Educating a Beneficiary About Their Person-Centered Plan for 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:

- **Home and Community-Based Services:** includes home health care; private-duty nursing; personal support services; home-delivered meals; adult day care; durable medical equipment (DME), supplies, and home modifications; respite care; and other needed services.
- **Beneficiary:** includes the person receiving Medicaid home and community-based services 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; SMA or State sister agency; Medicaid DME, supplies, and devices supplier; home modification business; or other providers of HCBS.
- **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 based on individual needs, goals, and preferences that includes HCBS.

This fact sheet summarizes the roles and responsibilities of providers and case managers to educate beneficiaries who do not participate in the person-centered planning process about their plan for HCBS. After reading this fact sheet, providers and case managers should be able to describe:

- Their roles in educating beneficiaries about their person-centered plan;
- Common errors that lead to improper payments as identified through analysis of PERM data;
- Possible solutions to those errors;
- The importance of their participation in reducing or eliminating errors and increasing quality of care; and
- Where to go for additional resources.

Overview of Requirements for a Person-Centered Plan

Federal regulations require a written person-centered plan for HCBS, whether provided through the State Medicaid Plan or a waiver program. The use of Federal funds is not approved for HCBS waiver services that are provided without a person-centered plan.[1]

Once a beneficiary's eligibility for Medicaid HCBS is determined, a comprehensive assessment of their physical, psychosocial, and functional needs is completed. The beneficiary and their treating physician or qualified case manager review the results and develop a plan. A person-centered planning process, which includes the beneficiary and their planning team, is used to develop their plan for HCBS. Reassessments must be completed at least annually, when a beneficiary has a change in circumstances, or at the beneficiary's request.[2] Beneficiaries can choose to self-direct or assign someone to direct all or part of their HCBS.

When reassessments are completed, the person-centered plan should be reviewed and updated accordingly. States may have additional language, updates, or monitoring requirements for a person-centered plan, including review of the plan at more frequent intervals.[3] For example, some States require that a person-centered plan for Medicaid home health services include measurable treatment goals[4] and require no more than 60-day intervals between reviews.[5] Beneficiaries who choose to self-direct their HCBS can change their plan when their circumstances change. Check with your SMA for additional requirements.

Some States contract with managed care organizations (MCOs) to provide long-term services and supports, including HCBS, for eligible beneficiaries. Other States may collaborate with State sister agencies to provide HCBS to eligible beneficiaries. In those instances, the beneficiary must follow the policies of the MCO or the State sister agency for proper payment to be made to a provider.

Providers and Case Managers: Role in Educating a Beneficiary About Their Person-Centered Plan

The person-centered plan should be the result of collaboration between the physician, case manager, beneficiary, and the beneficiary's support system. The plan guides the provider to ensure that the services performed meet the beneficiary's immediate and long-term needs, expectations, and goals. It is the role of the beneficiary's treating physician, case manager, or other State-agency-specified professional to approve the plan and discuss the contents with the beneficiary so they have a clear understanding of:

- The amount, duration, and scope of the services they receive (or if they elect to self-direct, the services funded);
- The type of provider for each service;[6]
- Their additional service needs;[7] and,
- Their responsibilities in implementing the plan.[8]

SMAs and State sister agencies recognize the importance of the beneficiary's role in implementing their plan.[9] The beneficiary's role increases if they choose the self-directed care option. This increased role includes active participation in the person-centered planning process. Many States provide the beneficiary who has not elected the self-directed care option 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 that their responsibilities include:

- Notifying the physician, case manager, and service provider about:
  - Changes in Medicaid eligibility;
  - Other insurance coverage and current information;
  - Changes in circumstances (admission to a hospital; health status; service needs; or location, such as a move or vacation); 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 provide only those services that are authorized in the plan;
- Requesting staff work only the amount of time authorized in the plan; and
- Requesting staff provide services for the beneficiary only and not for other family members in the household.[10, 11]

Common Errors Beneficiaries Make

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 errors for HCBS. The analysis identified common payment errors that are made when beneficiaries do not understand their role or responsibility for the services identified in their person-centered plan. They include:

- Not notifying the provider or case manager when they are a hospital inpatient, are away from home and will not need services, or have had a change in circumstance (change in location, no longer need services, or are no longer eligible for Medicaid);
- Not being aware of the amount, duration, and scope of the authorized services in the plan, including:
  - Requesting more services than authorized;
  - Asking staff to work more hours than authorized; and
  - Asking staff to provide assistance to family members.
- Not notifying the provider agency to report staff issues, including staff not showing up as scheduled, unusual occurrences, or complaints; and
- Not signing time sheets, logs, or other service delivery records to verify services were provided.

Promising Practices

There are some promising practices that can be integrated into the plan development process to correct a majority of the errors found. These include:

- Ensuring the beneficiary and members of their person-centered planning team are aware of the contents of their plan each time changes are made;
  - The amount, duration, and scope of the services they receive (or if they elect to self-direct, the services funded);
  - The type of provider for each service; and
  - Additional service needs of the beneficiary.
- Reminding the beneficiary of their responsibilities in implementing the plan, including refraining from asking staff to work more hours than authorized; and

- Reviewing the plan according to timelines established by the SMA or State sister agency and when the beneficiary has a change in circumstances.

Conclusion

Federal regulations require a written person-centered plan for HCBS whether services are provided through the State Medicaid Plan or a waiver program. The use of Federal funds is not approved for HCBS waiver services that are provided without a person-centered plan. The plan guides the provider to ensure that the services performed meet the beneficiary's immediate and long-term needs, expectations, and goals. The plan must be the result of collaboration between the case manager, beneficiary, the beneficiary's support system, and if required, their physician.

SMAs and State sister agencies recognize the importance of the beneficiary's role in implementing their plan. The beneficiary's role increases 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 with the assessment package and require the beneficiary to sign the form to indicate they understand their responsibilities.

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. Improper Medicaid payments may be reduced when the provider or case manager educates the beneficiary about the components of their plan and their responsibilities in implementing their plan.

As a provider, you 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

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

Information about PERM 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.

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