



# The Commonwealth of Massachusetts

## AUDITOR OF THE COMMONWEALTH

ONE ASHBURTON PLACE, ROOM 1819  
BOSTON, MASSACHUSETTS 02108

A. JOSEPH DeNUCCI  
AUDITOR

TEL. (617) 727-6200

NO. 2006-5124-3C

**INDEPENDENT STATE AUDITOR'S REPORT  
ON CERTAIN ASPECTS  
OF THE COMMONWEALTH'S  
PERSONAL CARE ATTENDANT PROGRAM  
JULY 1, 2005 THROUGH JUNE 30, 2007**

**OFFICIAL AUDIT  
REPORT  
JUNE 10, 2009**

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**INTRODUCTION**

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Personal care services, including Personal Care Attendant (PCA) and related services, are a significant resource for many of over 100,000 individuals living independently with disabilities in the Commonwealth. PCA services are designed to enable elderly people and people with permanent or chronic disabilities who might otherwise be institutionalized to live at home or within their community. The services may include helping with: bathing, dressing, transfers in and out of bed, toileting, range-of-motion exercises, night-time assistance, meal preparation, shopping, and other homemaking and related tasks referred to by PCA program guidelines as Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL). In Massachusetts, these Medicaid-funded services generally do not include skilled services such as Home Health, Occupational and Physical Therapy, or Speech and Language Therapy. They also typically do not include other services such as supervision or “cueing” (providing a prompt or direction to assist a person in performing an activity) required by certain individuals to prompt them to carry out activities they are physically capable of performing but unable to independently initiate due to cognitive limitations. Federal Medicaid policy also prohibits provision of PCA services to patients in hospitals or residents in nursing facilities, intermediate care facilities for individuals with mental retardation, or psychiatric institutions.

PCA services are primarily funded through the Commonwealth’s Medicaid state plan system and are administered by the state’s Executive Office of Health and Human Services (EOHHS) Medicaid Office of Long Term Care (OLTC), located at the Executive Office of Elder Affairs (EOEA), in coordination with other state agencies including the Massachusetts Commission for the Blind (MCB); the Departments of Public Health (DPH), Mental Health (DMH), and Mental Retardation (DMR); and the Massachusetts Rehabilitation Commission (MRC). During fiscal year 2008, PCA program services included in the Commonwealth’s state plan were provided by over 22,000 PCAs to over 16,000 Medicaid-enrolled consumers at a cost in excess of \$332 million. The Massachusetts service delivery system uses a nationally recognized consumer-directed model in which consumers or their designated surrogate decision-makers employ and direct individual PCAs with assistance and oversight provided by three Fiscal Intermediary (FI) organizations and 27 Personal Care Management (PCM) agencies contracted to provide intake, evaluation, and training services, as well as payroll processing and related activities, with reimbursement provided by the state Medicaid system. In addition to consumers served through the state's regular PCA program, an unquantified number, perhaps totaling several thousand additional people, receive Medicaid funds and PCA and related services through various Medicaid waivers, managed care, and other program arrangements. On a national level, Medicaid expenditures for PCA services increased by almost 69% between 2000 and 2004 and the U.S. Department of Labor, Bureau of Labor Statistics estimates that labor demand for people employed in this occupation will grow much faster than the average for all other occupations through the year 2014.

During fiscal year 2007, the state Legislature enacted Chapter 268 of the Acts of 2006, making certain changes to the PCA program. This Act amended Chapter 118G of the General Laws to add six additional sections pertaining to the PCA program, addressing perceived issues regarding PCA compensation and recruitment, training, and backup service

deficiencies. The additions include language in Section 31(b), which makes PCAs public employees for the purposes of Chapter 150E and Chapter 180, Section 17J by stating, in part:

*Personal care attendants shall be considered public employees as defined by and solely for the purposes of Ch. 150E and Ch. 180 Sec 17J. In addition, personal care attendants shall be treated as state employees solely for the purposes of Ch. 180, Sec 17A. The PCA Quality Home Care Workforce Council is the employer of personal care attendants. PCAs who are employees of the council are therefore NOT public employees for any other reason.*

Pursuant to these provisions, labor elections were conducted and on November 7, 2007, Service Employees International Union (SEIU) Local 1199 was selected as the PCA labor representative.

The Act creates a nine-person PCA Quality Home Care Workforce Council (Council) within EOHHS, but not subject to the control of EOHHS, to “insure the quality of long-term, in-home, personal care by recruiting, training and stabilizing the work force of personal care attendants,” and requires the Council to conduct a performance review every two years to be submitted to the Legislature and the Governor and made available to the public. The performance review will include the evaluation of consumer health, welfare, and satisfaction with services provided by PCAs, as well as an explanation of the full direct and indirect costs of personal care services, and may make recommendations for statutory amendments needed to further ensure the well-being of consumers and the efficient delivery of services. The first review was to be submitted before December 1, 2008.

The scope of our audit included a review of various aspects of the Commonwealth's PCA program as well as certain administrative and operational activities of several state agencies relative to their administration of PCA program services during fiscal years 2006 and 2007, as well as a limited review of certain matters both before and after that period, such as statistics necessary to evaluate program growth rates and aspects of the program undergoing changes at the end of fiscal year 2007. These state agencies included EOHHS and its OLTC, EOE, DMR, the Disabled Persons Protection Commission, the MRC, the Massachusetts Office on Disability, the Criminal History Systems Board, the Division of Health Care Finance and Policy, and the University of Massachusetts Medical School.

Our audit objectives consisted of the following:

1. To obtain an understanding of the PCA program in the context of overall efforts by the Commonwealth to help individuals with disabilities live independently in community settings.
2. To identify any program areas that could be improved based on the best practices of PCA programs nationwide.
3. To determine whether adequate controls have been established over certain aspects of the Commonwealth's PCA program to ensure that the program operates in an economical, efficient, and effective manner; that program objectives are achieved; and that significant risks that might interfere with the achievement of any program objectives are appropriately addressed.

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**1. VARIOUS ASPECTS OF THE PCA PROGRAM COULD BE IMPROVED TO BETTER ENSURE THAT QUALITY SERVICES ARE PROVIDED TO CONSUMERS IN AN EFFECTIVE, EFFICIENT, AND ECONOMICAL MANNER AND THAT THE OBJECTIVES AND EXPECTATIONS FOR THE PCA PROGRAM ARE FULFILLED** **18**


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During our audit, we reviewed the arrangements used by the Commonwealth to provide PCA program services and noted a number of areas in which improvements could be made to program services to better ensure that quality services are provided to consumers in an effective, efficient, and economical manner and that public objectives and expectations for the PCA program are fulfilled. These specific areas include the following:

**a. Compensation Provided to PCAs Should Be Regularly Reviewed and Modified to Ensure That Appropriate Numbers of PCAs Are Available to Consumers** **19**


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Existing PCA compensation arrangements may be inadequate to ensure that a sufficient number of PCAs are available. This is because PCAs are paid an across-the-board \$10.84 hourly wage rate without regard for differences in duties, skill levels, or other factors commonly used to establish appropriate wage levels. Health care and other benefits such as sick leave and vacation time are also not provided to PCAs. Further, since this wage rate remained unchanged since 2006 until it was adjusted as the result of newly implemented collective bargaining arrangements in fiscal year 2009 as our report was being drafted. While the wage rate is now scheduled to gradually increase to \$12.48 per hour over the three-year duration of the labor agreement, PCA wages and benefits have historically not kept pace with inflation and other compensation benchmarks, such as the state's median household income.

**b. The Process Used to Review the Background of PCAs and Surrogates Could Be Improved** **25**


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We found that although the level of risk associated with PCA abuse and fraud is relatively low, it remains important that appropriate background screening arrangements be established for these services. In contrast to practices in other states, background screening and follow-up service-monitoring arrangements available to the Massachusetts PCA program are fragmented, and Criminal Offender Record Information (CORI), which is available through the Commonwealth's Criminal History Systems Board, is not available in a user-friendly manner, is limited in scope, prone to error due to failure to use a fingerprint-based indexing system, and subject to consumer fees that are not reimbursed by Medicaid.

**c. Enhancements Could Be Made to Better Meet the Needs of Consumers for Assistance in Training Their PCAs and to Ensure That Appropriately Pre-Trained PCAs Are Available through Emergency, Backup, and Referral Attendant Registry Systems** **36**


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Although PCA program consumers appropriately retain control and responsibility for PCA training and receive individualized training assistance from the program's Personal Care Management contractors, the program lacks any system-wide voluntary training for core knowledge areas such as disability awareness and

independent living principles, program requirements, cardio-pulmonary resuscitation, and other first-aid/emergency response activities.

**d. Better Arrangements Are Needed to Provide Backup PCA Services and to Ensure the Safety of Consumers During Public Emergencies** **38**

Current PCA program arrangements call for consumers to develop their own individual backup service and emergency arrangements with limited advice from PCM contractors. In contrast to other states, Massachusetts Medicaid has not established or funded backup service PCA pools, and although more expensive PCA services provided by home health agencies are technically available for emergency use, program managers have not promoted their use. Improvements are also needed in statewide disaster response arrangements for PCA program participants.

**e. Program Services Should Be Broadened to Include Cueing and Supervision, Appropriate Health Care Tasks, and Enhanced Case-Management Services** **41**

Massachusetts has long excluded services such as cueing and supervision from the scope of the PCA program. However, we found that these service enhancements have long been identified as being cost-effective and essential for meeting the needs of certain consumer populations and have been implemented in other states.

**f. PCA Program Outreach Activities Could Be Improved** **47**

Other states have established formal outreach arrangements for their PCA programs, with wide public distribution of information on the program and related independent living options. However, Massachusetts Medicaid does not fund or directly conduct comparable outreach activities, and consumer advocates with whom we spoke stated that most potential new consumers learn of the availability of the program's services through word-of-mouth from existing participants. Inadequate outreach may result in a low level of utilization of personal care services in Massachusetts compared to program utilization rates in other states.

**g. Long-Term Care Services Should Be Rebalanced by Redirecting Institutional Funding to PCA and Related Community-Based Services** **48**

Although Massachusetts has historically been a leader in the development of consumer-directed personal care services, the PCA program and related community-based long-term care services now account for only a small percentage of Medicaid expenditures in the Commonwealth. Instead, resources are disproportionately allocated to expensive nursing homes and other long-term care facilities (e.g., 55% of state Medicaid total long-term care expenditures in 2005). Other states, such as Washington, Oregon, California, New Mexico, Vermont, and Maine, have moved to rebalance their long-term care systems to devote a far greater share of resources to personal care and related community-based services for elders and children and adults with disabilities. Extensive research has been conducted analyzing such efforts and documenting their effectiveness, and as a result, the federal government now advocates a nationwide rebalancing of long-term care resources to expand and enhance community-based services. The statistics we analyzed indicated that Massachusetts lags well behind other states in this reform effort, particularly in providing PCA and related services to elders, which could impose significant future financial burdens on the Commonwealth due to rapidly escalating nursing facility

per-diem rate trends (e.g., a projected 42.2% increase from fiscal year 2008 to fiscal year 2013).

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**2. THE PROCESS USED TO AUTHORIZE SERVICES COULD BE IMPROVED TO ENSURE UNIFORM AND EQUITABLE TREATMENT FOR CONSUMERS** **56**

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Federal Medicaid law stresses the importance of administering PCA services in a manner that is simple, efficient, uniform, equitable, in the best interest of consumers, and free of unreasonable delays in accessing services. We reviewed the process used to authorize PCA services for consumers in Massachusetts and identified areas in which this process could be improved. For example, it typically takes six to eight weeks for new consumers to access PCA services in Massachusetts and delays of up to 90 days are not uncommon. In contrast, similar programs in other states can make services available within two weeks or less. Our specific concerns in this area are as follows:

**a. Implementation of the Automated Prior Authorization System Has Not Resolved Processing, Tracking, and Delay Problems** **65**

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During our audit period, Medicaid implemented an Automated Prior Authorization System (APAS) for processing PCA program service authorization requests, which it believed would minimize inefficiencies within the authorization process. However, our analysis of information provided by both PCM contractors and the Medicaid Prior Authorization Unit found problems with the software package purchased for use by the Prior Authorization Unit. These individuals stated that they had found it difficult to generate satisfactory PCA tracking information from the software and were therefore continuing to use the manually maintained spreadsheet tracking system they had been using prior to the purchase of this software.

**b. Complicated and Inconsistent Submission Requirements and the Lack of Comprehensive Uniform Policies and Procedures Covering Application and Prior Authorization Processing May Be Causing Delays in the Process** **68**

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We found several problems with the procedures followed by the PCA program's Prior Authorization Unit that may be causing delays in the processing of consumer requests for PCA services. For example, the Prior Authorization Unit has not established formal procedures for the prioritized processing of requests for new consumers. Instead, requests for both new and ongoing PCA consumers are processed in the same queue for the assigned reviewer and each reviewer is allowed to self-manage the processing of assigned cases. The lack of comprehensive written policies and procedures could result in Prior Authorization Unit activities not being conducted in a consistent and efficient manner. Also, instead of conducting a thorough prescreening immediately upon receipt of a request, the Prior Authorization Unit simply assigns submissions to individual reviewers and relies on their assessment to identify deficient submissions once the case is eventually reached in queue. As a result, submission deficiencies can remain unidentified until a reviewer finally examines the submission, which can further delay the approval of PCA services. We also noted that in some instances, cases could be subject to multiple consecutive deferrals when reviewers fail to fully review requests and identify all issues at the same time. For example, our review of data from one PCM agency we reviewed providing data on 395 deferrals over a 12-month period indicated that 16 consumer cases were subjected to multiple consecutive deferrals in which the Prior

Authorization Unit had first raised one submission deficiency, waited for a response, and then raised a second deficiency rather than raising both matters at the same time. The adoption of formal internal Prior Authorization Unit operational standards requiring timely and comprehensive pre-screening reviews, in our opinion, would serve to minimize such deferral delays.

**c. Regulatory Provisions for Expedited Processing of Certain Cases Are Not Routinely Used** **81**

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130 Code of Massachusetts Regulations (CMR) 422.416(D) provides for the expedited processing of PCA service requests in certain situations in which “special conditions” exist, such as when consumers are transitioning out of nursing facilities. This regulation requires the PCM agency receiving the service request to notify Medicaid within 24 hours so that Medicaid can, if it so chooses, assume responsibility for conducting the evaluation and expedite prior authorization processing. However, we noted no evidence that Medicaid routinely uses this regulation to conduct evaluations or otherwise expedite processing for these consumers. In fact, according to the PCA contractors with whom we spoke, even though contractors continue to notify Medicaid of service requests for consumers leaving nursing facilities, Medicaid has not exercised its option to conduct those evaluations for several years.

**d. PCA Regulations and Prior Authorization Unit Practices May Not Adequately Address Federal Requirements Applicable to Services for Children** **83**

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The nation’s Medicaid Act, first established in 1965, was amended by Congress in 1989 to include special provisions in 42 United States Code §1396d(a)(4) designed to ensure that no Medicaid-eligible child will go without care deemed medically necessary by the child’s clinician. As incorporated into federal regulations and interpreted by the courts, this requirement mandates the provision of so-called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. The scope of those services must include medically necessary services needed to “correct or ameliorate” physical or mental illnesses and conditions in a child so long as the services are permitted by the Center for Medicare and Medicaid Services (CMS) to be delivered on either a mandatory or optional Medicaid state-plan basis. Unfortunately, as documented in a July 2001 Government Accountability Office (GAO) report, although the extent to which children in the Medicaid program across the country are receiving these services is not fully known, available evidence indicates that many are not receiving these services. During our audit, we noted that PCA program regulations and materials made no reference to the special federal provisions covering children and that the content of Medicaid regulations and materials (as well as the content of program materials in use by PCM contractors) did not specifically address these federal requirements.

**e. Prior Authorization Adjudication Notifications and Due Process Guarantees Could Be Improved** **83**

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PCM agency contractors with whom we spoke stated that they were concerned with the fact that consumer appeal rights to their authorized PCA services may be impaired by the PCA program’s use of what was in their opinion, confusing, untimely, and inadequate notification practices. For example, these PCM contractors

stated that Prior Authorization Unit determination notices, which are computer-generated, were often confusing due to complexities regarding service authorization issues, request documentation requirements, and mathematical and data-entry errors, and that often even PCM agency staff familiar with a particular request had to review details of case files in order to decipher the meaning of decision notices. We were also told that notice provisions were presented in language that was difficult to comprehend for many consumers and that, particularly in the case of consumers with surrogates, problems can arise when appeal deadlines pass.

**f. Special Prior Authorization Processing and Service Arrangements Established for Certain Categories of Consumers May Result in Inconsistencies in the Treatment of Some PCA Consumers** **88**

Federal Medicaid principles require comparable service arrangements for all program participants; however, we found certain situations in which different groups of consumers are subject to different prior authorization and PCA service delivery arrangements.

**g. The PCA Program Prior Authorization System Does Not Routinely Take Advantage of Regulations That Allow Reevaluations of Consumers with Stable Medical Conditions to Be Conducted Less Frequently** **92**

Program regulations allow certain consumers between the ages of 22 and 60 with stable situations to be authorized for service period durations in excess of one year before requiring that a reevaluation be conducted. However Medicaid's Prior Authorization Unit authorizes such extended duration service periods for only approximately 4% of consumers. Our analysis suggests that extended duration approvals could reasonably be authorized for far more consumers, thereby reducing the number of annual reevaluations that need to be conducted.

**h. The Consumer Evaluation and Service Authorization Process Could Be Enhanced by Use of Laptop-Based Software Systems** **95**

We noted that, in contrast to Massachusetts, other states have established effective automated processes to conduct evaluations and authorize PCA services. For example, the state of Washington has a far more streamlined and automated evaluation and approval process in which evaluations are conducted and documented by local evaluators using a sophisticated laptop computer software application and are then uploaded to the state agency for processing and finalization. One study reported that Washington's expedited process has reduced the average time required to make authorization decisions from 37 days to 17 days.

**3. THE MONITORING AND EVALUATION OF PCA PROGRAM SERVICES COULD BE IMPROVED** **97**

We found that the monitoring activities conducted by PCA program staff at FI and PCM agencies could be improved. For example, Medicaid's monitoring activities focus on compliance with various organizational and operational contractual requirements and place less emphasis on the collection, distribution, and analysis of information that could facilitate better program planning and decision making. Further, the contract monitoring activities that are being conducted, could be improved to better ensure that PCA program services are being provided in a manner consistent with applicable regulations



and the requirements of the contracts that fund these services. Our specific concerns follow:

**a. PCA Program Monitoring Is Not Designed to Assess the Overall Quality and Effectiveness of the PCA Program** **100**

Medicaid managers have implemented a monitoring approach that focuses on ensuring that PCM and FI contractors are in compliance with certain terms and conditions of their contracts. This monitoring focuses on compliance with four contract standards. However, our review determined that PCA program monitoring activities do not effectively assess whether or not PCA program service providers are achieving desired outcomes, identifying and resolving problems and barriers to success, and identifying and promoting implementation of programmatic improvements.

**b. PCA Service Provider Site Visits May Not Be Conducted with Adequate Frequency** **103**

PCM and FI contract provisions state that PCA program managers may conduct annual on-site monitoring visits to each contractor. Although there are no formal written policies and procedures relative to these monitoring activities, PCA program staff stated that site visits had regularly been conducted on an annual basis up until the end of fiscal year 2006, but that these PCM monitoring arrangements were in the process of being changed so that a site visit by program staff to each PCM contractor will only be conducted once every two years. However, our review of tracking sheets maintained by program managers revealed that regular site visits had not been conducted on an annual basis even prior to 2006. During our audit, PCA program managers provided us with what they referred to as a tracking sheet that detailed PCM agency site visits and follow-up activity they had conducted between May 2004 and November 2006. This tracking sheet documented a total of only 36 visits to 26 of 27 PCM contractors and made reference to only three prior site visits conducted since October 2002. Our separate review of agency records covering 10 of the 27 contractors documented an additional three site visits to two contractors between August 2003 and November 2005 that were not included in the tracking sheet provided to us by PCA program staff. Based on the documentation provided, we were able to confirm that only 43 PCM agency site visits were conducted from October 2002 through November 2006, as opposed to the 96 or more reviews that should have been conducted if visits were conducted annually.

