary's own home.[1, 2] HCBS can help an individual live in their own home or community instead of living in a facility. People who receive Medicaid HCBS include people with physical, mental, or intellectual disabilities, the aged, and those who have chronic conditions such as diabetes, heart disease, HIV/AIDS, or high blood pressure.[3]

A State's Medicaid plan for medical services is required to:

- Provide comparable services for each eligibility group;
- Provide services that are available statewide; and
- Not establish waiting lists for services.

States may receive a waiver to State Medicaid plan requirements in order to tailor services to meet the needs of targeted groups and offer a variety of unlimited services to assist people in remaining in the least restrictive environment.[4] Check with your State Medicaid agency for additional waiver eligibility groups.

Over the last 45 years, legislative changes have provided States with the opportunities for long-term care services to be delivered in the home and community.

In 1981, amendments to the Social Security Act added section 1915(c) allowing States to provide certain services to eligible individuals in home and community-based settings if the services cost less than the institutional care the beneficiaries would have required, the providers meet certain standards, and the services are provided according to a person-centered plan.[5]

Subsequent legislation and Supreme Court decisions, such as the Olmstead decision, established rights for eligible individuals to receive services in the least restrictive setting.[6]

More recent legislation added sections 1915(i), 1915(j), and 1915(k) to the Social Security Act, which allow States the option to establish HCBS under their respective State plans, provide beneficiaries the option to self-direct all or part of their care under certain circumstances, and make the income criteria to qualify for HCBS more liberal.[7, 8, 9]

HCBS may include home health care, personal support services, private-duty nursing, home-delivered meals, adult day care, DME and supplies, case-management services, respite care, and other waiver services. Through the waiver process, States can design programs that meet the needs of targeted populations with specific needs residing within their State. A State may have multiple waiver programs. Because no two Medicaid HCBS programs are the same, check with your State Medicaid agency for specific information about which services are available.

Eligibility for HCBS includes a financial assessment and a needs assessment. A portion of the eligibility process for HCBS may include an evaluation of the beneficiary's condition to determine if the beneficiary requires the level of care provided in an institutional setting or is at risk for institutionalization in the near future if HCBS were not available.[10]

Provider Licensure and Certification

States must provide safeguards to ensure the health and safety of beneficiaries. These safeguards include creating standards for each type of service provider and ensuring that providers and facilities meet applicable State standards, licensure, and certification requirements. For State Medicaid plan home health services, the person-centered plan must include the type of provider for each service.[11]

Person-Centered Plans

Once a beneficiary's eligibility for Medicaid HCBS is determined, a comprehensive assessment of the beneficiary's physical, psychosocial, and functional needs is completed. The results are then reviewed by the beneficiary's treating physician or qualified case manager who recommends a person-centered plan. Reassessments must be completed at least annually, when a beneficiary has a change in circumstances, or at the beneficiary's request.[12] The intervals may vary depending on the State regulations for each program.

The person-centered planning process is an ongoing process involving the beneficiary, their family, and other supports. Its intent is to identify and address a beneficiary's changing strengths, capacities, preferences, needs, and desired outcomes. The information gathered in the process along with medical assessments is used to create a person-centered plan. The plan is necessary to address a beneficiary's long-term care needs as an alternative to institutionalization.[13, 14]

Federal regulations require a written person-centered plan for HCBS, whether provided through the State Medicaid Plan or a waiver process. Use of Federal funds is not allowed for home and community-based waiver services that are provided without a written person-centered plan.[15] A person-centered plan:

- Must be established and periodically reviewed by the beneficiary's treating physician or qualified case manager;
- Must be developed in consultation with the beneficiary, the beneficiary's treating physician, health care support professional or other appropriate professional as determined by the State, and where appropriate the beneficiary's caregiver;
- Must be based on the most recent comprehensive assessment of the beneficiary's physical, psychosocial, and functional needs;
- Must take into account the extent of and need for any family or other supports for the beneficiary;
- Must identify the amount, duration, and scope of the services to be provided to the beneficiary (or if the beneficiary elects to self-direct personal support services, the services funded);
- Must indicate the type of provider for each service; and
- May identify additional service needs of the beneficiary.[16]

There may be additional person-centered plan requirements designated by the State Medicaid agency.

