Home and Community-Based Waiver Services Snapshot

Under approved State plans, State Medicaid agencies (SMAs) provide home health services for beneficiaries eligible for nursing facility services through the basic State plan. States may provide additional home and community-based services (HCBS) through "waiver" programs.[1] Under these programs, the Centers for Medicare and Medicaid Services (CMS) can waive various requirements allowing SMAs to provide additional services to different groups of beneficiaries. States can only provide waiver services to beneficiaries that would otherwise require care in a skilled nursing or intermediate care facility.[2]

CMS allows States to create multiple waiver programs serving the disabled, aged, or persons with chronic conditions.[3] Services may include home health services (such as, skilled nursing services, health aide services, medical supplies and equipment), private-duty nursing, adult day care, support services, personal care services, durable medical equipment (DME) and supplies, extended attendant aide services, home modifications, and therapeutic services.

HCBS improper payments are recognized as a significant problem by CMS and the U.S. Department of Health and Human Services, Office of Inspector General.[4, 5, 6] To help address the problem, CMS adopted regulations requiring closer screening of home health and DME providers enrolling in Medicaid. Specifically, the regulations require newly enrolling home health and DME providers to undergo unannounced on-site visits and fingerprint based criminal background checks on individuals who own five percent or more of the provider business.[7, 8, 9]

CMS is also seeking to reduce improper claims by educating SMAs, providers, and beneficiaries on preventing, detecting, and correcting errors that lead to such claims. CMS urges providers to establish a quality control process to ensure services are provided in accord with an approved person-centered plan of care, "based on an assessment of functional need," and agreed to by the beneficiary.[10] This is achieved by ensuring proper documentation of the care plan, that care was delivered, required qualifications of the caregivers, and compliance with State policies.[11, 12]

Beneficiaries and family members can also help prevent and detect fraud, waste, and abuse by reviewing provider documentation to ensure it is accurate and complete. Beneficiaries should notify providers when they identify errors, or if and when staff miss visits or fail to perform adequately. Working together with CMS, SMAs, providers, and beneficiaries can help improve quality of care and prevent improper payments for HCBS.

For More Information

A "Personal Care Services" Toolkit, "Home and Community-Based Services" Toolkit, and podcasts are available to help States, providers, and beneficiaries understand their roles in minimizing payment errors. These

materials are posted to the Medicaid Program Integrity Education page at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/HCBS.html on the CMS website.

To see the electronic version of this E-Bulletin and E-Bulletins on other topics posted to the Medicaid Program Integrity Education page, visit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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