**c. PCM Agency Monitoring May Not Accurately Assess Actual Program Activity** **105**

PCA program monitoring staff assess each contractor's compliance with contract standards and performance measures through a review of contractor self-assessments and report filings, coupled with site visits and consumer record reviews. However, written policies and procedures for this process have not been established and the process used by this staff may not accurately assess actual program activity. For example, no standards exist for determining the number of consumer records to be reviewed during these reviews and we found that sample sizes were non-statistical and often appeared to be too small for results to be used to form reasonable conclusions. For example, for one contractor serving approximately 1,700 consumers per year, reviewers examined only 24 consumer files. Our review of other

site review records indicated that sample sizes typically were only eight to 15 cases per PCM agency, regardless of whether the contractor served 45 consumers a year or 3,000 consumers annually.

**d. Sanctions for Noncompliance with Contractual Terms Are Not Standardized and Are Administered in an Inconsistent Manner**

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During our audit, we noted that PCA program managers had not developed standardized sanctions for instances in which they concluded that a PCM agency was noncompliant with contractual terms and conditions or performance standards. As of March 2008, PCA program staff had formally sanctioned only three contractors since October 2002. In each case, regardless of the nature of the alleged noncompliance, the sanctions involved suspending the contractor's ability to intake new consumers for a period of time while corrective actions mandated by PCA program managers could be implemented by the PCM agencies. However, we found a number of instances in which PCA program staff appeared to have administered sanctions against PCM agencies in an inconsistent manner. For example, one contractor for which only 62.5% of EOHHS program performance measures had been met had been sanctioned; yet similar action had not been taken against at least four other contractors with apparently worse compliance statistics than the sanctioned contractors. For the four non-sanctioned contractors with compliance statistics, compliance rates computed by PCA program managers ranged from a high of only 56% to a low of 38%. Further, sanctions were not implemented in a timely manner, as evidenced by the case of one contractor with a reported performance measure compliance rate of only 25% in 2004, which remained unsanctioned for over a year until sanctions were finally initiated during fiscal year 2006.

**e. PCA Program Monitoring Activities Should More Effectively Track and Analyze the Underutilization of PCA Program Services**

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In Massachusetts and other states, underutilization of PCA services has been identified as a significant problem that can jeopardize program effectiveness. During our audit, Medicaid managers provided us with a summary of utilization statistics for fiscal year 2004 that indicated that only 79% of authorized PCA service units were actually used, that 22% of consumers used less than 50% of their authorized service units, and that 5% of consumers had not made any use of their authorized services during this fiscal year. A Medicaid manager acknowledged to us that utilization tracking improvements were needed; however, we found a year later that improvements remained unimplemented and our own analysis of utilization data obtained from program contractors revealed that significant underutilization problems continue to exist. Specifically, based on our review of a sample of fiscal year 2007 data, we found that approximately 26% of all consumers and 48% of new consumers underutilized prior authorization approved service hours by 10% or more, whereas 10% of all consumers and 30% of new consumers underutilized approved service hours by 50% or more.

**f. PCA Program Staff Should Routinely Utilize Financial Statements Submitted by PCM Agencies to the Commonwealth in Monitoring Their Activities**

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Many PCM and FI contractors are required to annually file Uniform Financial Statements and Independent Auditor's Reports (UFRs) with the Commonwealth.

These UFRs are composed of audited financial statements as well as organizational and program-specific information on budgeted and actual revenue and expenses, supplemented with details on program staffing arrangements and service statistics. However, although PCA program managers stated that they annually obtain UFRs for their PCM and FI agencies, they acknowledged that they did not have the expertise to fully understand and interpret UFR filings as part of their monitoring activities.

**g. Site Visit Review Materials and Proposed Corrective Action Plans Submitted by Contractors Not Processed in a Timely Manner** 117

PCA program managers have not established standards for completing Corrective Action Plans (CAPs) that are generated when PCA staff identify deficiencies at a PCM or FI agency in a timely manner. During our analysis of PCA program monitoring data, we noted significant delays in the processing of CAPs relative to 31 monitoring visits that were conducted by PCA program staff at 23 PCM contractors from May 2004 through November 30, 2005. We determined that for 25 of the 31 visits, the amount of time it took to develop and finalize CAPs ranged from 127 days to 279 days. Many of the delays were attributable to PCA program managers not sending monitoring results to contractors until one to three months or more after the completion of site visits and additional delays arose when contractors were not notified in a timely manner of deficiencies in their proposed corrective action plans. For five other visits, we were unable to calculate the number of days it took to develop a CAP due to the lack of accurate record processing dates maintained on the tracking sheet by PCA program managers. The resolution for a sixth visit conducted in November 2004 remained outstanding due to a lack of compliance on the PCM contractor's part regarding resolution requirements and a lack of appropriate contract sanctions initiated by PCM program managers or other enforcement action in a timely manner.

**4. COMPENSATION ARRANGEMENTS FOR FI AND PCM AGENCIES SHOULD BE REEVALUATED ON A REGULAR BASIS AND ADJUSTED TO ENSURE THAT FAIR BUT NOT EXCESSIVE COMPENSATION IS PROVIDED FOR PCA PROGRAM SERVICES** 119

We found that the rates the Commonwealth pays to FI and PCM agencies are not routinely evaluated and adjusted to ensure that these organizations are provided with fair but not excessive compensation. As a result, we found that during the period covered by our audit, FI agencies were allowed to realize significant surplus revenues under their PCA program contracts, one in excess of 19%, whereas many PCM organizations incurred significant losses requiring funding by the PCM agencies' other revenue sources. Our specific concerns in this area follow:

**a. The Compensation the Commonwealth Provides to FIs May Be Excessive** 119

In reviewing the Uniform Financial Statements and Independent Auditor's Reports (UFR) data for years 2006 and 2007 for the three FI organizations with available FI Administrative Task revenue and expense information, we found that all three continued to report substantial excesses of revenue over expenses for both years, with a cumulative total of \$1,636,722 excess revenue over \$13,867,987 in expenses for the two-year period.

<b>b. PCM Agency Funding Appears to Be Inadequate</b>	<b>121</b>
Although administrative burdens placed on PCM contractors have increased, reimbursement rates have not kept up with the annual rates of inflation and many PCM agencies are now incurring losses in providing PCM program services. Although EOHHS' Division of Health Care Finance and Policy conducts periodic pricing reviews for PCM services, improvements could be made in this pricing methodology.	
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## INTRODUCTION

### *Background*

During 2005, the United States Census Bureau estimated that 14.1% of Massachusetts residents age five and older are affected by disabilities and that 2.5%, or approximately 143,000 of those individuals, experience self-care difficulties related to their disabilities. Residents of the Commonwealth deal with these self-care difficulties through a variety of means, ranging from getting by without assistance to residing in nursing homes and other long-term-care institutional settings. Community-based services, including the services of Personal Care Attendants (PCAs), provide an important alternative to the more costly and often “last resort” placement in long-term care facilities. Long-term-care institutional costs are typically borne by state and federal taxpayers through the Commonwealth’s Medicaid (MassHealth) program after individuals have exhausted their personal resources, a common occurrence when private nursing home rates often exceed \$250 per day. In Massachusetts during fiscal year 2006, Medicaid expended approximately \$1.6 billion on nursing home care for 44,607 individuals. The number of Massachusetts residents living in community settings with self-care-related disabilities continues to grow as a result of demographic changes in the Commonwealth, particularly in the percentage of the elderly population with disabilities. Over 15,000 individuals per year receive services through the PCA program, operated as a state service option under the Commonwealth’s Medicaid state plan system (MassHealth), and several thousand additional people receive PCA or related services through various managed-care and other program arrangements funded through Medicaid waivers, federal grants, and state appropriations.

PCA services may include assistance with bathing, dressing, transfers in and out of bed, toileting, range-of-motion exercises, night-time assistance, meal preparation, shopping, and other homemaking and related tasks referred to by PCA program guidelines as Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL). Although many of these services, such as shopping and meal preparation, are not traditional “health care” activities, they have been determined to be eligible for federal Medicaid reimbursement. States can provide personal care services to eligible Medicaid beneficiaries through the state Medicaid plan, and also through various federal waiver programs. Massachusetts does both, but primarily uses its state plan system for these services.

States that provide PCA services through a state plan program must conform to the general Medicaid program requirements established by Section 1902 of Title XIX of the Social Security Act (Act). The US Department of Health and Human Services (DHHS) Center for Medicare and Medicaid Services (CMS), which is responsible for oversight of the Medicaid program, allows states to provide these services through their regular state Medicaid plans on an optional basis and affords states considerable latitude in establishing eligibility standards, service delivery mechanisms, and the scope of covered service activities. Coverage can be limited to direct physical assistance with ADLs in the home or may be more broadly defined to also cover IADL assistance, additional health care tasks traditionally performed by professional or paraprofessional health care personnel, service in settings outside the home such as schools and worksites, and behavioral assistance such as supervision or “cueing” (providing a prompt or direction to assist a person in performing an activity) for consumers with cognitive impairments who may need behavioral direction in order to successfully perform ADL or IADL tasks at the right time.

Even greater flexibility in providing personal care and related community services exists under special waiver arrangements such as Home and Community-Based Service (HCBS) waivers provided for by Section 1915(c) of the Social Security Act.<sup>1</sup> For example, under CMS waiver provisions, it is possible to offer so-called flexible or individual budget-based “cash and counseling” service delivery models in which consumers are provided individual budget allocations to be used at their discretion to pay for a combination of self-directed or agency-directed PCA services and other independent living supports such as adaptive equipment and case-management or transportation services.<sup>2</sup> States may also use other options, such as managed-care approaches. Waiver provisions also allow greater flexibility in the use of cost-containment measures such as enrollment caps and waiting lists. However, in contrast to more permissive eligibility rules for state plan services, federal waiver rules

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<sup>1</sup> Waiver arrangements for personal care services have typically been approved across the nation under the HCBS waiver system; however, other waiver arrangements are also used, including Section 115 Research and Demonstration Waivers, Section 1915(b) Freedom of Choice and Self-Direction waivers, and combination approaches such as the federal CMS “Independence Plus” initiative. More recently, the Deficit Reduction Act of 2005 (DRA) provides states with increased flexibility to significantly reform their Medicaid programs without seeking waiver approval.

<sup>2</sup> On October 3, 2008, CMS promulgated 42 CFR Part 441, Medicaid Program: Self-Directed Personal Assistance Services Program State Plan Option (Cash and Counseling): Final Rule in the Federal Register (Volume 73, No. 193, page 57,854). The publication includes five pages of regulation implementing provisions of the Deficit Reduction Act of 2005, accompanied by 27 pages of public comments and CMS responses. The consumer-directed PCA program operated under the Massachusetts Medicaid state plan is operated under pre-existing federal Medicaid law and is not governed by the new federal regulations; however, the new 42 CFR Part 441 provisions and accompanying CMS comments address many of the issues covered in this report and provide insight into federal expectations regarding the future of consumer-directed personal care services across the nation.

often restrict participation and cover only individuals with disabilities so severe that they meet nursing facility admission guidelines. Expenditures are also capped to ensure that either savings are realized through the waiver services or that services are at least “budget-neutral” for federal Medicaid reimbursement purposes.

Like Massachusetts, most states use a combination of both state plan and waiver programs to provide personal care services to eligible consumers. All states offer the services in one form or another, with at least 30 states plus the District of Columbia providing at least some PCA services under their state plans. Some states also supplement Medicaid-funded PCA services with additional state-funded programs serving consumers not eligible for Medicaid or providing supplemental ancillary services (e.g., housing supports) not reimbursable by Medicaid.

PCA services funded through the Commonwealth’s Medicaid state plan system are administered by the state’s Executive Office of Health and Human Services (EOHHS) Medicaid Office of Long Term Care (OLTC), located at the Executive Office of Elder Affairs (EOEA), in coordination with other state agencies including the Massachusetts Commission for the Blind (MCB); the Departments of Public Health (DPH), Mental Health (DMH), and Mental Retardation (DMR); and the Massachusetts Rehabilitation Commission (MRC). During fiscal year 2008, PCA program services included in the Commonwealth’s state plan were provided by over 22,000 PCAs to over 16,000 Medicaid-enrolled consumers at a cost in excess of \$332 million. On a national level, Medicaid expenditures for PCA services increased by almost 69% between 2000 and 2004 and the U.S. Department of Labor, Bureau of Labor Statistics estimates that labor demand for people employed in this occupation will grow much faster than the average for all other occupations through 2014.

Nationally, the majority of PCA services are provided through two service delivery models: agency direction and consumer direction. In the agency-directed delivery model, a home health, personal care, or other licensed agency employs, pays, and supervises the PCAs. Under the consumer-directed model, the consumer has more control over the services received, usually acts as the “employer-of-record” for the PCA, and determines when, how, and by whom PCA services are provided. In consumer-directed models, consumers typically hire, train, schedule, supervise, and, if necessary, fire their own PCAs. A hybrid model also exists, combining selected attributes of the agency-directed and consumer-directed models. Under the hybrid model, the consumer and agency are often “co-employers,” with the agency serving as the legal employer while the consumer

generally remains responsible for selecting, training, scheduling, supervising, and terminating the PCA. Although PCA service approaches vary from state to state and have in the past predominately been provided through agency-based delivery models, there has been a growing national movement, supported by both community advocates and federal officials, to promote use of delivery models with consumer-directed arrangements, since evaluation studies indicate that such models are often preferred by consumers, less expensive than agency-operated models, and, despite the use of staff who are typically neither licensed nor certified, just as safe for participants in consumer-directed programs as those served in either institutional settings or through agency-operated community-based services such as those provided by home health agencies.

Massachusetts state plan personal care services are delivered through a consumer-directed PCA program that was one of the first such programs in the nation. The scope of services falls in the mid-range of federally permitted service parameters. In Massachusetts, PCAs generally do not perform skilled health care tasks such as Home Health, Occupational and Physical Therapy, or Speech and Language Therapy, and, in contrast to programs in the majority of states, the program excludes supervision and cueing assistance. Massachusetts policy also prohibits the provision of PCA services to patients in hospitals or residents in nursing facilities or similar institutions. That prohibition is consistent with federal program restrictions, although those restrictions can be at least partially waived by CMS.

According to a 1991 DHHS report<sup>3</sup>, the Commonwealth first began Medicaid funding of PCA services in 1976 when the state Medicaid office added PCA services to the state's Medicaid Plan at the request of the MRC. Program participants hired their own PCAs as independent contractors and reimbursement was provided by the state Medicaid program at rates established by the Commonwealth. At that time, six Independent Living Centers<sup>4</sup> (ILCs) performed both programmatic services such as eligibility determination, training and monitoring, and fiscal services on behalf of the state Medicaid office. During this period, the program, recognized as a national leader in the development of consumer-directed PCA services, almost exclusively served adult wheelchair users who needed 14 or more hours of assistance per week. Concern grew among

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<sup>3</sup> Case Studies of Six State Personal Assistance Service Programs Funded by the Medicaid Personal Care Option, U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy, December 1991.

<sup>4</sup> Independent Living Centers are a group of area-based, consumer-governed nonprofit organizations recognized by the federal government under 29 United States Code (U.S.C.) § 796 that provide a variety of advocacy, information, and other program services to individuals with disabilities, including those receiving PCA services.



representatives of other disability groups that program services were limited to people with physical disabilities in geographic areas served by the six ILCs and were not readily available to residents of other communities, and were not available to individuals with cognitive or other disabilities that prevented them from carrying out consumer responsibilities to self-manage PCA activities and related paperwork. In response to those concerns, a Commonwealth taskforce including state officials and consumer advocates moved in 1988 to more broadly define eligibility to include children and people whose disabilities did not require use of a wheelchair, including individuals with mental retardation or other cognitive impairments. It was expected that the Department of Mental Retardation (DMR) would fund the additional support services needed by those individuals and that Medicaid would fund the PCA portion. Under the reforms, consumers with significant cognitive impairments were able to participate by designating substitute decision makers (“surrogates”) to assist them in self-managing their PCA services and the operational support system was opened to participation by consumer-governed nonprofits other than the original six ILCs. The consumer governance requirement was later lifted and participation was broadened to include non-consumer-governed organizations. A distinct additional program component called Transitional Living Services (TLS), operated by one of the six ILCs, also existed during this period for the purpose of transitioning small numbers of consumers from hospitals and other non-independent living situations to independent community-based living arrangements supported by PCA services. The initial TLS arrangement was discontinued in the early 1990s for a combination of reasons, including adoption of a federal restriction on the provision of residential services by federally recognized ILC organizations. However, the TLS component was later re-established in 1998 for a small number of consumers with brain injuries served through a community living arrangement between a federally financed nonprofit housing organization and a for-profit rehabilitation hospital.

Further changes to program operations were made in the late 1990s when the Internal Revenue Service determined that, under most consumer-directed service models such as that in Massachusetts, PCAs were consumer employees rather than independent contractors. In order to comply with significantly increased paperwork and tax-filing burdens associated with that determination, Medicaid restructured administrative operations in 1998 and 1999, awarding free-standing Fiscal Intermediary (FI) contracts to four nonprofit organizations for the purpose of handling such tasks as payroll processing and tax filings; and, in 2002, formal contracts were established with Personal Care Management (PCM) organizations for eligibility evaluation and

related non-fiscal consumer support services. At that time, PCM provider participation was again expanded to 23 organizations and, under an open enrollment process, participation gradually expanded to the 27 PCM ILCs, Aging Service Access Point (ASAP) agencies,<sup>5</sup> and other nonprofit contractors active at the time of our audit. Since then, one PCM agency has dropped out and three more have been added to the system. FI and PCM contractor listings appear in Appendices I and II.

In addition to the PCA services under the Medicaid state plan's regular PCA program, specialized PCA services for elders are an integral component of a managed care program called Senior Care Options (SCO), which is operated under the authority of the Medicaid state plan and serves approximately 7,700 elders with Medicaid or dual Medicaid/Medicare eligibility participating in the state plan's regular PCA program. The SCO initiative utilizes one nonprofit and two for-profit managed-care organizations to address both acute and long-term care needs of enrollees using a Nurse Case Manager approach. Services to enrollees include PCA and other community-based service supports, with PCA services typically provided under a consumer-directed model using the same Fiscal Intermediaries contracted for the regular PCA program, although agency-employed PCAs are also available under the SCO program. PCA services to a small number of elders have also been provided under the state's HCBS waiver covering frail elders and personal care services have been authorized but not implemented under an HCBS waiver for Traumatic Brain Injury services.<sup>6</sup> A variety of additional Massachusetts Medicaid waiver or special program arrangements also provide personal care ADL/IADL assistance in some form. By far the largest is the HCBS waiver covering a variety of community-based habilitation and related services to clients of the Department of Mental Retardation. That waiver was expected to exceed \$948 million in services to over 15,000 individuals during fiscal year 2007<sup>7</sup>. Although not defined as personal care services,

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<sup>5</sup> Aging Service Access Point (ASAP) agencies, originally known as "Home Care Corporations," are a group of area-based nonprofit consumer-controlled elder service organizations governed by provisions of Chapter 19A, Sections 4 and 4B, of the General Laws, and are responsible for the provision of state- and federally funded case-management and related services needed to help elders remain in their homes. ASAPs do not directly provide homemaker, home health, or similar direct service activity themselves, and instead pass through state funding to sub-contracted direct-care agencies. During fiscal year 2006, only 14 of the Commonwealth's 27 ASAP contractors functioned as PCM agencies.