It is the responsibility of the beneficiary's treating physician or the case manager assigned to assess and reassess the beneficiary to verify eligibility, monitor the person-centered plan, and make updates to the person-centered plan as appropriate.

Documenting Services

In order for proper payment to be made for HCBS, Federal guidelines require that documentation exists to support:

- That the HCBS recipient is eligible;
- That the services are in accordance with the person-centered plan; and
- That the services were provided.[17]

State Medicaid agencies may require additional documentation for waiver programs, may require documentation be in specific formats, or may require documentation be submitted with some types of claims for payment to be made. Check your State Medicaid agency website or provider manual for further information.

Providers are responsible for the collection, validation, and storage of documentation in support of claims. Federal guidelines require that records be stored for a minimum of three years.[18] States may require that records be stored for more than three years.

Beneficiary Responsibility

State Medicaid agencies and State sister agencies recognize the importance of the beneficiary's role in implementing their person-centered plan.[19] The beneficiary's role expands if they choose the self-directed care option. Many States provide the beneficiary with a list of their responsibilities for home health and personal support services. Many also provide a form that requires the beneficiary's signature to indicate they understand their responsibilities. The beneficiary's responsibilities include:

- Notifying the physician, case manager, and service provider about:
 - Changes in Medicaid eligibility;
 - Other insurance coverage and current information;
 - Changes in circumstances (hospital inpatient; health status; service needs; or location, such as a move or vacation);
 - Request for change to the person-centered plan; and
 - Change in responsible party.
- Treating service providers as professionals;
- Signing time sheets, logs, or other service delivery records to verify services were provided;
- Notifying the provider agency or case manager, if required:
 - When they are away from home and unable to keep scheduled visits;
 - When services are no longer required;
 - When staff have missed visits; and
 - To discuss concerns about delivery of services or staff.
- Requesting staff to provide only those services that are authorized in the person-centered plan;
- Requesting staff work only the amount of time authorized in the person-centered plan; and
- Requesting staff provide services for the beneficiary only and not for other family members in the household.[20, 21, 22]

Common Errors That Lead to Improper Payments

Improper payments for HCBS may occur when Medicaid funds are paid to the wrong entity, are paid in the wrong amount, are not supported by documentation or policy, or are used for services other than those identified in the person-centered plan. PERM data was analyzed to determine the root cause of payment errors for HCBS. The PERM analysis identified four types of common errors:

- No documentation;
- Insufficient documentation;
- Number of units error; and
- Policy violation.

No Documentation

Sometimes providers do not submit any documentation at all to support the services billed. The root causes of payment errors for no documentation for HCBS include:

- Providers and beneficiaries or caregivers (if care is self-directed) not submitting service logs, person-centered plans, progress notes, or other documentation to show services were provided; or
- Providers not following documentation retention requirements.

Insufficient Documentation

Insufficient documentation errors occur when the documentation submitted by a provider does not fully support the procedure code billed. The root causes of payment errors for “insufficient documentation” for HCBS include:

- Service logs missing date(s) of service delivery, in-out times, activities performed, and signatures for validation;
- Incomplete and out-of-date person-centered plans; or
- Failing to submit attendance logs if services were provided while the beneficiary was in another facility, such as adult daycare.

Number of Units Error

Number of units errors occur when a provider bills for an incorrect number of units for a procedure code. The root causes of payment errors for number of units error for HCBS include:

- Providers not cross-checking number of units billed with number of units documented;
- Providers billing for a month of services when the beneficiary was an inpatient for part of the month; or
- Miscalculating the units for the type of service or supply.

For example, procedure code A4520-Incontinence garment, any type, one unit equals one item. However items are delivered in a case of multiple units (for adult diapers or pull-ups, the number of units in a case is dependent on the size of the garment). A provider billed for 360 units (60 units per case times 6 cases), but the delivery ticket indicated delivery of 288 units (48 units per case times 6 cases).