<sup>6</sup> The provision of waiver-based personal care services to approximately 10 individuals with brain injuries has also been approved by CMS as part of the Commonwealth's April 2004 Section 1915(c) HCBS waiver renewal application for Medicaid services to individuals with Traumatic Brain Injuries (TBI); however, at the time of our audit work, we were told by state officials that the envisioned TBI waiver-based personal care service arrangements had not been implemented. Waiver arrangements for individuals with brain injuries are currently being restructured as the result of federal litigation.

<sup>7</sup> Preliminary expenditure data reported by CMS for the waiver indicates that actual expenditure levels have been lower than planned by EOHHS and authorized by CMS for 2007.

ADL/IADL assistance to consumers is an integral element of many of the residential and other program services within that waiver. In addition, CMS grant funds have at times been used on a very small scale to operate PCA-related demonstration projects such as the “cash and counseling” Real Choices pilot program serving 14 non-Medicaid eligible consumers. Individual budget “cash and counseling” arrangements, including PCA-type ADL/IADL assistance, have also been provided to DMR consumers through a flexible individual support initiative operated by that department in conjunction with Public Partnerships, LLC, a nonprofit affiliate of Public Consulting Group, Inc., which indirectly contracts through the University of Massachusetts Medical School to provide “Intermediary Service Organization” services, somewhat similar to combined FI and PCM functions, to participating DMR consumers. In past years, MRC and other agencies have also funded PCA services for small numbers of individuals ineligible for Medicaid coverage. However, as health care reform has evolved in recent years to expand Medicaid coverage to additional populations and to expand other community-based service arrangements through special Medicaid waiver programs, these supplemental expenditures have been terminated.

At the time of the above-mentioned 1991 DHHS study, the Commonwealth’s PCA program was reported to have served 1,775 consumers at a cost of approximately \$24.5 million. However, additional statistics reported in separate studies indicate that despite its early implementation date in 1976, Massachusetts did not significantly expand program participation through the 1980s and early 1990s. According to a November 1993 DHHS report<sup>8</sup> summarizing data from a study prepared by the World Institute on Disability, in 1988, Massachusetts was one of four states with personal care service participation rates per 1,000 Medicaid aged/disabled recipients ranging from only four to eight per 1,000 - in contrast to New York and six other states with participation rates ranging from 125 per 1,000 (New York) to 215 per 1,000 (South Dakota). A later study of 1998-1999 participation rates, measured as participants per 1,000 state population rather than per 1,000 Medicaid-recipient population, reported that Massachusetts provided personal care services to an estimated 3,700 individuals at that time, a participation rate of only 0.61 per 1,000 population. That participation rate was below the national average of 2.59 per 1,000 and far below states such as California, Texas, New York, Michigan, and Arkansas, with participation rates ranging from 4.32 to 7.33 per 1,000 state

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<sup>8</sup> “The Medicaid Personal Care Services Option Part I: Cross-State Variations and Trends over Time,” Assistant Secretary for Planning and Evaluation Research Notes, issued by the DHHS Office of the Assistant Secretary for Planning and Evaluation.

population.<sup>9</sup> Although Massachusetts personal care service participation rates have increased in recent years, they remain low. In contrast, Massachusetts utilization statistics for more expensive nursing homes and other long-term care facilities are high, as reflected by the 720 nursing home beds in Massachusetts per 100,000 people age 65 or older, compared to a national average of approximately 540 per 100,000 elders. Massachusetts Medicaid service and expenditure patterns continue to be disproportionately slanted towards more expensive institutional care arrangements despite the long-recognized cost and consumer-preference considerations discussed in an EOHHS 2003 white paper on “Transforming Long-Term Supports in Massachusetts” and national long-term care reform literature in general. Massachusetts Medicaid currently expends well over half of its long-term care funds on institutional care, a far higher percentage than those for states recognized as leaders in the national effort to re-balance long-term care supports. For example, in the state of Washington, the corresponding percentage of expenditures on nursing homes and other long-term care facilities is reported to be just 35%.

To be deemed eligible for state plan PCA program services, an individual must be eligible for benefits under the state’s Medicaid MassHealth program or the CommonHealth Plan,<sup>10</sup> and all of the following conditions must be met:

- The personal care services are prescribed by a physician or a nurse practitioner responsible for the oversight of the individual’s health care.
- The individual’s disability is permanent or chronic in nature and impairs functional ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) without physical assistance.
- The individual, as determined by the PCM agency, requires physical assistance with two or more ADLs (mobility, including transfers; medications; bathing/grooming; dressing or undressing; range-of-motion exercises; eating; and toileting).
- Medicaid has determined that the PCA services are medically necessary and has granted a prior authorization for PCA services and the member is able to supervise the PCA or have a surrogate assist in supervising them.

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<sup>9</sup> State Medicaid Programs Offering Personal Care Services, Allen J. LeBlanc, Ph.D., M. Christine Tonner, M.P.H., and Charlene Harrington, Ph.D.; Health Care Financing Review/Summer 2001/Volume 22, Number 4.

<sup>10</sup> The CommonHealth Plan, which predates the recent statewide Commonwealth Care healthcare reform initiative, provides Medicaid-administered subsidized health coverage to certain individuals not eligible for the regular MassHealth Medicaid coverage. Eligible consumers participate in the Medicaid system on a sliding fee buy-in basis. This arrangement allows people with disabilities to participate in the PCA program if they have jobs or other sources of income that would otherwise make them ineligible for Medicaid coverage.

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Although an individual's need for assistance with IADLs is not factored in to the above-described eligibility determination, if an individual is determined to meet ADL eligibility requirements, the program will pay for PCA assistance with IADLs such as meal preparation and clean-up, housekeeping, laundry, shopping, maintenance of medical equipment, transportation to medical providers, and completion of paperwork required for the member to receive personal care services.

Even though state plan PCAs are legally the employees of individual consumers,<sup>11</sup> pay and benefit arrangements are established by the Commonwealth rather than negotiated by consumers and their employees. PCAs are paid a fixed hourly rate (\$10.84) established by EOHHS's Division of Health Care Finance and Policy (DHCFP). With limited exceptions, compensation is based on the actual time spent performing approved task activities, measured in service unit increments of 15 minutes at a rate of \$2.71/per unit. No provision is made for "fringe" benefits such as health insurance and Medicaid does not pay for sick, vacation, or other leave time with the exception of statutorily mandated jury duty time and four paid holidays per year.<sup>12</sup> Overtime arrangements are tightly controlled through special approval arrangements and their use is infrequent. Each PCA completes a bi-weekly time sheet, which is approved by the employer (the consumer of PCA services) and forwarded to the assigned FI agency for processing. Payments are then either electronically transferred to each PCA's bank account or are mailed to the consumer for distribution to the PCAs. For the purpose of covering employer tax, unemployment, and worker's compensation insurance obligations, an additional "Employer Expense Component" (\$1.44 per hour through March 2008 and \$1.48 per hour thereafter), is added to the \$10.84 hourly rate and paid to the Fiscal Intermediary organization appointed for the consumer. The FI is then responsible for ensuring that all required tax and insurance payments are completed.<sup>13</sup> FIs process payments to PCAs through special trust accounts established with funds advanced by the Commonwealth to each FI at the start of each FI's contract. Trust account funds are replenished on an ongoing basis through FI billings to Medicaid, which Medicaid then processes with the federal government's Centers for Medicare and Medicaid Services (CMS). The Commonwealth, in turn, is reimbursed by CMS for 50% of program costs.

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<sup>11</sup> Exceptions involve temporary emergency substitute PCA services provided by approved Home Health Agencies and services provided to consumers residing in DMR residential programs, as described in Audit Result No. 1.

<sup>12</sup> As described in the Subsequent Event section appearing in Audit Result 1(a) regarding PCA compensation, a collective bargaining agreement was ratified in late November 2008, which will gradually increase the hourly wage rate to \$12.48 over a three-year period and also implement certain compensated leave and health coverage changes.

<sup>13</sup> Under an alternative processing plan referred to as "Option 2," consumers may, with state approval, elect to carry out all payroll processing responsibilities on their own. However, this option is little used, with only 43 participating consumers during fiscal year 2007.

In addition to their payroll and related tax-processing tasks, FIs perform a variety of administrative functions on behalf of the Commonwealth, such as verifying the consumer's ongoing Medicaid eligibility status and ensuring that the service hours billed for each consumer are within the service limits pre-authorized by Medicaid. Although FIs perform many employer-related functions, consumers remain responsible for a variety of matters, such as providing employment and income verifications to lenders, future employers, and even state assistance agencies seeking information on their past or current employees.

FI organizations are initially paid for their administrative services on an enrolled consumer-per-day basis. The FI's actual costs for the fiscal year are then reviewed and reconciled to the total payments it received from the Commonwealth. As long as actual costs are within a plus or minus percentage variance corridor (initially 20% in 1999, which has since been lowered to 15%, then 10% in 2006), the contractor either absorbs any loss or retains any excess. Variances outside this permitted corridor are either due the Commonwealth or subject to supplemental reimbursement in which reasonable costs have been incurred beyond the variance limit. Administrative payments to FIs averaged approximately \$545 per enrollee per year in fiscal year 2004 and \$546 in fiscal year 2006. The Massachusetts PCA program initially utilized the services of four FI organizations; however, one contract was terminated effective December 30, 2005 and service responsibilities were reassigned to other FI contractors.

Contracted PCM agencies perform activities such as eligibility and level of service need evaluations; orient consumers and surrogates to the program; and provide any skills training needed to hire, train, and direct PCAs. Three of the PCM agencies also hold the FI service contracts. Unlike Fiscal Intermediary payment arrangements, PCM contracts use multiple rates covering service sub-components, with no year-end reconciliation process. During our audit period, PCM agencies were paid \$177.63 for conducting an initial evaluation and \$102.48 for a reevaluation. Intake and Orientation and Skills Training services to consumers were paid at a rate of \$47.76 per consumer per month. As discussed in Audit Result No. 4 on pricing issues, these rates remained in place until March 2008.

Between fiscal year 2000 and 2007, funding for PCA services increased by 169%, as indicated in the following table. During this same period, consumer enrollment increased by 192%, resulting in a decrease of 7.9% in average annual expenditures per consumer. As of July 1, 2007, the program was

reported by its managers to be serving 15,753 consumers with 22,176 participating attendants. PCA payroll totaled over \$265 million for fiscal year 2007, with an additional \$8.1 million in administrative payments to FI contractors and \$9.9 million in PCM contractor payments. Just under \$1 million was also expended that year for 16 consumers in the program's Transitional Living Service (TLS) component.

Medicaid proposals to change various aspects of the program, such as imposition of eligibility, service restriction, or other cost-containment or restructuring measures, have been the subject of controversy between PCA program managers and consumer advocates, with advocates often expressing concern regarding a perceived focus by Medicaid managers on promoting managed-care "medical model" services rather than consumer-directed services despite national policy trends supporting their expansion. Many advocates characterize their efforts to secure consumer-controlled resources necessary for independent community living as a civil rights struggle and have sought legislative intervention on their behalf due to conflicts with Medicaid officials over the years. In the early 1990s, consumers engaged in a sit-in at the State House in order to obtain a wage increase for PCAs; in fiscal years 1997 and 2000 through 2003, consumers successfully secured state budget language provisions prohibiting changes to program standards or regulations without prior review and approval by an oversight group established by the Legislature. Permanent restrictions were eventually imposed by the Legislature as part of Chapter 171 of the Acts of 2002, which mandates specific consultation measures and plan filings with the Legislature prior to implementation of changes for "personal care," "personal care surrogacy," and other "flexible support" services. The table on the following page summarizes PCA service expenditures from fiscal year 2000 through 2007:

**PCA SERVICE EXPENDITURES\***

	Fiscal Year 2000	Fiscal Year 2001	Fiscal Year 2002	Fiscal Year 2003	Fiscal Year 2004	Fiscal Year 2005	Fiscal Year 2006	Fiscal Year 2007	8 Year Net Change %
PCM Agencies	12	13	14	23	24	24	27	28	133.33%
Consumers	5,401	6,672	8,179	10,570	11,770	13,775	14,828	15,753	191.67%
Option 2 Consumers not Using FI Services	81	68	47	48	47	44	45	43	-46.91%
PCA Employees	12,886	10,402	12,476	17,135	19,116	19,337	21,712	22,176	72.08%
Average Annual Expenditure per Consumer	\$19,529	\$20,010	\$19,454	\$18,343	\$18,856	\$17,706	\$18,067	\$17,994	-7.86%
PCA Payroll	\$98,297,017	\$124,197,161	\$147,673,089	\$180,022,348	\$207,569,714	\$228,061,641	\$250,857,525	\$265,443,990	170.04%
FI Admin. Fees	\$3,379,285	\$4,161,657	\$5,129,222	\$6,155,579	\$6,413,449	\$7,172,941	\$7,675,428	\$8,116,083	140.17%
PCM Agency Service Fees	<u>\$3,800,798</u>	<u>\$5,149,534</u>	<u>\$6,318,075</u>	<u>\$7,708,694</u>	<u>\$7,958,878</u>	<u>\$8,667,861</u>	<u>\$9,366,219</u>	<u>\$9,906,854</u>	160.65%
Total Annual PCA Program Expenditures	<u>\$105,477,100</u>	<u>\$133,508,352</u>	<u>\$159,120,386</u>	<u>\$193,886,621</u>	<u>\$221,942,041</u>	<u>\$243,902,443</u>	<u>\$267,899,171</u>	<u>\$283,466,927</u>	168.75%
PCA to Consumer Ratio	2.4	1.6	1.5	1.6	1.6	1.4	1.5	1.4	-41.67%
Average Payroll per PCA	\$7,628	\$11,940	\$11,837	\$10,506	\$10,858	\$11,794	\$11,554	\$11,970	56.92%
Transitional Living Service Fees	Data not available	\$415,865	\$744,506	\$944,356	\$941,076	\$966,614	\$968,454	\$977,324	N/A

The Commonwealth receives federal reimbursement for PCA program expenditures on a 50% basis from the Centers on Medicare and Medicaid Services (CMS). Expenditure amounts reported above include both federal and state net-share amounts. However, the table excludes both state overhead costs associated with the administration of the program and federal reimbursement (also made on a 50% basis) for state allowable administrative costs.

\*Data was provided to us by PCA program officials except for the percentage change column and PCA to Consumer Ratio, and Average Payroll per PCA employee rows, which were calculated by OSA auditors. .



There have recently been some significant programmatic changes. After extensive consumer advocacy and litigation, Medicaid revised the regulatory definition of “family member” in PCA program regulations defined by 130 Code of Massachusetts Regulations (CMR) 422.000 to allow an adult child, parent of an adult child, son-in-law, or daughter-in-law of the member to be paid as a PCA effective March 1, 2006. The spouses, surrogates, parents of members under age 18 (including adoptive or foster parents), or any other legally responsible relatives continue to be prohibited from receiving Medicaid PCA payments, as was the case prior to the regulation change.

In July 2006, the state Legislature unanimously overrode a Governor’s veto and enacted Chapter 268 of the Acts of 2006, amending Chapter 118G of the General Laws to add six additional sections pertaining to the PCA program. The Act creates a nine-person PCA Quality Home Care Workforce Council within EOHHS, but not subject to the control of EOHHS, to “insure the quality of long-term, in-home, personal care by recruiting, training and stabilizing the work force of personal care attendants” and includes the numerous provisions regarding council membership and responsibilities, as summarized below:

*Council members will be selected by the Governor, the State Auditor and the Attorney General, a majority of which shall be consumers or consumer surrogates, and the Council will carry out the following duties:*

- *Undertake recruiting of prospective personal care attendants*
- *Provide training opportunities for personal care attendants and consumers*
- *Establish a PCA referral directory for use by consumers*
- *Provide routine, emergency, and respite referrals of PCAs to consumers*
- *Give preference in the recruiting, training, referral, and employment of PCAs to individuals who would qualify for public assistance if not employed as PCAs*
- *Cooperate with state and local agencies on health and ageing, and other federal, state and local agencies in providing services.*

*The PCA Quality Home Care Workforce Council may:*

- *Execute contracts and other instruments to carry out its duties*
- *Offer and provide fee-based recruitment, training, and referral services to PCAs and consumers other than those in the Medicaid PCA program*
- *Issue rules and regulations*
- *Establish offices, employ employees, incur expenses, and create liabilities*

- *Solicit and accept federal and other governmental grants and cooperate with other agencies in applying for grants*
- *Coordinate activities with similar agencies in other states*
- *Establish technical advisory committees*
- *Keep records and engage in research and gathering statistics*
- *Acquire, hold, or dispose of real or personal property and construct, lease, or otherwise provide facilities for the activities of this section*
- *Delegate its powers and duties consistent with the purposes of the statute*

Section 31(b) of the Act also implements a collective bargaining system to replace the DHCFP PCA wage-setting process and makes PCAs public employees for the purposes of Chapter 150E and Chapter 180, Section 17J, of the General Laws by stating, in part:

*Personal care attendants shall be considered public employees as defined by and solely for the purposes of Ch. 150E and Ch. 180 Sec 17J. In addition, personal care attendants shall be treated as state employees solely for the purposes of Ch. 180, Sec 17A. The PCA Quality Home Care Workforce Council is the employer of personal care attendants. PCAs who are employees of the council are therefore NOT public employees for any other reason.*

Pursuant to these provisions, labor elections were conducted and on November 7, 2007, Service Employees International Union (SEIU) Local 1199 was selected as the PCA labor representative.

The Council is also directed to conduct a performance review every two years to be submitted to the Legislature and the Governor and made available to the public. The performance review is to include an evaluation of the health, welfare, and consumer satisfaction as well as an explanation of the full direct and indirect costs of personal care services and may make recommendations for statutory amendments needed to further ensure the well-being of consumers and the efficient delivery of services. The first review is to be submitted before December 1, 2008; however, state resources available to the Council for carrying out its responsibilities have been limited due to existing state budget issues. For example, an initial fiscal year 2009 appropriation (No. 4000-0050) request of \$728,073 for the Council has been reduced to \$300,000 in the final budget enacted for the year.

Finally, on August 3, 2006, the state Legislature approved Chapter 211 of the Acts of 2006. Pursuant to the legislation, pre-admission counseling and an assessment of community-based service options such as PCA services are to be provided to all Medicaid-funded consumers seeking admission to

long-term care facilities. Pre-admission counseling will also be offered to consumers paying privately. This legislation also requires Medicaid to report to the Legislature on the number of individuals who have been diverted from entering long-term care facilities as a result of this counseling.

***Audit Scope, Objectives, and Methodology***

The scope of our audit included a review of various aspects of the Commonwealth's PCA program and certain administrative and operational activities of several state agencies relevant to the administration of the PCA program during fiscal years 2006 and 2007, as well as a limited review of certain matters both before and after that period, such as statistics necessary to evaluate program growth rates and aspects of the program undergoing changes at the end of fiscal year 2007. These state agencies included the Executive Office of Health and Human Services and its "MassHealth" Medicaid Office of Long Term Care, the Executive Office of Elder Affairs, Department of Mental Retardation, Disabled Persons Protection Commission, Massachusetts Rehabilitation Commission, Massachusetts Office on Disability, Criminal History Systems Board, Division of Health Care Finance and Policy, and the University of Massachusetts Medical School.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence that provides a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives, which consisted of the following:

- To obtain an understanding of the PCA program in the context of overall efforts by the Commonwealth to help individuals with disabilities to live independently in community settings.
- To identify any program areas that could be improved based on the best practices of PCA programs nationwide.
- To determine whether adequate controls have been established over certain aspects of the Commonwealth's PCA program to ensure that the program operates in an economical, efficient, and effective manner; that program objectives are achieved; and that significant risks that might interfere with the achievement of any program objectives are appropriately addressed.