Policy Violations

Policy violation errors occur when billing or payment for services provided is not consistent with documented policy. The root causes of payment errors for policy violations for HCBS include:

- Providers billing Medicaid when the beneficiary is covered by other primary insurance such as Medicare;
- Documentation is not compliant (for example, signatures are missing on the person-centered plan or beneficiary has not signed the form indicating that a home modification is complete);
- Documentation does not meet basic requirements (for example, records were not maintained for the required time period); or
- The beneficiary was not eligible for Medicaid Long-Term Care Services and Supports when the services were provided.

Promising Practices

There are some processes that can be integrated into daily practice to correct a majority of the errors found. These include implementing simple but effective quality-control measures for reviewing services provided, beneficiary records, claims, and other documentation to ensure that all program and billing requirements are met. This fact sheet is part of a larger toolkit containing additional fact sheets that discuss how to avoid the most common billing errors through basic quality controls and job aids that assist you with review of documentation for compliance. The entire toolkit is available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html> on the CMS website.

Conclusion

The Medicaid program covers long-term care services in various settings through a variety of programs. HCBS are key components in allowing individuals who otherwise may require institutional long-term care services to instead receive services in their own home or community.

Since 1981, Federal legislation has provided States with options to waive some of the Medicaid requirements to establish HCBS, expand eligibility, and allow beneficiaries to self-direct their care.

States must provide safeguards to ensure the health and safety of the beneficiaries, including ensuring that providers and facilities meet applicable State standards, licensure, and certification requirements. Use of Federal funds is not allowed for home and community-based waiver services that are provided without a written person-centered plan. In order for proper payment to be made for waiver services, Federal guidelines require that documentation exists to support: the eligibility of the HCBS recipient; that the services are in accordance with the person-centered plan; and, that the services were provided. State Medicaid agencies may require additional documentation for waiver programs, may require documentation be in specific formats, or may require documentation be submitted with some types of claims for payment to be made.

Improper HCBS payments may occur when Medicaid funds are paid to the wrong entity, are paid in the wrong amount, are not supported by documentation or policy, or are used for services other than those identified in the plan of care. PERM data was analyzed to determine the root cause of HCBS payment errors. The analysis identified common errors in four areas: no documentation, insufficient documentation, number of units error, and policy violations. There are some promising practices that can be integrated into daily practice to correct a majority of the errors found.

Providers can play a significant role in the fight against Medicaid fraud, waste, and abuse. CMS hopes you share its commitment to eliminate payment errors and fraud, waste, and abuse in the Medicaid program. By increasing your awareness of common errors and applying remedies in your daily practice, you will help strengthen the integrity of the Medicaid program and reduce improper payments. For further information, review the toolkits about HCBS at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html> on the CMS website.

Additional Resources

Links to State Medicaid agency websites are available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html> on the Medicaid website.

Information about Medicaid HCBS is available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html> on the Medicaid website.

Information about Long-Term Services and Support is available at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/long-term-services-and-supports.html> on the Medicaid website.

Information about Managed Long Term Services and Supports is available at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/medicaid-managed-long-term-services-and-supports-mltss.html> on the Medicaid website.

Information about payment accuracy and improper payments is available at <https://paymentaccuracy.gov/about-improper-payments> on the Internet.

Information about the PERM program is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM> on the CMS website.

To see the electronic version of this fact sheet and the other products included in the “Home and Community-Based Services” Toolkit, visit the Medicaid Program Integrity Education page at <https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/edmic-landing.html> on the CMS website.

Follow us on Twitter  [#MedicaidIntegrity](https://twitter.com/MedicaidIntegrity)

References

1 U.S. Department of Health and Human Services. Center for Medicaid Services. Home and Community-Based Services. Retrieved September 11, 2015, from <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/home-and-community-based-services.html>

2 U.S. Department of Health and Human Services. Administration for Children and Families, Centers for Medicare & Medicaid Services, and Substance Abuse and Mental Health Services Administration. (2013, July 11). Joint State Director Letter. Retrieved September 10, 2015, from <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>

3 U.S. Department of Health and Human Services. Center for Medicaid Services. Home and Community-Based Services. Retrieved September 11, 2015, from <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/home-and-community-based-services.html>

4 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (1999). State Medicaid Manual: Chapter 4, Services, § 4442.2–3. Retrieved September 11, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>