However, our objectives did not include a determination or quantification of the program's effectiveness in reducing nursing facility utilization and associated Medicaid expenditures.

To achieve our objectives, we became familiar with PCA program requirements by reviewing all applicable laws and regulations relative to PCA services. We spoke with representatives from various public and private agencies, including the above-identified state agencies, program contractors, and the Bureau of Special Investigations within the Office of the State Auditor. In addition, we conducted numerous interviews with consumer advocates and with individuals involved in the administration of PCA services in other states such as Pennsylvania and Kansas. We also reviewed documents such as organizational charts, contracts, PCA program-monitoring records, contractor Uniform Financial Statements and Independent Auditor's Report (UFR) filings made each year with the Commonwealth's Operational Services Division (OSD), and PCA service authorization and delivery information. In addition to our review of documents and data maintained by state agencies, we obtained other information on PCA and related services from federal agencies, academic and advocacy entities such as the Independent Living Research Utilization program and the Center for Personal Assistance Services, and information maintained on Internet sites by Medicaid programs and their contractors in other states. These resources were used to develop audit background information on personal care service issues across the nation and to provide normative and best-practice standards for our evaluation of program arrangements in Massachusetts.

The conclusions in our report are based only on the information we were able to obtain through the above-identified sources.

At the conclusion of our audit we met with EOHHS officials who told us that the agency had made improvements to the PCA program's prior authorization process for program services and had implemented an expedited procedure for processing requests for PCA services. In addition, a draft copy of our report was provided to EOHHS for its review and comments. EOHHS officials provided us with a letter that stated, in part:

*Although MassHealth is accustomed to providing detailed responses to draft reports from the Office of the State Auditor (OSA), we have determined that a point-by-point response would not be productive at this time for this review.*

*As we have indicated in previous responses to OSA reviews of the MassHealth Personal Care Attendant (PCA) program, the program is a critical component of MassHealth's community long term care delivery system. We are committed to maximizing the extent to which people with*

*disabilities and elders are able to live successfully in their homes and communities. This commitment necessitated an approach to continuous quality improvement that is reflected in our strategic goals and objectives, in the priorities of our program management and program integrity staff, and in our work with consumers and advocates identifying, designing, and developing program and process improvements. I want to acknowledge that the work of the OSA has been very helpful in advancing our PCA program work in this regard.*

*Over the extended period of time during which OSA was conducting the referenced review, there were significant changes in the external environment impacting our administration of the program, as well as numerous internally-directed program improvement activities, that relate to many of the issues discussed in the report. For example, the establishment of the PCA Quality Home Care Workforce Council has focused significant effort on a collective bargaining agreement that now governs wage rates for PCAs as well as other issues of recruitment and retention of the workforce. Additional examples include the MassHealth program's focus on improving the prior authorization process to expedite Consumer access to services and significant enhancements to our internal capacity to support program integrity initiatives.*

*MassHealth disagrees with many of the methods, facts, and conclusions contained in the report, but appreciated the thorough nature of the OSA review. We look forward to continuing to work with your office to identify opportunities for improvement in the quality of services provided to MassHealth members, and of the effective use of MassHealth resources.*

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## AUDIT RESULTS

### 1. **VARIOUS ASPECTS OF THE PCA PROGRAM COULD BE IMPROVED TO BETTER ENSURE THAT QUALITY SERVICES ARE PROVIDED TO CONSUMERS IN AN EFFECTIVE, EFFICIENT, AND ECONOMICAL MANNER AND THAT THE OBJECTIVES AND EXPECTATIONS FOR THE PCA PROGRAM ARE FULFILLED**

During our audit, we reviewed the arrangements used by the Commonwealth to provide Personal Care Attendant (PCA) program services and noted a number of areas in which improvements could be made to program services to better ensure that quality services are provided to consumers in an effective, efficient, and economical manner and that public objectives and expectations for the PCA program are fulfilled.

In October 2006<sup>14</sup>, The United States Department of Health and Human Services Office of the Inspector General (HHS-OIG) issued a report (OEI-07-05-00250) entitled “State’s Requirements for Medicaid-Funded Personal Care Service Attendants.” In this report, the HHS-OIG noted that 43 states had established multiple sets of requirements for PCAs depending on the service model in which they were being delivered and that seven states had in fact developed uniform requirements for all their PCA programs. Although the report’s information on Massachusetts is erroneous in various respects, the document provides valuable information on the range of service arrangements and program requirements for personal care attendant services in other states. This report found that most states provide PCA services through multiple program models, typically using a combination of state plan and waiver arrangements. The HHS-OIG survey identified 238 PCA programs nationwide, including 31 programs operated under state Medicaid plans and 207 under Medicaid waivers. For 105 of the programs, multiple service delivery models existed within each program. As a result, this survey identified a total of 301 separate sets of program standards applicable to PCA services. We used the information in this report as well as numerous other reports to compare PCA programs in other states to the Massachusetts PCA program. Based on this comparison, and our analysis of Massachusetts PCA program records and data, we identified a number of areas within the operation of the Massachusetts PCA program that we believe could be changed to enhance the quality of program services to consumers and better ensure that PCA program objectives are met in the

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<sup>14</sup> The report was subsequently revised in December 2006. Report data cited here is as presented in the revised HHS-OIG report.

most economical and efficient manner. These specific areas are discussed in the following sections.

**a. Compensation Provided to PCAs Should Be Regularly Reviewed and Modified to Ensure That Appropriate Numbers of PCAs Are Available to Consumers**

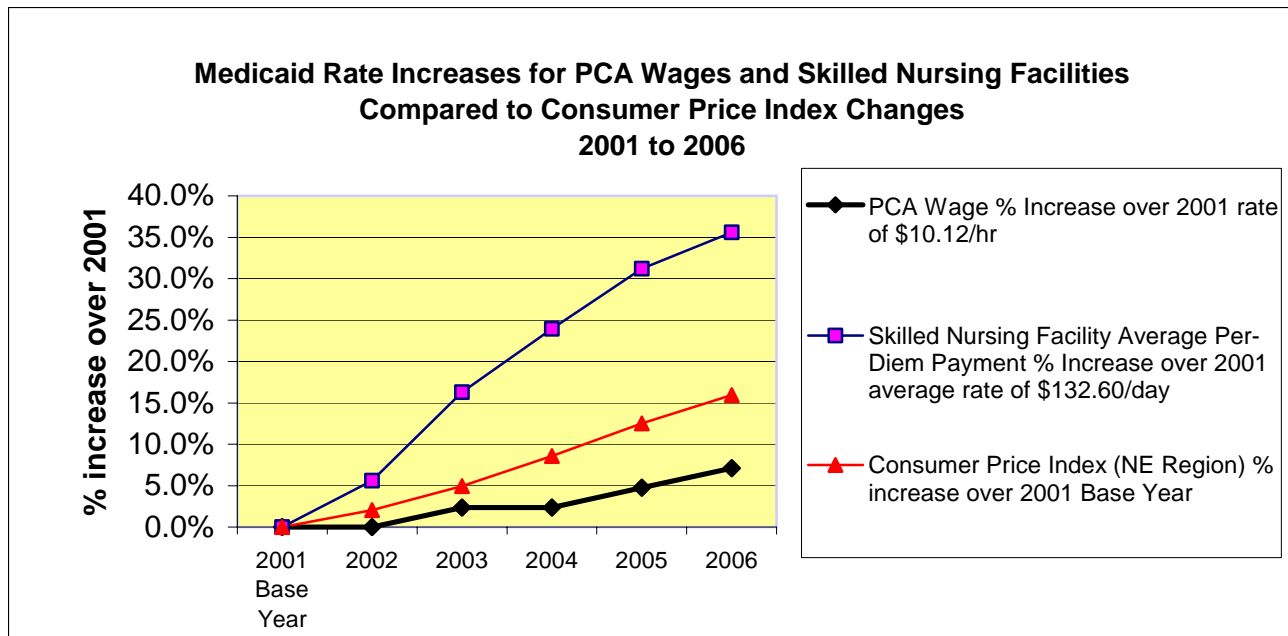
It is important that PCA compensation is fair and equitable in order to ensure that the supply of individuals willing to work as PCAs is adequate to meet the program's demand. During our audit we attempted to analyze the level of compensation being provided to PCAs to determine whether this compensation is reasonable. In order to do this, we first compared Massachusetts PCA rates to rates paid in other states and adjusted this amount to compensate for differences in the cost of living in each geographic area. Since actual Medicaid PCA average pay data was not available for all states, our cross-state analysis was based on "Personal Care/Home Care Aide" job classification wage data maintained by the US Bureau of Labor Statistics (BLS). This data varies somewhat from actual rates paid to Medicaid-funded PCAs (e.g., a BLS-reported average of \$10.46 for Massachusetts vs. the actual \$10.84 Medicaid rate). The results of our analysis, which are detailed in the table on the following page, indicate that, when adjusting for the differences in the cost of living, Boston ranked 23<sup>rd</sup> out of the 26 major cities in our sample in compensation provided to its PCAs and Home Care Aides. It should be noted that our analysis of differences in the comparative cost of living was limited to a comparison between major cities and was not a statewide analysis due to a lack of statewide data and the existence of multiple statistical approaches used for developing such comparisons. For the purpose of our analysis, we used comparative cost-of-living data for significant population centers in each state. Comparative differences, as posted on [www.bestplaces.net](http://www.bestplaces.net) as of December 15, 2006, were used to adjust the raw wage data obtained from the Bureau of Labor Statistics.

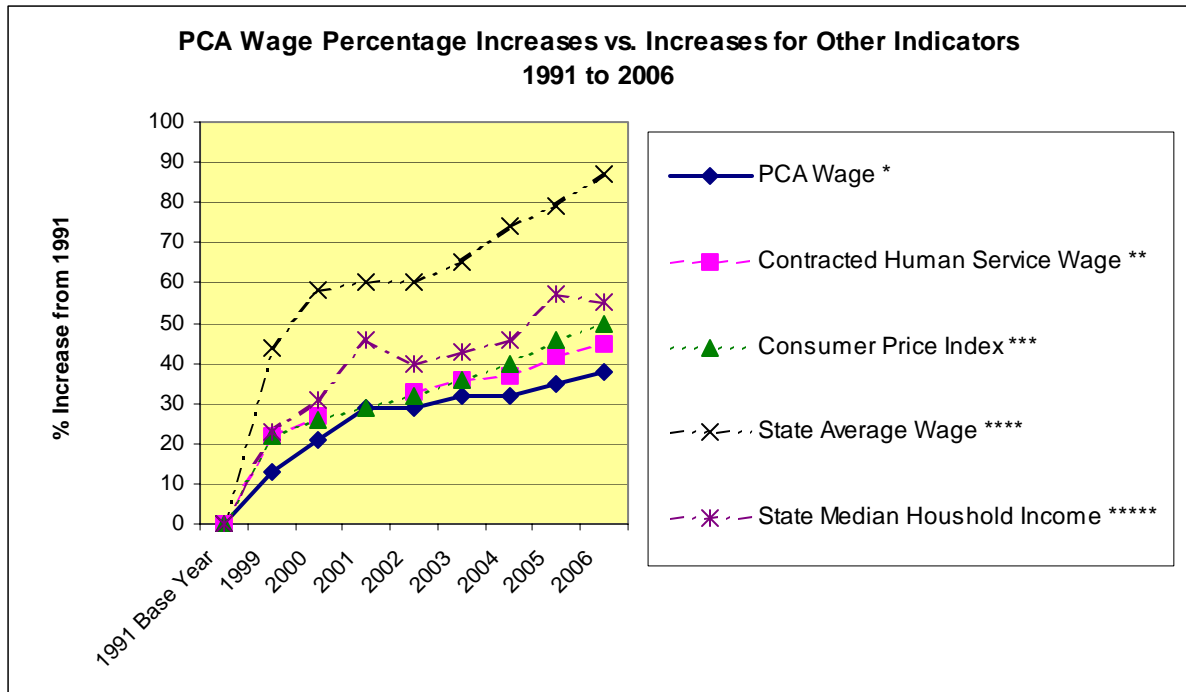
**Personal Care/Home Care Wage Variances by City/ State**

State	Locality	2005 Personal Care/Home Care Aide Wage	Wage-Adjusted Comparative Cost- of-Living Differences	% Difference from Boston, Massachusetts	Rank
Alaska	Anchorage	\$14.01	\$17.66	68.9%	1
Minnesota	St. Cloud	\$10.04	\$16.00	52.9	2
Nebraska	Omaha	\$9.11	\$15.01	43.5	3
Michigan	Grand Rapids	\$8.70	\$14.02	34.0	4
Utah	Salt Lake City- Ogden	\$8.64	\$13.47	28.8	5
Missouri	St. Louis	\$8.10	\$13.35	27.6	6
Oklahoma	Tulsa	\$7.53	\$13.32	27.3	7
New Mexico	Albuquerque	\$8.72	\$13.31	27.2	8
Montana	Missoula	\$8.07	\$13.30	27.1	9
Oregon	Portland	\$9.68	\$13.12	25.4	10
Wisconsin	Madison	\$9.28	\$13.06	24.9	11
South Dakota	Sioux Falls	\$8.10	\$13.05	24.8	12
Idaho	Boise	\$8.02	\$12.92	23.5	13
West Virginia	Charleston	\$7.04	\$12.60	20.5	14
Maryland	Baltimore	\$9.53	\$12.56	20.1	15
North Carolina	Raleigh-Durham	\$8.14	\$12.17	16.3	16
New Hampshire	Portsmouth- Rochester	\$9.33	\$12.08	15.5	17
Connecticut	Hartford	\$9.55	\$11.94	14.1	18
Washington	Seattle-Bellevue	\$9.59	\$11.59	10.8	19
Arkansas	Fayetteville- Springdale	\$6.70	\$11.17	6.8	20
Maine	Portland	\$8.58	\$11.01	5.3	21
Texas	Houston	\$6.32	\$10.53	0.7	22
Massachusetts	Boston	\$10.46	\$10.46	Base	23
Nevada	Reno	\$8.58	\$9.64	-7.8	24
New Jersey	Newark	\$9.33	\$9.33	-10.8	25
DC	Washington	\$8.05	\$8.22	-21.4	26



As displayed in the following chart, we also compared the wages paid to PCAs to the percentage increase in compensation provided by the Commonwealth to skilled nursing facilities, and to the median program hourly wage rates paid to direct care workers working under state contracts, and the increase in the consumer price index between the period 2001 through 2006. Our analysis revealed that compensation paid to PCAs has increased an average of only 38% over this 15-year period, whereas the consumer price index increased 50% and the amount of compensation paid to entry-level Direct Care workers at the state’s contacted human service providers increased 45% during this same period. Over the same period, the state median household income increased 55% and the state average wage increased 87%. Clearly, the compensation being paid to PCAs during calendar year 2006 has not kept up with the rate of inflation. When adjusted for inflation, the 1991 PCA wage rate of \$7.85 per hour would be the equivalent of \$11.76 in 2006 dollars. Even that rate would rank only 19 out of 26 in the multi-state comparative cost-of-living analysis. Since 2006, inflation has continued at higher rates, including a recently announced rate of approximately 5% for the year ended July 2008, while the rate established by Medicaid for PCA compensation has remained unchanged since 2006 at \$10.84 per hour.





\* PCA Wage: Hourly wage rate increased from \$7.85 in 1991 to \$10.84 in 2006, a net increase of 38% over 15 years

\*\* Contracted Human Service Wage: Median program wage rate for Direct Care Worker I positions at state human service contractor agencies – Data not available for 2001. 45% increase over 15 years.

\*\*\* Consumer Price Index for Northeast Region as reported by US Bureau of Labor Statistics – 50% increase over 15 years.

\*\*\*\* Massachusetts Average Wage as reported by US Bureau of Labor Statistics – 87% increase over 15 years.

\*\*\*\*\* Massachusetts Median Household Income as reported by US Census Bureau – 55% increase over 15 years. (57% through 2005)

Note: Although PCAs receive no health benefit other than worker's compensation insurance, contracted human service workers and other wage earners in the Commonwealth typically receive health benefits at least partially subsidized by employers. Under the Commonwealth's recent health care reform system, employer-funded health benefits for PCAs employed by individual consumers are not mandated since each consumer employs fewer than 10 PCAs, the legal threshold for triggering coverage. Unless coverage is provided for by negotiations under the recently enacted Workforce Council system, PCAs will generally be required to individually purchase at least minimal health coverage under sliding fee arrangements established pursuant to health care reform legislation.

Other problems with PCA compensation include:

- PCA compensation deficiencies are compounded by the failure to pay higher rates for long-term PCAs, merit/training/qualification considerations, or for PCAs working in more difficult settings. In contrast, California allows local entities responsible for operating its program (typically county government) to adjust pay rates for local market conditions. The state of Washington increases compensation in the form of vacation and health benefits for PCAs working at least 86 hours per month. In December 2003, New Mexico adopted a payment system in which PCAs are paid at a higher hourly rate for the first 100 hours of work per month. States such as Missouri with "cash and counseling"/individual budget-type programs often allow consumers wide latitude in determining how much of their allotted budgets (which include funds for adaptive

equipment and other needs in addition to PCA services) should be paid to their PCAs. When this is done, guidance is often provided regarding factors to consider, such as local wage markets, job duties and required skill levels, transportation costs, increases for length of service considerations, etc. A 2006 study, “Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants,” prepared by the Paraprofessional Healthcare Institute on behalf of the AARP Public Policy Institute, documents a wide range of compensation arrangements in use for PCA services across the nation and describes at least seven different types of strategies used to improve direct-care wages and benefits, including the collective bargaining approach recently provided for by the Commonwealth’s enabling legislation establishing the PCA Quality Home Care Workforce Council. Our review of such diverse national arrangements identified no inherent reason for using a rigid fixed-rate model historically used by the Massachusetts PCA program.

- Massachusetts pays for only four holidays per year for PCAs and provides no other paid leave time other than jury duty compensation (i.e., no sick, vacation, personal, bereavement, paternity, etc.). Further, since the PCA program is structured to categorize individual consumers as the employers of record, PCAs are not guaranteed health coverage under the recent health reform legislation mandating coverage through employers with 10 or more employees. Instead PCAs will, if not separately provided for through compensation benefits negotiated through the new PCA Quality Home Care Workforce Council, be covered only through the individual low-income buy-in provisions of the health reform law.

Compensation may also be inadequate in other respects. With certain limited exceptions such as jury duty compensation and time for the four paid holidays covered by the program, Medicaid reimburses PCA services based on the traditional 15-minute unit of reported actual service time. Special provisions have also been made for compensation of services performed between midnight and 6:00 am. For consumers requiring service during those hours, Medicaid typically reimburses for a minimum eight-unit/two-hour period, paying the equivalent of \$21.68 per night regardless of when or how often hands-on assistance is required by the consumer from the PCA during the night or whether or not the PCA is required to remain “on-call” through the night<sup>15</sup>. If the PCA effectively has to remain available on-site throughout the night in order to provide 15 minutes of hands-on assistance at 1:15 am, 2:45 am, 4:15 am, and 5:45 am, compensation is still limited to \$21.68 for two hours of hands-on service time. Medicaid will pay for additional time only if the Prior Authorization Unit reviewer has determined that more than two cumulative hours of hands-on assistance is required per night. However, the approval of this additional compensation is

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<sup>15</sup> Both advocates and documentation maintained by Medicaid managers have raised questions regarding the consistency of this practice with applicable wage and hour laws.

not a common occurrence since our review of data provided by the Stavros personal care management (PCM) agency covering 3,213 prior authorization determinations revealed that of 1,351 consumers with night hour approvals, only 14 (1.0%) had received approval for more than the two hours per night. Massachusetts consumer advocates with whom we spoke stated that in their opinion, Medicaid's practice of establishing approved service and reimbursement levels without fully factoring in the true time required to actually provide necessary assistance over the course of a day and week has contributed to service access, quality of care, underutilization, and PCA recruitment and retention issues. As described further in Audit Result No. 2 on the use of the prior authorization process for cost-containment purposes, similar time-for-task driven compensation arrangements in Texas have been determined to be unreasonable and prohibited by a federal District Court settlement agreement.

***Recommendation***

We recognize that there are significant state budget implications presented by the need to address the PCA compensation deficiencies described above. However, we believe that in order to ensure that a sufficient number of PCAs are available to meet the increasing demand for PCA services, the Commonwealth should consider addressing the following PCA compensation issues:

- Increasing overall hourly wage rates, which are clearly deficient relative to both associated fringe benefits provided and comparative cost-of-living factors;
- Permitting more flexible variable wage rates based on factors such as differences in duties;
- Making needed improvements in health care, leave, and other benefits; and
- Changing on-call/intermittent coverage compensation arrangements needed to better meet consumer assistance needs and ensure compliance with wage and hour laws.

A multi-year plan for addressing these issues should be negotiated pursuant to the PCA Quality Home Care Workforce Council legislation for presentation to the state Legislature.

***Subsequent Events***

As our draft report was being provided to EOHHS for comment in late November 2008, the Commonwealth and 1199 SEIU United Healthcare Workers East ratified a collective bargaining agreement covering the terms of PCA compensation. The three-year agreement provides for a wage increase to \$11.60 per hour retroactive to July 1, 2008, a second increase to \$12.00 per hour effective July 1, 2009, and a final increase to \$12.48 per hour effective July 1, 2010. Other provisions of the agreement address certain paid leave and health coverage compensation terms, subject to further negotiation regarding details of the final arrangements to be implemented.

**b. The Process Used to Review the Background of PCAs and Surrogates Could Be Improved**

Background checks for PCAs, referred to in Massachusetts as Criminal Offender Record Information (CORI) checks available through the Commonwealth's Criminal History Systems Board (CHSB), are an optional component of the Massachusetts PCA program. Massachusetts Medicaid requires PCM contractors to educate consumers regarding the availability of information that can be used to promote safe services and high-quality health care but has made no additional provisions for ensuring that background check information is made readily available to consumers. In contrast to federal recommendations and arrangements in at least some other states, Massachusetts Medicaid does not pay for the cost of obtaining background information and consumers may be required to pay as much as \$30 per CORI check. Those background checks that are conducted on PCAs at the request of consumers are limited in scope, covering only certain criminal records available from Massachusetts courts, rather than the nation as a whole, and omit non-court record information such as substantiated abuse complaints made to the Disabled Person's Protection Commission (DPPC) and similar information available through the state's Sex Offender Registry and other state sources such as the state's Department of Public Health (DPH) registry covering Certified Nurses' Aides (CNAs). In fact, background check information sources in Massachusetts remain highly fragmented in comparison to states that have moved on behalf of their consumers to consolidate information from multiple sources into a single report. CORI reports provided by CHSB are also difficult to interpret and are sometimes erroneous due to problems such as identification errors attributable to the fact

that the Massachusetts system, unlike those in other states, does not use a fingerprint-based indexing system<sup>16</sup>. Further, consumer and PCA program contractor access to criminal background records is limited under existing statutory and regulatory provisions. The program has also made no provision for providing background checks on non-PCA surrogate decision makers designated to assist cognitively impaired consumers now comprising the majority of the program's consumer base.

The previously mentioned 2006 HHS-OIG report and other sources document a wide range of national approaches to PCA background checks, with most programs providing for at least limited-scope criminal record checks, which tend to be mandatory for programs in which PCAs are employed by agencies and often serve multiple consumers. However, checks are typically discretionary and conducted at the option of consumers for consumer-directed programs and consumers are usually given the authority to determine whether to exclude a job candidate based on the results of the background check.

In contrast to Massachusetts, some states have established comprehensive systems by gathering nationwide criminal record data and, in some cases, consolidating it with other available data such as sex offender and abuse/neglect registry information, and with state and federal listings of individuals and organizations excluded from participation in activities such as contracting or the provision of Medicaid or other health or social services. Even when states do not check national data for all PCAs, provisions are sometimes made to supplement in-state data checks where PCAs have lived in other states in the past (e.g., the state of Washington PCA background check system supplements a state criminal record check with a national check where the PCA has resided in-state for less than three years). National studies of these issues, both for employees in general<sup>17</sup> and for direct-care staff in particular,<sup>18</sup> document arrangements across the nation and the usefulness of practices such as fingerprint-based indexing and consolidating comprehensive data from multiple sources.

The 2006 HHS-OIG report points out that “the struggle to balance beneficiary protections with consumer choice” is a factor in the variation across states in requirements.

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<sup>16</sup> Massachusetts is reported to be the only state in the nation not yet using fingerprint-based indexing according to a 2005 Boston Foundation report, “CORI: Balancing Individual Rights and Public Access.”

<sup>17</sup> E.g., the June 2006 US Department of Justice “Attorney General’s Report on Criminal History Background Checks.”

<sup>18</sup> E.g., Appendix F of the US DHHS 2004 report: “Nursing Aides, Home Health Aides, and Related Health Care Occupations - National and Local Workforce Shortages and Associated Data Needs.”

Massachusetts CORI-related statutes and regulations and arrangements in other states across the nation are designed to balance often-controversial competing interests involving the public's right-to-know with the privacy, rehabilitation/non-discrimination rights of individuals. For PCA programs, there are also issues of balancing the need to ensure that attendants are qualified with the competing need to ensure that a sufficient pool of attendants is available, and determining the extent to which checks should be mandatory and the circumstances under which PCAs should be excluded from participation, with little consensus on where to strike the balance. Although it does not expressly address the issue of PCA background checks, a May 2007 report of a task force on CORI employer guidelines<sup>19</sup> convened by the Boston Foundation and the Crime and Justice Foundation documented many of the issues involved and the adverse economic and other consequences that result from existing CORI arrangements and employment practices in the Commonwealth. At the same time that the Massachusetts CORI system omits significant relevant background information available from other states and from non-judicial sources, the analysis conducted by the task force suggests that the widespread existence of minor criminal records for approximately 30% of the population coupled with public misconceptions, CORI data inaccuracies, and problems in interpreting information presented in existing CORI reports result in the widespread inappropriate exclusion of ex-offenders who are in reality low-risk job applicants<sup>20</sup>.

The Violent Crime and Law Enforcement Act of 1994 directed the U.S. Department of Justice (DOJ) to “develop guidelines for the adoption of appropriate safeguards by care providers and by states for protection of children, the elderly, or individuals with disabilities from abuse.” In April 1998, the DOJ issued a document entitled “Guidelines for the Screening of Persons Working with Children, the Elderly, and Individuals with Disabilities in Need of Support.” These guidelines expressly reject the concept of uniform across-the-board background screening systems and instead present advice on establishing formal policies providing appropriate screening arrangements such as formal application forms; interviews; reference checks; local state and federal criminal, abuse, and sex offender

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<sup>19</sup> Available at: [http://crjustice.org/cji/cori\\_may2007.pdf](http://crjustice.org/cji/cori_may2007.pdf).

<sup>20</sup> Inappropriate exclusion is not limited to cases involving individuals with minor convictions. Both background research and our own interviews with consumer advocates document cases in which consumers have reported that some of their best PCAs are former convicts.

background checks; and other measures. According to this report, the establishment of these screening measures should be based on specific situations; individual program circumstances; and analysis of considerations such as relative risk, cost, access, time constraints, and other factors such as the appropriate use of available information in which conflicting public policy considerations exist. The screening guidance, which is based on the work of the American Bar Association with extensive advisory committee input, expressly calls for use of a formal assessment process to develop appropriate screening systems and provides seven pages of detailed decision-making model guidance. However, we were provided with no evidence that PCA program officials had appropriately assessed risk and other factors relevant to program background check issues.

In order to assess the level of risk relative to the program, we reviewed program arrangement data maintained by the state's Disabled Persons Protection Commission, available national information, and information regarding PCA program fraud referrals to the Bureau of Special Investigations within the Office of the State Auditor. Our review did not include testing of CORI results for samples of program PCAs due to both legal issues and the fact that Medicaid PCA program managers do not compile electronic PCA employee data maintained by individual Fiscal Intermediary (FI) contractors. Based on review of available information, we found that reported levels of serious abuse, neglect, and fraud are relatively low for the PCA program compared to overall abuse reporting rates for the statewide population of persons with disabilities. However, since underlying actual abuse rates may significantly exceed reported rates, we believe that the risk for incidents of neglect or abuse by potential PCAs still needs to be seriously considered in the administration of the Commonwealth's PCA program so that better-informed policies and practices can be implemented, particularly as program participation expands for consumers with cognitive impairments.

Our review developed the following information relevant to background check issues for the PCA program in Massachusetts:

***Abuse of Consumers by PCAs***

As noted by the 1998 DOJ guidelines, available data studies "are sketchy," but it was estimated by one 1990 study that 12.8% of the then estimated two million incidents of elder



abuse occurring in the home were perpetrated by service providers; similarly, a 1993 American Association of Retired Persons (AARP) study suggested that elder abuse is a “fact of institutional life,” with 10% of interviewed staff admitting to personally abusing patients and 40% admitting to at least one psychologically abusive act in the preceding year. The DOJ guidelines also note that:

*Although the incidence of abuse may be relatively small, abuse traumatizes the victims and shakes public trust in care providers and organizations serving these vulnerable populations.*

Similarly, a 2000 survey developed by the National Association of State Adult Protective Service Administrators indicates that overall abuse rates may actually not be so small for persons with disabilities as a whole, but studies note significant variances in abuse and neglect patterns across different settings and consumer and caregiver populations. For example, unlike patterns for younger persons with disabilities, the most significant issues for elders, particularly elders over age 80 who may be more likely to experience extreme frailty and cognitive impairments, is reported to be self-neglect, followed by somewhat lower levels of other problems such as financial exploitation, as well as physical and emotional abuse by spouses and other family members – often those struggling to cope with the stresses of living with and caring for elders<sup>21</sup>.

Like many other states, Massachusetts has a fragmented system for addressing these issues, with responsibilities distributed across multiple public agencies. Data regarding abuse and neglect is not collected in one central location and the responsibility for investigating abuse and neglect complaints involving both consumers in the PCA program and other persons with disabilities is split by age category. The Disabled Persons Protection Commission (DPPC) is responsible for persons ages 18 through 59; the Elder Protective Services Program administered by the Executive Office of Elder Affairs (EOEA), through Aging Service Access Point (ASAP) contractors, is responsible for individuals age 60 and up; and the state’s Department of Children and Families (formerly the Department of Social

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<sup>21</sup> The report on a survey developed by the National Association of State Adult Protective Service Administrators and conducted in 2000 for the National Center on Elder Abuse references some of the limited research on abuse and neglect patterns, including studies covering self-neglect as well as other reports identifying family members as the perpetrators in as many as 61.7% of abuse cases.

Services)<sup>22</sup> is responsible for children. Even for individuals within the age jurisdiction of the DPPC, actual investigative activity is often delegated to other state agencies, primarily the Department of Mental Retardation, which performs over 50% of DPPC investigations. Research also suggests that both self-neglect and financial exploitation are more frequent than physical abuse. Yet DPPC lacks the statutory authority to address self-neglect situations and, contrary to recommendations appearing in the US DOJ screening guidelines that “abuse” be defined to include fiduciary abuse or exploitation and that such abuse be included in abuse registry tracking systems, DPPC can only indirectly address financial abuse or exploitation situations when individual circumstances demonstrate that the activity resulted in serious physical or emotional harm.

DPPC maintains extensive data on abuse and neglect reports it receives as well as resulting investigative activity, referrals for prosecution, and resulting criminal charges. Despite the above-described limitations, the DPPC data provides a valuable resource for analyzing disability-related abuse and neglect issues. During our audit, we reviewed DPPC complaint report data for fiscal years 2000 through 2005 as well as other demographic data for the Commonwealth and the PCA program. Based on our review of this information, we noted the following:

- For fiscal year 2005, DPPC received 5,666 reports to its abuse hotline system, of which 162 involved allegations of PCA-related abuse allegations.
- Since DPPC investigators do not perform CORI checks on all alleged perpetrators but instead conduct checks only when past criminal records are either alleged or suspected, the true number of alleged perpetrators with positive CORI results remains unknown. However, multi-year DPPC data for cases related to the PCA program during fiscal years 2003 through 2005 showed that, out of 171 cases screened for investigation by the DPPC, only five alleged perpetrators (2.9% of the 171 cases) were identified as having “positive CORI results.”

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<sup>22</sup> Pursuant to Chapter 176 of the Acts of 2008, enacted July 8, 2008, the Department of Social Services has been renamed the Department of Children and Families. While certain changes are being made to child abuse reporting and investigation arrangements, the system continues to be operated separately from the systems for elders and adults with disabilities.

- DPPC statistics include “repeat cases” in which the alleged victim, perpetrator, or both are previously known to DPPC from prior reports or investigations. DPPC reports that, of 162 total PCA-related reports received in fiscal year 2005, 129 (79.6%) involved alleged victims known to DPPC through prior complaint reports. 63 (38.9%) of the alleged perpetrators were also known to DPPC from prior reports, often involving the same victim/perpetrator pairs. Although some of these cases may involve unfounded repeat accusations, the significant volume of repeat cases suggests the possible existence of programmatic issues for at least a small group of PCA program participants.
- We noted that for fiscal years 2000 through 2005, DPPC reported a statewide total of 544 cases in which criminal charges had been filed. Of that total, 22 involved personal care services, an average of approximately four per year for a program employing over 20,000 PCAs.
- Analysis of DPPC data on PCA-related abuse and neglect reports compared to data for non-PCA-related reports processed in fiscal year 2005 revealed that the incidence level for PCA-related complaints was only 2% for the estimated 7,350 PCA users between ages 18 and 59 that year, compared to an overall incidence level of 14% per year for all persons in the Commonwealth between the ages of 18 and 59 with disabilities. PCA-related complaints were also more likely to be screened-out as not warranting investigation and, if investigated, to be determined to be unsubstantiated. Only 18 PCA-related cases were substantiated that year, with an additional six cases for which substantiation determinations were pending at year-end, a potential substantiated abuse incidence rate of only 0.3%. In contrast, the corresponding substantiated abuse rate for the estimated 36,673 state residents with disabilities in that age group was 1.2%

This information suggests that, although PCA-related abuse and neglect issues certainly exist in the Commonwealth, PCA program consumers do not appear to be at increased risk as a result of participation in the program compared to other persons with disabilities who do not utilize PCA program services.

### ***PCA Program Fraud***

Nationally, fraud has been identified as a major concern for Medicaid, Medicare, and other health care systems, with estimates of fraud running at 10% or more of national Medicaid expenditures. However, fraud risks are believed to vary significantly for different types of Medicaid service activities and payment arrangements. Limited information available from PCA program reviews conducted by the United States Government Accountability Office (GAO)<sup>23</sup> and by the Robert Wood Johnson Foundation<sup>24</sup> suggests that fraud problems may

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<sup>23</sup> GAO-HEHS-98-50R, available at: <http://archive.gao.gov/paprpdf1/159745.pdf>.

<sup>24</sup> Kevin J. Mahoney, "Quality Because of Choice, Not in Spite of It," *Advances*, Robert Wood Johnson Foundation, Issue 3, 2002.

not be significant for consumer-directed personal care programs. In addition to certain system-wide fraud controls, Medicaid requires FI and PCM contractors to screen activity such as timesheet submissions and information gathered through evaluations and home visits for potential fraud. PCA program managers forward any suspicious activity to the Bureau of Special Investigations (BSI) within the Office of the State Auditor. However, these monitoring and reporting arrangements only address fraud against the Commonwealth, such as falsification of disability and function level, and submission of false timesheets for services that have never been delivered. Situations involving financial exploitation or neglect of consumers are only indirectly addressed when fraud investigations conducted by BSI happen to identify such abuses.

During our audit, we asked Medicaid managers for records relative to potential cases of PCA program fraud. In response, we were provided with a copy of a multi-year log of incidents that Medicaid had referred to the state's BSI, within the Office of the State Auditor, for investigation. In analyzing this log, as well as information being maintained by BSI, we noted that despite the significant overall growth of the PCA program (a 26% increase in consumers between 2004 and 2006 and a 13.6% increase in PCAs), there was no clear trend in referral growth.

### ***Consumer Surrogates Are Generally Not Subject to Background Checks***

Currently, the Massachusetts PCA program does not mandate or even formally recommend the use of background checks for surrogates. As a result, surrogate background checks are unlikely to be conducted except for certain PCA program consumers for whom surrogates may be employees of state agencies or their contracted human service providers.<sup>25</sup> Since many consumers with surrogates are themselves unable to take action on their own behalf or self-report abuse, neglect, or financial exploitation, there is a higher risk that any problems will go undetected in the absence of appropriate service-monitoring arrangements. During our audit, we noted evidence that background checks and other programmatic controls have been implemented elsewhere in the nation for PCA service surrogates and surrogates with similar types of decision-making responsibilities in other programs. For example, in the case

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<sup>25</sup> In such cases the surrogates would not be checked due to their status as surrogates, but instead due to their status as human service staff subject to state agency background check requirements. However, even in those cases consumers and their family members are unlikely to be informed regarding background check results and the frequency or scope of checks conducted for the surrogates designated to assist them.

of educational decision-making surrogates with comparable decision-making responsibilities to those of PCA program surrogates, the Missouri Department of Education policy states:

*Anyone who is 18 years old or older and has no conflict of interest concerning the child's education may serve as an educational surrogate. A criminal record check and child abuse or neglect check are required. Also, an educational surrogate may not be an employee of a public agency providing care, custody or educational services to the specific child in need of educational surrogate representation.*

### ***Inadequate Program Arrangements for Background Checks***

Medicaid's contracts with PCM agencies simply call for PCM agencies to provide information to consumers regarding safety- and quality-related resources such as optional CORI checks, the Disabled Persons Protection Commission (DPPC), and the state's Sex Offender Registry operated by the Executive Office of Public Safety. PCM agencies are not required or paid to conduct CORI checks on behalf of consumers and Medicaid PCA program managers have not coordinated any systemic background check activities. In reviewing PCA-related abuse and neglect issues with DPPC staff, we were told that DPPC had informal arrangements with a limited number of PCM agencies and other human service organizations to check potential direct care workers against DPPC data on known perpetrators of abuse or neglect. However, these arrangements remained little used during our audit period, with only four of the 27 PCM agencies requesting such checks. PCM contract provisions do not directly address the issue of obtaining background information for consumer surrogates. Moreover, neither program regulations nor contract language reference the statutory provisions set forth in Chapter 6, Section 172C, of the General Laws, enacted as Chapter 444 of the Acts of 1997, which mandates CORI checks by "any agency or organization that employs or refers personal care attendants" (as well as other agencies providing community-based services to elders or persons with disabilities), stating that "such entities shall obtain all available criminal offender record information concerning any such individual from the criminal history systems board prior to employing such individual, accepting such individual as a volunteer or referring such individual for employment to an elderly or disabled person." However, the statutory language appears to apply only to PCAs employed or referred by agencies and organizations and does not address background checks for the vast majority of PCAs directly recruited and employed by consumers, as is the case in the Massachusetts PCA program. Most PCM staff members we interviewed

appeared to be unaware of these statutory requirements and we saw no evidence that Medicaid had taken any specific actions to ensure compliance with this statute. In fact, we noted that one statewide recruitment and referral Internet site for PCAs and other direct care workers that has been established in part with Massachusetts Medicaid support refers PCAs to consumers without conducting the required CORI checks. Instead, consumers are referred to a third-party for-profit personnel agency through which background checks may be purchased.