5 Social Security Act § 1915(c)(2). Retrieved September 11, 2015, from http://www.ssa.gov/OP_Home/ssact/title19/1915.htm

6 U.S. Government Publishing Office. (2014, January 16). Federal Register Volume 79, Issue 11, 79 FR 2948—Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers. Retrieved September 11, 2015, from <http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf>

7 U.S. Government Publishing Office. (2014, January 16). Federal Register Volume 79, Issue 11, 79 FR 2948—Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers. Retrieved September 11, 2015, from <http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf>

8 U.S. Government Publishing Office. (2008, October 3). Federal Register Volume 73, Issue 193, 73 FR 57854. Medicaid Program; Self-Directed Personal Assistance Services Program State Plan Option (Cash and Counseling). Retrieved September 11, 2015, from <http://www.gpo.gov/fdsys/pkg/FR-2008-10-03/pdf/E8-23102.pdf>

9 U.S. Government Publishing Office. (2012, May 7). Federal Register Volume 77, Issue 88, 77 FR 26827. Medicaid Program; Community First Choice Option. Retrieved September 11, 2015, from <http://www.gpo.gov/fdsys/pkg/FR-2012-05-07/pdf/2012-10294.pdf>

10 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (1999). State Medicaid Manual: Chapter 4, Services, § 4442.2. Retrieved September 11, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>

- 11 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (1999). State Medicaid Manual: Chapter 4, Services, § 4442.4. Retrieved September 11, 2015 from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 12 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (1999). State Medicaid Manual: Chapter 4, Services, § 4442.5(A). Retrieved September 11, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 13 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (2014, January 10). Summary of Key Provisions of the 1915(c) Home and Community-Based Services (HCBS) Waivers Final Rule [Fact Sheet]. Retrieved September 11, 2015, from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/1915c-Fact-Sheet.pdf>
- 14 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (1999). State Medicaid Manual: Chapter 4, Services, § 4442.6. Retrieved September 11, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 15 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (1999). State Medicaid Manual: Chapter 4, Services, § 4442.6. Retrieved September 11, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 16 Social Security Act § 1915(i)(1)(G) and § 1929(d)(1). Retrieved September 11, 2015, from http://www.ssa.gov/OP_Home/ssact/title19/1900.htm
- 17 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (1999). State Medicaid Manual: Chapter 4, Services, § 4442.11. Retrieved September 11, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 18 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (1999). State Medicaid Manual: Chapter 4, Services, § 4442.5(B). Retrieved September 11, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 19 Social Security Act § 1915(i)(1)(G)(ii)(I)(aa). Retrieved September 11, 2015, from http://www.ssa.gov/OP_Home/ssact/title19/1915.htm
- 20 Nevada Department of Health and Human Services. Division of Health Care Financing and Policy Provider Portal. (2011, February 17). Personal Care Aide (PCA) Services: Recipient Responsibilities. Form NMO-3236. Retrieved September 11, 2015, from https://www.medicaid.nv.gov/Downloads/provider/FA-24_NMO-3236_Recipient_Responsibilities.pdf
- 21 Vermont Division of Disability and Aging Services. Department of Disabilities, Aging & Independent Living. (2008, July). Choices for Care Moderate Needs Manual. Section V.1. Retrieved September 11, 2015, from <http://ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-moderate/policies-cfc-moderate-documents/secv1-app-eligibilitydeterminationprocedures.pdf>
- 22 Colorado Department of Health Care Policy and Financing. (2015, February). Consumer Directed Attendant Support Services (CDASS) Training Manual. Retrieved September 11, 2015, from <https://www.colorado.gov/pacific/sites/default/files/Section%202%20Roles%20and%20Responsibilities.pdf>

Disclaimer

This fact sheet was current at the time it was published or uploaded onto the web. Medicaid and Medicare policies change frequently so links to the source documents have been provided within the document for your reference.

This fact sheet was prepared as a service to the public and is not intended to grant rights or impose obligations. This fact sheet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. Use of this fact sheet is voluntary. Inclusion of a link does not constitute CMS endorsement of the material. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

October 2015