In contrast, we noted that the state of Oregon's regular Medicaid state plan PCA program has established a system of discretionary background checks for caregivers, which are conducted at state expense – a subsidization approach that is sought by consumer advocates in Massachusetts and recommended by the previously referenced DOJ guidance. In one of its PCA-related HCBS waiver programs, Oregon also mandates background screening checks for both direct-care providers and surrogates (although not for immediate family members), while still allowing discretion in final surrogate appointment decisions and without use of a mandatory exclusion process for either surrogates or caregivers. Oregon has also established standards requiring adherence to that state's protective service and abuse rules and has recognized the importance of financial exploitation issues, even when prosecution has not occurred, by including the following definition in its program standards:

*"Fiscal Improprieties" means the Personal Care Attendant committed financial misconduct involving the client's money, property or benefits. Improprieties may include financial exploitation, borrowing money from the client, taking the client's property or money, having the client purchase items for the provider, forging the client's signature, falsifying payment records, claiming payment for hours not worked, and similar acts intentionally committed for financial gain.*

### **Recommendation**

Based on our research, we believe that the most desirable practice for background checks in a consumer-directed PCA program such as that instituted in Massachusetts is a system where background screening systems such as CORI checks and abuse and sex-offender registry checks are available without cost to consumers but are not necessarily mandated or associated with mandatory exclusion policies. Background check procedures should balance the highly sensitive issues of PCA rehabilitation/privacy issues with a consumer's right to make informed decisions in selecting an individual to provide PCA services. Although some

of the issues we identified (e.g., fingerprint-based checks) involve operational, policy, and statutory arrangements outside its control, we believe that EOHHS should work proactively with other state agencies and the state Legislature to implement improvements consistent with the above-referenced 1998 US DOJ guidelines and background check practices adopted in other states. We recommend that EOHHS and its agencies and the PCA Quality Home Care Workforce Council consider the following:

- Either use Medicaid funds to pay for optional background checks requested by consumers or work with the Criminal History Systems Board to ensure that checks are performed without charge to consumers.
- Work with state agencies and the state Legislature to expand screening data and procedures to include other appropriate information, such as information on known abusers available from sources such as DPPC, the Department of Children and Families, the Elder Protective Services program, and records for licensed or certified health and human service professionals and paraprofessionals such as Certified Nursing Assistant abuse registries. Consolidated information from multiple sources, including out-of-state data, should be available to consumers with easy-to-understand information provided in response, accompanied by appropriate educational materials providing a balanced perspective on background check and employment exclusion issues.
- Establish formal provisions for screening individuals functioning as surrogates for PCA program consumers.
- Either enforce existing statutory requirements for performance of CORI checks by entities providing PCA and human service direct-care worker referral services, or seek modification of statutory language if such mandates are believed to be inappropriate.
- Integrate key screening information systems into post-screening service monitoring and quality assurance systems. Although the US DOJ guidelines were developed prior to the widespread implementation of consumer-directed services and do not adequately address issues of service-monitoring arrangements for services in which direct-care workers are employees of consumers rather than organizations, many of the DOJ guidelines remain appropriate. These include recommendations for use of codes of conduct, policies on reporting and investigation of suspected abuse and neglect, education and training on prevention and identification of abuse, use of ongoing monitoring, and periodic updating of screening information for program participants. In instances where consumers with surrogates are the employers and recipients of screening information, it may be desirable to also make the information available to program contractors for risk-assessment and service-monitoring purposes. Although abuse and neglect issues may have been less of a concern in prior periods in which the vast majority of program consumers were able to manage problems themselves or self-report them to others, changing program demographics warrant a reassessment of arrangements with flexible provisions designed

to meet the needs and preferences of the program's diverse consumer base without intruding on or impairing consumer choice and control.

**c. Enhancements Could Be Made to Better Meet the Needs of Consumers for Assistance in Training Their PCAs and to Ensure That Appropriately Pre-Trained PCAs Are Available through Emergency, Backup, and Referral Attendant Registry Systems**

A key feature contributing to the success of consumer-directed PCA programs is the flexibility to meet individual needs in the manner desired by the consumer. This feature has been recognized at the national level and federal officials have refrained from establishing detailed training requirements for state plan Medicaid PCA programs. Training of attendants in the Massachusetts PCA program has been entirely the responsibility of the consumer or the consumer's surrogate, with "train the trainer" assistance provided by PCM contractors on an as-needed basis. Some consumers require little or no training assistance from PCM agencies, some rely on existing PCAs to assist in training new PCAs, some rely on their surrogates, and some rely extensively on PCM agency Skills Trainers for assistance. Assistance can be infrequent or minimal for ongoing consumers with relatively uncomplicated care needs or those with stable PCA employee arrangements. For new consumers or those with cognitive impairments, complicated or changing care needs, or those facing significant PCA turnover issues, extensive PCM assistance may be required. However, as the Massachusetts PCA program has expanded over the years to serve individuals with cognitive impairments, more frail elders, children, and consumers with complex multi-disability issues, concerns have been raised regarding the adequacy of existing Massachusetts training arrangements and PCM contractor resources available to assist consumers in training their PCAs. Factors such as increased PCA turnover rates associated with wage and benefit issues can also increase training burdens and problems involving the need to rely on inadequately trained backup caregivers. Another concern raised by consumer advocates with whom we spoke was the lack of training documents, such as guides and manuals, that the PCA program makes available to consumers. In comparison, we found of such resources were available in states such as Missouri<sup>26</sup>, Pennsylvania, Arkansas, and Texas. It was also suggested to us by consumer advocates that the Massachusetts PCA program could benefit from the development of a more formal training program to be

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<sup>26</sup> For an example of a resource developed primarily for consumers with spinal cord injuries, see "Enhancing Independence – A Personal Attendant Training Manual," developed in collaboration with the University of Missouri – Columbia, School of Health Professionals by Services for Independent Living, Inc., an Independent Living Center in Columbia, Missouri.



offered without charge for voluntary use by consumers and PCAs, particularly where PCAs may participate in the on-call backup service registry system to be developed by the PCA Quality Home Care Workforce Council. A training program might cover topics such as:

- Cardio-pulmonary resuscitation (CPR) and other first aid/emergency response activity,
- Infection control,
- Body mechanics and transfer/injury prevention techniques,
- Program requirements and procedures, and
- Disability awareness and independent living/consumer choice and control principles, issues, and resources.

We found that similar training approaches have been used in a number of other states; however, we were also cautioned that, in addition to raising program costs, excessive use of formalized training approaches can adversely affect consumer direction in which PCAs may need to “unlearn” generic standardized practices inconsistent with the needs and desires of consumer employers.

### ***Recommendation***

Section 30(b) of the enabling legislation for the PCA Quality Home Care Workforce Council (Chapter 268 of the Acts of 2006) calls for the Council to identify, improve, and coordinate training resources as well as PCA recruitment and referral resources for the program. Subsequent to the completion of our audit work in March 2008, the Council moved to partially address training issues by establishing PCA “scholarships” for two one-day CPR training sessions conducted in two locations in the state during August 2008. However, financial resources under the control of the Council are extremely limited and, as discussed in Audit Result No. 4 on PCM pricing issues, pricing changes are needed to ensure that adequate PCM resources are available to carry out program activities including the provision of adequate flexible assistance to consumers regarding individual PCA training needs. Under the direction of the Workforce Council, Massachusetts Medicaid should allocate additional resources to coordinate statewide activity to develop and provide access to training materials and activities for consumers and their PCAs. We believe the Council and EOHHS should consider establishing an ongoing consumer-directed system for providing standardized

“PCA 101” training as described above. Information regarding the training status of individual PCAs should be incorporated into the PCA registry and referral system also being developed by the Council.

**d. Better Arrangements Are Needed to Provide Backup PCA Services and to Ensure the Safety of Consumers During Public Emergencies**

In October 2006, the AARP Public Policy Institute issued a report entitled “Bridging the Gaps: State and Local Strategies for Ensuring Backup Personal Care Services.” During January 2005, the Institute sent a written survey to state officials in all 50 states who were responsible for personal care service programs. Although Massachusetts did not respond to this survey, 38 of the 50 states responded with information regarding what they do in terms of backup management systems for PCA services. According to this report, “Ensuring backup service should be a required component of any state’s oversight responsibility for publicly financed home and community-based services...”

Backup and emergency service arrangements have also been identified as an issue in Massachusetts and the Legislature has empowered the PCA Quality Home Care Workforce Council to establish a statewide PCA worker registry system to facilitate both PCA recruitment and backup service needs of consumers. We examined these issues as part of our audit to assess the adequacy of both past arrangements and planned improvements and, based on our examination, noted the following:

The current contracts that the Commonwealth enters into with PCM agencies only address the emergency/backup PCA service issue in a cursory manner. Specifically, each PCM contractor is responsible for developing their own internal operational contingency plans for advising and assisting consumers in developing their own personal arrangements for how to deal with emergencies and for situations in which PCAs may fail to show up for work. However, these arrangements have been inadequate for reasons such as the absence of an effective statewide PCA registry and the fact that Massachusetts has, until now, focused on PCA emergency and backup service needs at the level of individual consumers. The program requires individual consumers to develop their own emergency and backup service arrangements without establishing system-wide measures other than a little-used provision for approval of substitute emergency services by home health agencies. The availability of

that emergency home health agency system appears not to have been broadly advertised to consumers and Medicaid managers have closely monitored utilization and discouraged use of those arrangements due to the significantly higher costs of providing personal care through home health agencies and perceived abuses in which Medicaid managers assert some consumers have inappropriately relied on the home health agency services for extended periods. Although PCM contractors are required to assist consumers through the Skills Training process in developing individual backup service plans, the program itself has not made arrangements to facilitate individual backup service arrangements such as expediting or authorizing retroactive Fiscal Intermediary enrollment and payment arrangements for emergency caregivers not already PCAs for the consumer. We found that, although not required by contract, we found that some PCM agencies have attempted to establish area-based PCA registries to at least advise consumers of the potential availability of individuals for PCA work. For example, the Center For Living and Working, located in Worcester, maintains a "PCA Pool List" of approximately 200 PCAs, providing information on PCA names and telephone numbers, availability information, and whether the PCA has a car and is able to do lifting (e.g., to transfer a consumer between bed and wheelchair). We learned that a similar effort to develop a registry in the Boston area had been made several years ago but had been unsuccessful due to issues such as inadequate resources needed to maintain the system. Massachusetts Medicaid has indirectly provided support along with that received from Medicaid agencies in several other states as well as from DMR and some of its contracted providers for an Internet-based direct care workforce registry operated by a nonprofit entity in association with two for-profit entities. However, that registry system charges consumers and the consumer input we received during our audit suggested that this service alone has not adequately met PCA consumers' needs due to issues such as apparently outdated listings. As documented by the AARP survey and similar reports, statewide registry and backup service arrangements have been established or are under development in at least a dozen states and considerable work has already been done on identifying best practices, such as the importance of multiple forms of access other than through the Internet, provision of information without charge to consumers, the specific information that should be presented, use of on-call worker pool arrangements with guaranteed response times, and monitoring to ensure the timeliness and quality of backup service delivery.

Although individually developed emergency/backup service plans and registry/pool arrangements are designed to meet the routine emergency/backup service needs of individual consumers, national studies, including one specific to Hurricane Katrina, also indicate the need for comprehensive planning, communication, coordination, and response arrangements covering services to PCA consumers in order to ensure that evacuation/shelter-in-place and other needs are adequately addressed in times of disaster or other public emergencies. For example, a comprehensive plan would address such questions as how a PCA is to be identified as emergency personnel with the need to reach an assigned consumer in the event of a disaster in which transportation problems arise or travel restrictions are imposed by authorities. Further, it is unclear how authorities will even know where consumers are located in the community and which ones may require emergency assistance/monitoring. To date, disaster response planning related to the PCA program has been focused on prompting individual consumers to develop personal disaster response plans. Although individual planning is important, it may not be sufficient to ensure the system-wide safety of consumers in the PCA program. We believe that it may be more effective to address this issue on a statewide programmatic basis. Consumer advocates with whom we spoke during our audit stated that the Massachusetts Statewide Independent Living Council and the Massachusetts Office on Disability have been working to address disability-related statewide disaster response issues at least since September 2006. However, arrangements are far from complete and, as asserted by both advocates and officials in other states, the challenges of developing state-wide emergency response arrangements are complex and require that significant resources be devoted to deliver adequate assistance to PCA consumers and other individuals living in the community with disabilities.

***Recommendation***

EOHHS and the PCA Quality Home Care Workforce Council should, in addition to implementing the planned PCA registry, consider devoting resources to planning and implementing additional statewide arrangements such as direct care worker pools with response time guarantees to meet the needs of many individual consumers, and to work with other public agencies as needed to better prepare the Commonwealth to assist those with disabilities in the event of public emergencies.

**e. Program Services Should Be Broadened to Include Cueing and Supervision, Appropriate Health Care Tasks, and Enhanced Case-Management Services**

The effective provision of assistance to persons with significant disabilities who reside in the community often requires the delivery of a wide array of services, including housing assistance, medical care, and other services needed to supplement personal care services. Although not all of those services are federally reimbursable through Medicaid, federal standards afford states considerable latitude in defining the scope of activity to be included in PCA services. Massachusetts Medicaid officials have elected to exclude a variety of activities from the state's PCA program that are permissible under federal policy. One of the most notable exclusions is cueing/supervision (providing a prompt or direction to assist a person in performing an activity) assistance. Although many consumers require no cueing or supervision assistance, such assistance has been identified as crucial for groups such as individuals with certain mental illnesses, various developmental disabilities such as autism spectrum disorders, and brain injuries, strokes, and Alzheimer's disease or other forms of dementia. PCA program advocates with whom we spoke stated that the prohibition on cueing and supervision assistance in Massachusetts has, in their opinion, resulted in the underutilization of PCA services by certain groups. According to national surveys, at least 50% of state plan PCA programs and 70% of waiver-based PCA programs across the nation now permit and even promote the provision of cueing and supervision assistance.

In 1999, the U.S. Supreme Court issued its judgment on the case of *Olmstead v. L.C.*, which was brought against the Georgia State Commissioner of Human Resources on behalf of two women with developmental disabilities. The ruling by the court provided clarification as to how states should comply with Title II of the Americans with Disabilities Act (ADA). Specifically, it recommended that states should consider developing "Olmstead Plans" that would increase community-based services and reduce institutionalization for individuals receiving Medicaid services. The EOHHS response to the *Olmstead* decision included formation of an *Olmstead* Advisory Group and various subcommittees. In 2002, recommendations were issued for enhancements to the PCA program. Included in the report of the Subcommittee on Community Services and Support was the recommendation that "eligibility must include people with disabilities who need prompting and cueing in order to complete activities of daily living, or personal safety supervision for those with a

surrogate.”<sup>27</sup> Unlike the majority of states that have moved to cover cueing/supervision services, Massachusetts Medicaid has never implemented the recommendation made by the Subcommittee. Medicaid managers and advocates stated that the PCA program did not implement the Olmstead Advisory Group subcommittee recommendations because Medicaid considered cueing and supervision coverage to be a “budget buster.” For example, during the 184<sup>th</sup> legislative session (2005-2006), Medicaid opposed passage of Senate Bill 132, which would have required such coverage, asserting to the Senate Committee on Ways and Means that:

*Cueing and supervision are not currently part of the services under the Personal Care Attendant (PCA) program. Cueing is verbal instruction to help members initiate an activity, for example “brush your teeth.” The cost of expanding PCA services to include cueing and supervision may be cost-prohibitive...*

*PCA currently serves 13,000 members and costs roughly \$250 million annually. This legislation would open the program to chronically disabled persons who would only require cueing or supervision including persons with mental retardation, mental illness, autism, elder persons with dementia or Alzheimer’s. This change to PCA will increase both the number of persons receiving services and the extensiveness of covered services. Although data sources are unavailable to make any sort of precise estimate, program staff estimate the increase in individuals receiving services will be in the range of 25 percent to 50 percent based on their experiences with the target population. The size of this estimate is partially accounted for by the expectation that persons with brain injuries requiring cueing and supervision would transition much more slowly, if ever, out of the Transitional Living Program. In addition, based on their knowledge of the extensiveness of cueing and supervision services, program staff estimate that adding cueing and supervision as covered services would increase the total provision of covered services per enrolled beneficiary by 25 to 50%. In combination, these two factors will result in a 50% (best case) to 100% (worst case) increase in MassHealth costs. In the best case scenario, the program would add 3,250 members at a cost of \$62.5 million/year (\$19,230 average annual cost) and also increase service costs the same amount for an overall estimated annual cost of \$125 million. In the worst case scenario, program enrollment increases by 50%, or 6,500 members, and service expenditures increase a like amount, leading to an overall annual cost increase of \$250 million.*

Although we were not able to identify any comparative studies on the costs, benefits, and participation impacts of providing coverage in other states, available data on overall per

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<sup>27</sup>As reported by the hcbs.org Clearinghouse for the Community Living Exchange Collaborative, disability advocates, in general, were unhappy with the state plan. As a result, the People’s Olmstead Plan, spearheaded by the Massachusetts Statewide Independent Living Council and others, was published in January 2003 to be used as a tool and resource in the construction of a Massachusetts Olmstead plan. It is located at <http://www.masile.org/docs/peoples.html>. Both documents include the quoted recommendation as well as other recommendations pertaining to the PCA program and related services that continue to be outstanding issues over five years later such as failure to pay for surrogate and case-management activities, inadequate compensation rates for the program, excessive delays in processing prior authorization requests, and inadequate coordination with supportive living and other related services, etc.

consumer personal care service expenditures across the nation indicate that per consumer costs appear not to be driven upwards by 25 to 50% per enrollee, as asserted in Medicaid's response to the Legislature. For example, the Medicaid Personal Care Expenditure per person served in 2002 for the state of New York was only \$18,010 – an amount comparable to the \$17,778<sup>28</sup> reported for Massachusetts - even though much of New York's population lives in high cost-of-living areas and New York Medicaid covers cueing and supervision. If Medicaid's assertions that cueing and supervision coverage would result in a 25 to 50% increase in expenditure per consumer are correct, the change would raise the 2002 Massachusetts average from \$17,778 per consumer to between \$22,222 and \$26,667 per consumer – an improbable average that would be substantially higher than New York or any other state in the nation. Also, it appears doubtful that the majority of PCA programs across the nation would have included cueing/supervision as a covered service if they had determined that such coverage was not cost-effective.

Similarly, national policy literature such as the 1999 Robert Wood Johnson Foundation Report of the National Blue Ribbon Panel on Personal Assistance Services has long advocated the use of PCAs to perform certain health care tasks traditionally performed by health care personnel or by able-bodied persons for themselves. Such activity has historically been prohibited on a de facto basis in the Massachusetts program despite assertions by advocates and even Medicaid's own Hearings Board that Medicaid staff have erroneously characterized PCA performance of certain health care tasks as illegal<sup>29</sup>. Although the issue is complicated by interpretation of state Nurse Practice Act provisions, advocates and personal care service managers in other states stress the benefits of including a broad range of health care tasks in the scope of permitted PCA activity so long as appropriate technical assistance and oversight are available. A former Medical Director for the Massachusetts Medicaid office, who now directs a Senior Care Options service program that makes extensive use of PCAs used by consumers with appropriate assistance from the program's nurse case managers, also emphasized the benefits of these arrangements to us, noting the often

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<sup>28</sup> Figures as reported by the AARP Public Policy Institute 2006 edition of Across The States, Profiles of Long-Term Care and Independent Living, State Data and Rankings Supplement. Available at: [http://assets.aarp.org/rgcenter/health/d18763\\_2006\\_ats\\_rankings.pdf](http://assets.aarp.org/rgcenter/health/d18763_2006_ats_rankings.pdf). The \$17,778 figure stated for Massachusetts, which is reportedly derived from Medicaid data reported to CMS, conflicts with the \$19,454 figure appearing in the table on page 12 of this report, as reported to us by Medicaid managers, and presents yet another example of the unresolved questions regarding the accuracy of data provided by Massachusetts Medicaid program managers.

<sup>29</sup> See Audit Result No. 2 regarding Prior Authorization issues.

problematic aspects of attempting to address consumer needs and coordinate service activity using multiple agency-directed care providers (e.g., home health care/VNA staff) on a long-term basis.

In addition to cueing/supervision and delegated health care services, national policy study literature available through organizations such as the Center for Personal Assistance Services and the National Clearinghouse on the Direct Care Workforce stresses the importance of service coordination or case-management activity in ensuring that necessary resources needed to supplement PCA services are effectively and efficiently made available for PCA program participants. Some Massachusetts PCA program consumer populations, such as individuals receiving services from DMR or the Massachusetts Rehabilitation Council (MRC), may have adequate case-management arrangements in place and many other consumers may not need or desire case-management assistance. However, consumer advocates with whom we spoke stated that there are increasing numbers of consumers who need and desire such services, particularly since Massachusetts Medicaid has not elected to offer comprehensive case-management services on an across-the-board basis to all consumers with disabilities, but has instead elected to target these services for certain populations such as children under the protection of the state's Department of Children and Families. Although narrowly defined case-management-type activities such as Skills Training are included as an integral part of Personal Care Service and some other Medicaid program options, the Center for Medicare and Medicaid Services (CMS) also recognizes and funds a distinct freestanding Targeted Case Management service option including services that will "assist individuals eligible under the State plan in gaining access to medical, social, educational, and other services." Although the term "Targeted Case Management" remains in use as the result of original CMS provisions for targeting case-management activities to certain populations, Medicaid laws were actually amended under the Tax Reform Act of 1986 to permit states to provide more general non-targeted case-management services. Medicaid-funded case-management activities may now be provided on both a targeted and non-targeted basis. The federally permitted scope of case-management services is substantially broader than the limited activities carried out by Skills Trainers and other PCM agency staff as authorized by Massachusetts Medicaid officials. Federal rules permit reimbursement for a broad scope of activity such as planning, coordinating, and monitoring



person-centered services received by Medicaid-eligible individuals across multiple Medicaid and non-Medicaid-funded services, such as housing, education, transportation, and other services, so long as case-management payments available from other funding sources are not duplicated. Yet PCM contractors here are not permitted to bill for case-management activity beyond the narrow definitions established by Massachusetts Medicaid regulations and contract language for “Intake & Orientation” and “Skills Training.” Although PCM contractors often play an important role in linking PCA consumers to appropriate case-management resources external to the PCA program, whether operated through separate programs run by the same nonprofit agency or by other state or private agencies, case-management activities for PCAs and other community-based services in Massachusetts remain largely fragmented, varying significantly in philosophy, scope, resources, and other respects across programs and consumer populations.

We noted different characterizations by interviewees of the enhancements needed to promote successful programming, reflecting a variety of philosophies and viewpoints. Professionals often refer to the need for expanded “case management,” “care management,” or “service coordination.” Others use such terms as “supports brokers,” “consultants,” or “counselors” (terms often used in conjunction with “cash and counseling” personal care services in order to emphasize the primary decision-making role of the consumer rather than the manager/coordinator), or describe a need for “peer support” and paid “advocates,” or as one PCM agency manager stated, “allies” to assist consumers.<sup>30</sup> Regardless of the terms used, there was wide agreement that, in addition to the need for better case-management arrangements for dealing with consumer direct-program service issues, improvements are also needed as a practical matter to help consumers negotiate a complicated system of PCA and independent living-related support services with conflicting eligibility requirements and service options. Although the CMS Case Management state plan option represents one approach to addressing these issues, we noted that the parameters of that option were in flux

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<sup>30</sup> Newly promulgated CMS regulations governing the operation of cash and counseling type personal assistance services operated under provisions of the Deficit Reduction Act of 2005, draw a distinction between the traditional use of the term “case management” and more appropriate alternative terms due to fundamental differences in the relationship and assistance provided by individuals who are agents of consumers and primarily responsible for facilitating consumer needs in a manner that comports with consumer preferences. In fact, in comments accompanying the new cash and counseling service regulations, which is separate from the Case Management regulations, CMS asserts that traditional case managers can perform in this new role “only if they receive training in the self-directed service delivery model that includes a demonstrated capacity to understand that they are to assist the participants with fulfilling their preferences, and not supplant the participant’s preferences with their views or preferences.”

at the time our audit work was completed. In December 2007, CMS published a 17-page “interim final rule” for comment prior to a planned March 2008 implementation of changes proposed for Medicaid-funded optional state plan case-management services. The proposed rules are complex and, while offering increased flexibility in some areas and reinforcing principles of consumer choice and control, use of person-centered planning approaches, and comprehensive need assessments, significant constraints also were established, including the exclusion of activity such as eligibility determinations and outreach from the scope of state plan option case-management services and prohibitions on various administrative arrangements including use of so-called “bundled” or per-person-per-month reimbursement mechanisms such as those currently used for certain PCA program contract services as described in Audit Result No. 4 on pricing mechanisms. Although some of the proposed changes received significant praise during the regulatory comment period, extensive criticisms were presented by multiple states and national advocacy organizations, which also initiated efforts to block or modify the policy changes through litigation and proposed federal legislation.

***Recommendation***

The current prohibition on cueing/supervision assistance and the de facto restrictions on PCA assistance with various health needs should be examined by EOHHS/Medicaid, the PCA Quality Home Care Workforce Council, and consumer and legal advocates, with input from other knowledgeable parties regarding issues such as the experience of other PCA and related programs around the nation in expanding the scope of activity permitted for PCAs. A comprehensive analysis of the financial and programmatic impact of providing cueing and supervision assistance through the PCA program should be conducted. Program regulations and policies and, if necessary, Nurse Practice Act provisions should also be modified to provide clear guidance on the scope of permitted activities and any special requirements warranted for particular types of medical assistance. The Massachusetts program is long overdue for nationally recognized reforms expanding the scope of assistance provided by consumer-directed PCAs.

Adoption of a Medicaid Case Management state plan option approach to serve all PCA program consumers may or may not be a desirable approach compared to other options

such as expanding the scope of case-management activities conducted by PCM contractors. However, we believe there is both the need and opportunity for significant enhancements in case-management services to PCA program consumers. The issue should be included in discussions between the Commonwealth, service providers, and consumer advocates.

**f. PCA Program Outreach Activities Could Be Improved**

The Commonwealth's contracts with PCM agencies do not specifically address the PCM agency's role in outreach and service coordination activities. Further, the PCM contract reimbursement system established by the Commonwealth provides no mechanism for reimbursing PCM agencies for conducting outreach activities. PCA and related independent living program outreach activities have commonly been identified as an important success factor in many other states. In fact, federal standards for Independent Living Centers (ILCs) expressly call for "aggressive outreach" activity. In Massachusetts, PCM contractors play a key role in program outreach and in coordinating PCA program activity with other service resources despite the failure of contract provisions to address these matters. However, our review of contractor financial filings and our interviews with consumer advocates and PCM contractors indicate that PCA program outreach activities are generally conducted on a voluntary basis by PCM agencies, using charitable donations and other resources to carry out outreach activity that they regard as essential to their organizational mission. In contrast, other states have established more formal outreach arrangements as part of their PCA programs or have established informal arrangements to promote outreach activities. For example, in Kansas, program outreach efforts targeted at reaching residents of nursing homes to inform them of PCA services and related independent living options have been informally established between the state and Independent Living Centers participating in the PCA program. Under these arrangements, Kansas state employees accompany ILC representatives to long-term care facilities to ensure that the facilities provide residents access to outreach activities. Other states have prepared and widely distributed user-friendly public information materials offering single-package comprehensive descriptions of all available personal assistance and related home- and community-based service options and how to access them. Even Georgia, which has only recently moved to implement PCA services, has far more informative and user-friendly program outreach materials than Massachusetts. The state of Washington has published a 24-page consumer guide to that

state's Medicaid-funded long-term care service options, which is available in eight different languages<sup>31</sup>. Yet in Massachusetts, reference to the availability of PCA services on EOHHS/EOEA/Medicaid internet sites and in public informational materials on community-based long-term care services is minimal and fragmented compared to information available in other states such as Connecticut, which has a consolidated information site devoted to long-term care options with information on available service and support options, including PCA and other in-home care services, and how to access them. PCM contractors and consumer advocates with whom we spoke stated that most Massachusetts consumers learn of the availability of PCA services by "word-of-mouth" from existing consumer participants in the program rather than through state-sponsored outreach efforts.

***Recommendation***

EOHHS should work in close cooperation with PCM agencies, waiver service providers, consumer advocates, and a broad spectrum of state and local agencies and nonprofit groups to enhance outreach activities needed to ensure widespread familiarity by individuals with disabilities and their family members, health care and other service professionals, clergy and others, as well as the public at large, with PCA and related community living support service options. Targeted efforts are also needed to address the needs of currently under-served populations such as elders, children, and individuals for whom changes in the program's service scope, such as the inclusion of cueing and supervision or broad-based case-management tasks, might make it a more viable alternative to institutional care or to existing community service options. The Massachusetts PCA program should place greater emphasis on widespread use of the PCA program and related services. Extensive outreach activities are needed if such rebalancing initiatives are to succeed.

**g. Long-Term Care Services Should Be Rebalanced by Redirecting Institutional Funding to PCA and Related Community-Based Services**

Decades of research by governmental and private organizations has established that long-term care programming has disproportionately been composed of nursing home and related institutional care and that resources and services need to be "rebalanced" to provide greater

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<sup>31</sup> The English language version is available at <http://www1.dshs.wa.gov/pdf/Publications/22-619.pdf>.

emphasis on PCA and other home and community-based services. It has been demonstrated that personal care and related community-based programs are more effective when programs are flexible and provide multiple service options to consumers, and where consumers are permitted to plan and control service arrangements. Further, such arrangements result in increased consumer satisfaction, particularly when consumers are allowed to design and control service arrangements within the widest parameters permissible under federal statutes and regulations. Federal CMS officials have endorsed this philosophy and encourage states in this direction<sup>32</sup>, going so far as to make it clear that traditional state program development/planning approaches in which services are planned and controlled by professional staff with consumer participation limited to input or advisory roles are inadequate.

The Massachusetts PCA program has historically been a national leader in consumer-directed services. However, for many years the Commonwealth has apparently attempted to contain PCA program growth, whereas other states have proactively expanded their programs as effective alternatives to institutional care. As noted in the Background section of this report, personal care service participation rates are lower and institutional care per-capita and expenditure statistics in Massachusetts are higher compared to other states with more balanced long-term care arrangements. For example, nationally, 50% of all Medicaid long-term care expenditures are for nursing facilities, whereas the Massachusetts percentage is 55% (2005 data as reported by the AARP Public Policy Institute). Among states identified as leaders in the provision of personal care and other community-based long-term care service alternatives, the nursing home expenditure rates run as low as 30% (e.g., Oregon and New Mexico, with 35% for Washington and 39% for California). Other data indicates that the rebalancing progress has been even slower in Massachusetts when it comes to targeting Medicaid expenditures for personal care and related community-based services to elders. One CMS-funded systems change study<sup>33</sup> indicates that Massachusetts has only devoted 13% of its long-term care expenditures for persons over age 65 to community-based services, a

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<sup>32</sup> CMS has funded extensive research on these issues and posted numerous reports on its Internet site. Just one example of CMS-sponsored research on some of these issues is a 2006 report: *Medicaid Home and Community-Based Services for Older People and Persons with Physical Disabilities: Beneficiary Satisfaction, Service Use and Expenditures*.

<sup>33</sup> *Design of Evaluation Options of the System Change Grants* (December 2006), prepared for CMS by RTI International and available at the CMS Internet site: <http://www.cms.hhs.gov/Reports/downloads/Walsh.pdf>.

percentage far lower than in states such as the above-identified national leaders, which have reported percentages ranging from 27% for Washington to 51% for Oregon. The CMS funded study's statistic is just the percentage for Medicaid community-based long-term care expenditures for individuals over age 65, rather than the overall percentages for all care types and age groups. Accordingly, although nursing facility expenditures account for 50% of all national Medicaid long-term care expenditures, they account for an even higher percentage of Medicaid long-term care expenditures for elders. The national average of Medicaid long-term care funding for persons over age 65 that is devoted to community-based services is approximately 22%; accordingly, the Massachusetts average of 13% is less than 60% of the national average. For individuals under age 65, Massachusetts is somewhat above average, devoting 71% of long-term care expenditures to community-based services. However, that percentage is attributable primarily to Medicaid DMR waiver expenditures described in the Introduction to our report, rather than to PCA service expenditures. And even for the under-65 age group, Massachusetts falls behind 13 other states with percentages as high as 97% in Vermont. These statistics indicate that although Massachusetts has made significant rebalancing progress regarding services to DMR clients, progress has lagged for other population groups.

From the late 1990s through 2003, PCA program participation increased primarily due to enrollment of the DMR consumers. The rapid growth reported for the program over the last decade in fact appears to be essentially a phenomenon of catching up with other states, with elders now supplanting DMR consumers as the driving growth population. According to Medicaid Prior Authorization Unit monthly report data, 36% of new consumers entering the program in July 2006 were over age 70, compared to a percentage of only 19% for consumers whose annual reevaluations were processed that month, suggesting a significant increase in participation over the course of that year. Despite these positive case-mix changes, data for fiscal years 2005 through 2007 suggests that overall program growth rates are now leveling off. The slower increase in program participation, which could be regarded as good news in terms of cost containment, should actually be a matter of concern in light of the continuing out-of-balance characteristics of the Commonwealth's long-term care system. For example, in 2000, California had already reached the point where over 75% of its PCA program consumers were elders over age 65. By 2005, California ranked sixth in the nation

in rebalancing efforts as measured by the reduced percentage of Medicaid funds expended on nursing facilities. The size and scope of the PCA program and related community-based long-term care services in Massachusetts remains modest compared to states now recognized as leaders in rebalancing their long-term care systems.

The above-referenced CMS-funded systems change study used statistical research techniques and analysis of CMS datasets to evaluate questions such as whether community-based systems can support consumers with higher levels of impairment in the community, whether rebalancing or reform efforts result in higher rates of discharge from nursing facilities to the community, and whether observed changes over time in measures such as discharge rates and levels of impairment are statistically associated with system reforms. The study reports that even individuals with high levels of impairment can be supported in the community, that rebalancing and reform efforts increase discharge rates from nursing facilities to the community, and that improvements observed over time are statistically associated with reform initiatives. Notably, the study identified a significant relationship between Medicaid community discharge rates and the number of nursing facility beds per 1,000 elders. Higher state bed numbers per 1,000 elders are associated with lower community discharge rates. The study also documented that:

*Nationally, 55% of the sample residents under age 65 and 41% of those over age 65 expressed the desire to go home when they were admitted to the nursing facility. Thirty-eight percent of the younger group and 29% of the older group both wish to go home and had the support of another person for returning to the community. Facility staff evaluated 60% of the younger group and 44% of the older group as potentially able to return to the community. ... In summary we see that even as ADL impairment levels are increasing in the facility sample, there is an increase in the desire, support and perceived potential to return to the community.*

In reviewing this data, we noted that the Massachusetts' statistic of 55.4 nursing facility beds per 1,000 elders is unusually high. We calculated a national rank of 14 for Massachusetts on that measure. In contrast, Washington, Oregon, New Mexico, and California, four states nationally noted for their PCA and community-based service reform activities, all ranked at least 41 or greater. Those four had between just 25.3 and 32.1 facility beds per 1,000 elders and also had significantly lower nursing facility Medicaid expenditure shares as reported above. All four also had higher rates of discharge to the community than did Massachusetts for consumers age 65 and above (ranging from 23.6% to 31.3%, compared to 17.5% for

Massachusetts and a nationwide average of 20.7%). A number of additional states such as Vermont, Maine, New York, Texas, and Alaska, all noted for various PCA community-based service and rebalancing reforms, compared favorably to Massachusetts in the Medicaid community-based service expenditure share, discharge rate, and beds per 1,000 elder statistics reported by the study for consumers over age 65. Massachusetts has a community discharge rate of 53.4% for consumers under age 65, slightly above the national average of 49.2%. However, expenditures for those under age 65 may be attributable to extensive discharge placement activity for individuals covered by consent decrees primarily involving clients of the Department of Mental Retardation.

Consumer advocates with whom we spoke stated that they believe greater rebalancing efforts are warranted, both to address the needs and desires of consumers and to minimize the financial burden on the Commonwealth associated with the rapidly escalating nursing home per-diem rate trends referenced in Audit Result No. 1 on PCA compensation issues. Medicaid's own projections indicate that per member per month average nursing facility costs will increase by 42.2% from fiscal year 2008 through fiscal year 2013 – a rate of increase far above historical rates for the PCA program and other non-medical community-based services. Consequently, it is prudent to vigorously pursue proven community-based long-term care rebalancing and reform approaches so long as nursing facility cost inflation rates substantially exceed rates for alternative community-based services and society continues to value consumer desires and the sometimes intangible quality-of-life benefits associated with independent living.<sup>34</sup>

In addition to the above-referenced CMS-funded study, we noted another national study on the “Prospects For Transferring Nursing Home Residents To the Community” reported in the journal *Health Affairs*<sup>35</sup>, which analyzed available CMS data for fiscal year 2005 and confirmed that “thousands of elderly Americans could live in the community, with proper

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<sup>34</sup> We do not assert that the costs of maintaining consumers in the community are inherently lower than costs that would be incurred by institutional care. As some advocates acknowledge, lifetime costs may actually be higher for some individuals due to the fact that average life expectancies may be significantly extended when individuals are served in the community rather than in institutions. Other factors such as indirect costs and benefits of economic productivity changes also complicate such analyses, as do the significant societal value judgments involved. An evaluation of the reasonableness of CMS budget neutrality waiver requirements and calculation methodologies is beyond the scope of our audit.

<sup>35</sup> *Health Affairs*, 26, no. 6 (2007): 1762-1771 DOI: 10.1377/hlthaff.26.6.1762; available at: <http://content.healthaffairs.org/cgi/content/full/26/6/1762>.



supports, rather than in the nursing homes they now live in.” That study found that, using broad yet still conservative definitions of “low care”<sup>36</sup> that exclude many individuals with care needs that are not as high as those of many people who still live successfully in the community with appropriate supports, an estimated 11.8% of current long-stay nursing facility residents across the nation are “low care.” Although that estimate is significantly lower than the data quoted above from the other CMS-funded study, the results are not necessarily in conflict, as the second study states:

*We acknowledge that many people with more substantial care needs can, and do, live in the community with appropriate formal and informal supports, which means that both our broad and narrow definitions of low care are necessarily conservative.*

The estimated “broad definition” percentage of low care residents reported for Massachusetts was 10.6% of the state’s 46,423 long-stay nursing home residents covered by the data set. The study also reported that 9,210 (25.7%) of 35,818 total new nursing home admissions in Massachusetts that year became long-stay residents (i.e., residing in a facility for at least three months). Although the data for Massachusetts was somewhat better than national averages, the study highlighted the relative success of states such as Oregon, Washington, Vermont, and Maine, which the study noted had been previously credited with effectively rebalancing their long-term care systems. In those and other states, percentages of “low care” long-stay nursing home residents are lower than in Massachusetts. Also, smaller percentages of newly admitted persons become long-stay residents in three out of the four states, and the percentages of those becoming long-stay residents who are classified as “low care” are uniformly lower than in Massachusetts. An extract of this data appears in the following table:

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<sup>36</sup> The study applied two definitions of “low care,” a broad but still conservative definition requiring that a nursing facility resident “does not require physical assistance in any of the four late-loss ADLs – bed mobility, transferring, using the toilet, and eating – and is not classified in either the “Special Rehab” or “Clinically Complex” Resource Utilization Group (RUG-III) group,” and an even narrower definition. While the study presents data and results using both definitions, our audit analysis uses the study’s data based on the broader definition.

**Selected Data on the Prevalence of “Low Care” Nursing Home Residents by State in 2005 \***

	Massachusetts	Oregon	Vermont	Washington	Maine	US Average
Percent of Long-Stay Residents Who Are Low Care	10.6	9.2	8.4	6.9	1.8	11.8
Percent of New Admissions Becoming Long-Stay	25.7	15.7	29.1	19.4	22.9	26.7
Percentage of Cases Becoming Long-Stay That Are Classified as Low Care.	11.7	10.9	11.1	8.1	2.1	13.5

\*Data derived from the CMS Nursing Home Resident Minimum Data Set, based on the “broad definition” of low care. See Exhibits 1 and 2 of the study at <http://content.healthaffairs.org/cgi/content/full/26/6/1762> for data on all states.

This data suggests that substantial room for improvement exists in Massachusetts. In fact, consumer advocates and PCM contractors with whom we spoke stated that thousands of long-term care facility residents in the Commonwealth have expressed a desire to return to community living situations with PCA and related support services and many are probably capable of doing so successfully if appropriate supports are provided to them. Massachusetts Medicaid managers might fairly point to existing and planned community-based service options other than the PCA program, such as various Medicaid-managed care initiatives for elders and new Community First waiver initiatives as rebalancing measures; however, advocates expressed concern about the lack of consumer control over the design of these initiatives, and excessive reliance on fragmented waiver-based approaches rather than addressing identified issues for the keystone PCA program. Such concerns appear to be consistent with evolving national best-practice advice. For example, a September 2005 study of “Strategies to Keep Consumers Needing Long-Term Care in the Community and out of Nursing Facilities,”<sup>37</sup> which included a review of nursing home diversion and transition initiatives in eight states, including the four states compared to Massachusetts in the above table, identified various characteristics of successful approaches, stating:

*The state Medicaid programs that are most successful at keeping people in the community do not operate separate “transition” or “diversion” programs. Rather*

<sup>37</sup> Prepared by Laura Summer of the Georgetown University Health Policy Institute for the Kaiser Commission on Medicaid and the Uninsured. Available at: <http://www.kff.org/medicaid/7402.cfm>.

*they have made systemic changes to increase the capacity for community-based care, to inform consumers about options for care, and to assist consumers as they make choices about care.*

That study identifies the following consistent themes:

- A philosophical commitment and legislative direction,
- Fast eligibility determinations,
- Making community care available immediately, and
- Procedures to track and manage placements.

***Recommendation***

Based on our Audit Results and national best-practice advice, we recommend that state officials work cooperatively with advocates, independent living service experts, and the Legislature to enhance Massachusetts PCA and related community-based services, with the purposes of rebalancing available resources toward more community-based PCA programs and other consumer-controlled service arrangements. Any reform strategies should be developed with significant direction by advocates and should be focused on the prompt implementation of system-wide changes rather than the implementation of fragmented, freestanding, transition and diversion projects or the small-scale demonstration-type waiver or grant projects that have characterized past systems change activities in the Commonwealth.

A proactive cooperative effort with advocates to enhance and expand existing keystone community-based services such as the PCA program is needed, with an emphasis on more flexible and integrated support systems, expanded outreach, and diversion and transitional assistance arrangements to better meet consumer needs. As an example of options available to improve the flexibility and integration of support systems, we noted that on September 29, 2008, CMS announced a new rule implementing Deficit Reduction Act of 2005 provisions that allow states to modify state plan personal care service options to provide care in ways that previously required waivers of existing Medicaid laws. As a result, it is now possible to offer consumer-directed individual budget (“cash and counseling”) programs as part of regular state plan personal care service programs without obtaining CMS waiver approval so long as the existing state plan PCA services remains available to consumers not

wishing to participate in a cash and counseling model program. Massachusetts now has the option to enhance its existing PCA programs and address issues such as the need to supplement ADL and IADL assistance provided by PCAs with additional independent living supports (other than room and board costs) as an integrated part of the program. This can be done by directly providing additional cash allotments to be used for purposes such as purchasing wheelchair ramps or other items that foster independence; however, EOHHS and consumer advocates would need to closely examine the relative benefits of pursuing this option and the competing need for increased resources required to address PCA wage and other program deficiencies identified by our audit for the existing PCA program.

As our report was being prepared, state officials at the Executive Office of Health and Human Services and Elder Affairs resumed work with disability advocates to develop the Commonwealth's first official Olmstead Plan and announced the plan on September 12, 2008, nine years after the Supreme Court's decision. The administration is to be commended for moving forward with long-neglected rebalancing policy and planning development. Progress in implementing such reforms will require a broad public commitment to a reallocation of long-term care resources currently devoted to institutional care and a commitment to an additional upfront investment in enhancements to present community-based services in order to realize future cost benefits. In the absence of such resource rebalancing, well-documented demographic and institutional care cost trends can reasonably be expected to result in long-term financial pressures on the Commonwealth that could significantly impair community-based service efforts.

## **2. THE PROCESS USED TO AUTHORIZE SERVICES COULD BE IMPROVED TO ENSURE UNIFORM AND EQUITABLE TREATMENT FOR CONSUMERS**

Federal Medicaid law and national best practice policy studies stress the importance of administering services in a manner that is simple, efficient, uniform, equitable, provided on a comparable basis to all eligible individuals (with limited exceptions such as those requiring enhanced services for children), operated in the best interest of consumers, accompanied by appropriate appeal processes, and free of unreasonable delay in accessing services. We reviewed the process used to authorize services for consumers against these standards and identified areas in which this process could be made more efficient. For example, the time required for new consumers to access PCA services in Massachusetts can often take two to three months or

longer, compared to several other states in which services can be accessed in just a few days. We determined that these delays can be attributed to a number of factors, including failure to use state-of-the-art computerized systems for conducting and processing evaluations and prior authorization requests; the lack of comprehensive uniform written policies and procedures; processing backlogs in the Prior Authorization Unit; both formal and informal complicated documentation requirements established by Medicaid; and the failure to expedite processing of high-priority cases such as those involving consumers about to be discharged from hospital, rehabilitation, and nursing facilities, thereby delaying discharge and unnecessarily increasing utilization of expensive in-patient services. Our review also identified aspects of authorization and service arrangements that could be improved to better ensure uniform and equitable treatment and adherence to federal standards applicable to the provision of PCA services to children.

The Massachusetts PCA program relies on a community-based system of contracted independent PCM agency staff to gather eligibility and service need documentation, to conduct face-to-face in-home assessments and evaluations of consumers and their service needs, and to make resulting service recommendations within parameters established by state program regulations. As required by state PCA program standards, PCM agencies use licensed Registered Nurses and Occupational Therapists to conduct the face-to-face evaluations of individuals applying for PCA services. Assessments and evaluations<sup>38</sup> are required to be conducted upon intake for new consumers and periodically thereafter for ongoing consumers – typically on an annual basis. The process results in the PCM agency’s submission of a written request for prior authorization approval by Medicaid for the services to be provided to the individual consumer. These requests are processed through a Prior Authorization Unit operated by Commonwealth Medicine, a division of the University of Massachusetts Medical School (UMMS). Once the request has been submitted by a PCM agency, a desk review of this request is conducted by staff

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<sup>38</sup> Massachusetts Medicaid uses the term “assessment” to refer to a determination of an individual’s ability to manage the PCA program independently (with or without the assistance of a surrogate). This activity occurs as part of the initial intake process prior to a more detailed review of the consumer’s individual assistance needs. The terms “evaluation” and “reevaluation” are used to refer to the determination made by PCM agency professionals regarding the scope and type of PCA services to be provided to the consumer. However, PCA programs in other states often use the terms differently and may refer to the scope and type of service determinations as “assessments” and “reassessments.” In October 2008 CMS promulgated regulations covering implementation of “cash and counseling” type consumer directed personal assistance services using the term “evaluation” for what Massachusetts Medicaid calls an “assessment” and the term “assessment” for what Massachusetts calls an “evaluation.” This report uses the terms as used by Massachusetts Medicaid.

nurses at the Medicaid/UMMS unit, where a determination is made to (a) approve the request as submitted, (b) modify requested service hours, (c) “defer” approval pending submission of additional information, or (d) deny the request. When an approval is issued, information such as consumer identification, reference numbers, approval period duration, and service limits are entered into Medicaid’s separate computerized internal control system, known as REVS.<sup>39</sup> Medicaid provider organizations and contractors use this system to verify eligibility and service authorization status prior to submission of claims to Medicaid for processing. In the case of the PCA program, FIs carry out this verification processing as part of the control process they exercise over PCA payroll payment and Medicaid claims submissions made for reimbursement purposes. UMMS Prior Authorization Unit review activity is carried out at two sites, one located in Auburn, Massachusetts, where requests covering consumers residing in the central and western areas of the state are processed, and one located in Boston, covering the eastern portion of the state. Special separate authorization arrangements have been established for certain consumer populations such as persons with visual impairments, whose requests are processed by PCM contractors through the Massachusetts Commission for the Blind (MCB)<sup>40</sup>. For consumers receiving Transitional Living Services (TLS), the TLS service operator submits requests directly to PCA program managers at the state program office, bypassing both the PCM agency evaluation process and the UMMS Prior Authorization Unit. In addition, supplemental preliminary approval processing is mandated for certain consumers also receiving services from the state’s Department of Mental Retardation (DMR). Additional special processing arrangements have also been established in certain cases such as those involving children seeking both PCA services and in-home skilled nursing services, who are separately evaluated through the Community Case Management program operated by UMMS on Medicaid’s behalf to manage in-home nursing services for eligible children. Except as noted, the prior authorization issues described below apply to the regular prior authorization process, but not necessarily to the other processing variations described above.

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<sup>39</sup> The system, known as the Medicaid Management Information System (MMIS), is operated by Massachusetts Medicaid in accordance with federal CMS standardized data specifications and includes an automated Recipient Eligibility Verification System (REVS) available to Medicaid contractors/providers on a password-restricted basis.

<sup>40</sup> As this audit report was being drafted, plans to consolidate the separate prior authorization processing arrangements for consumers served through MCB into the regular Medicaid approval process were announced as part of “9C” emergency budget reductions proposed during fiscal year 2009.

During our audit, we reviewed available information on various programmatic and administrative aspects of PCA programs across the nation, including a 1999 report issued by the United States Government Accountability Office (Adults with Severe Disabilities Federal and State Approaches for Personal Care and Other Services, HEHS-99-101) and the aforementioned 2006 HHS-OIG report, as well as other summary and state-specific information available on the Internet. Separately, the GAO and HHS-OIG reports include information on both the use of consumer-directed vs. service provider agency-directed service models and information on the use of utilization/cost-control systems such as the prior authorization system used by Massachusetts. In analyzing this national information we noted that, while prior authorization systems are in frequent use, they are typically used by states where, unlike Massachusetts, program models rely on service provider agencies to both evaluate consumer assistance needs and then deliver the PCA services to those consumers. In such circumstances, prior authorization systems have been used as a means of controlling conflict-of-interest situations where service providers have financial incentives to “over assess” consumer service needs. However, that rationale for use of a prior authorization approval system does not usually exist for consumer-directed program models such as the one used in Massachusetts, where independent evaluators assess consumer service needs but services are provided by other parties and the evaluation agency does not stand to gain financially by over-assessing consumers. We noted that states operating consumer-directed programs were far less likely to include prior authorization controls and that, where used, they appeared to be used either by states with hybrid consumer-directed/agency-directed program models or that the “prior authorization” appeared to be simply an expenditure control where the results of the independent evaluation were directly translated into a “prior authorization” limit on PCA services (e.g., a fixed number of dollars or hours per time period) without imposing a case-by-case clinical desk review by state staff or other parties prior to issuance of the service authorization. Some states impose prior authorization controls only when evaluators have recommended high levels of assistance (e.g., over 40 hours per week in Nebraska). In fact, it appeared from our research that Massachusetts may be the only state with a non-hybrid consumer-directed program model that requires a state-operated clinical desk review of professionally conducted evaluation results prior to authorizing any amount of PCA services for program consumers.

Federal Medicaid law 42 United States Code (U.S.C.) § 1396a(a)(8) mandates that each state Medicaid plan “provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals.” Paragraph (3) of the same act requires that each state also “provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness,” and paragraph (19) requires that eligibility for care and services “will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of recipients.” While this federal statute does not provide additional guidance on what constitutes “reasonable promptness” or “simplicity of administration,” Massachusetts has addressed the reasonable promptness requirement through 130 Code of Massachusetts Regulations (CMR) 450.303(A), which states, in part:

*(A) The Division acts on appropriately completed and submitted requests for prior authorization within the following time periods. . . .*

*(4) For durable medical equipment—within 15 calendar days after a request for service.*

*(5) For all other MassHealth services—within 21 calendar days after a request for service.*

Massachusetts classifies PCA services in the generic “all other MassHealth services” 21-day processing category. This 21-day PCA prior authorization request processing timeframe begins from the date that all preliminary intake and evaluation processing has been completed and the PCM agency has submitted a prior authorization request to Medicaid on behalf of the consumer. However, regulations and contract provisions allow for up to 45 days of preliminary intake assessment and evaluation processing at the PCM level before completed prior authorization request materials are submitted to the Prior Authorization Unit. Thus, even if all submission requirements are met and no processing delays arise, Massachusetts Medicaid effectively deems it permissible for cases to routinely take up to 66 days processing time from the date a consumer requests PCA services from the PCM agency to the date of prior authorization approval. Also, as a practical matter, consumers often are not able to recruit and hire PCAs until they receive notification of the number of service hours per week that have been approved for by the Prior Authorization Unit, potentially adding additional post-approval processing time before services can be initiated.



Once an initial prior authorization approval is secured, consumers must typically be re-evaluated annually and secure new prior authorization approvals. Medicaid requires PCM contractors to complete the reevaluations and submit associated prior authorization requests at least 21 days prior to the expiration date of the existing authorization so that the approval process can be completed in a timely manner without service interruption. However, PCM contractors and consumer advocates with whom we spoke told us that it typically takes them at least six to eight weeks to initially assess a consumer's need for PCA services and that therefore delays of up to 90 days from the date a consumer requests PCA services until they actually receive these services are not uncommon.

In a 2003 survey of PCA services in 20 states (not including Massachusetts) conducted by the University of California at Los Angeles (UCLA), the University received input from 10 states claiming to have average processing times that are clearly better than Massachusetts, often reported averaged elapsed periods of two weeks or less between the request for service and the start of service. In fact, with the exception of states reporting delays associated with waiting lists established for waiver-based programs, none of the 20 states that participated in this survey reported longer delays than those claimed to exist for Massachusetts.

During our audit, we attempted to determine whether Medicaid's Prior Authorization Unit was authorizing and/or reauthorizing services within the prescribed 21-day period. In order to do this, we first attempted to analyze July 2006 data maintained by the Prior Authorization Unit's Auburn and Boston offices. However, we found that this data was so inadequate that it was not possible to track the total elapsed days from the date of submission of the PCA service request to the date of decision for at least 44% of the 1,119 cases reported for that month and that for the remaining cases it was often possible to track only the portion of processing time for a case that occurred within the calendar month. This was because the Prior Authorization Unit information that was provided to us for our review, with limited exception, identified only cases where prior authorization requests had been received during the month, without reporting activity on cases still in process from the prior month. Consequently, the apparent processing time for reported cases was distorted, since complete processing time data was provided only where case requests had been submitted, completely processed, and a new prior authorization had been approved all within the same month. We also noted questionable patterns in the number of processing days reported. For example, data covering 405 cases reported by the

Auburn unit showed only 225 non-deferred cases where a “Date-In” had been recorded and a final decision had been reached by the end of the reporting period. Fifty-four cases were reported as in deferred status at month-end, while the status of the remaining 126 cases was unclear, with the deferral status field having been left blank and the same date entered in both the Date-In and decision date fields. All 126 bore dates between July 5 and July 10, 2006. Since none of the 405 cases bore “Date-In” dates prior to July 3, 2006, it appeared that cases carried over from the prior month may have simply been redated without tracking the total days elapsed since the original date of submission, the number of days consumed by processing at the unit and, if applicable, the number of processing days associated with deferrals needed to secure additional information regarding the case. Even for the 225 cases marked as non-deferred, 199 had dates seemingly indicating that the cases had been processed on the day the request was received. We also found the accuracy of those dates to be questionable, since the Boston unit had reported same-day completion for only one of 238 cases despite the fact that reviewer caseloads appeared to actually be higher for Auburn with its 202 reported cases per reviewer as opposed to 178 per reviewer in Boston. We conducted a subsequent visit to the Prior Authorization Unit and found that computer system dates were not adequately controlled and that unit staff could and commonly did alter recorded dates. As a result, we concluded that the Prior Authorization Unit and PCA program managers had no reliable management systems to track prior authorization activity and processing time.

Analysis of this data indicated the existence of an average 15-calendar-day processing backlog at the Boston office, with some cases backlogged for at least 20 days. That backlog was composed of just the days elapsed between the date of submission by the PCM agency and the date Prior Authorization Unit reviewers began reviewing each case. Since additional days were consumed by review and follow-up data-entry activity, typical processing time was obviously longer than 15 days. In fact, we found that where cases had been delayed to gather more information and were classified as either “Information Request” or “Off Hold” (signifying that a hold on processing had been lifted and processing had resumed but had not yet been completed by month-end), the cases had remained in processing an average of over 20 days before month-end.

Unlike other cases listed on the July 2006 report, the list of cases for which approval action had been formally deferred by the Boston office as of month-end included cases submitted before the start of the month. For 40 cases remaining in deferred status at month-end, the median

number of processing days through the end of the month was 34, due to the fact that 29 (72.5%) of the 40 cases had been carried over from June. Since additional processing time consumed from the end of the month to the date when these deferred cases were eventually resolved was not reported, it was not possible to determine average total processing days for either those cases or for the entire group of Boston cases. However, the report indicated that the deferred cases had apparently been backlogged or in review at the unit for a median of 19 days before a determination had been made to defer them, suggesting that, regardless of any deficiencies that may have existed in the submissions, the processing delays were being significantly extended due to the initial processing backlog at the unit. In fact, the excessive processing backlog prior to the reviewer decision to defer action pending submission of additional information effectively placed the unit in violation of Medicaid's own regulation governing processing time limits. By allowing up to four days for a PCM agency to respond to requests for additional information without triggering an extension of the 21-day processing limit, the regulation indirectly requires that the unit identify any need for additional information by approximately day 16 of the process if the contractor is to be afforded four days to submit the requested information and the reviewer is to examine the submitted additional material and reach a decision by the 21<sup>st</sup> day. If cases remain backlogged for longer periods before a reviewer examines the initially submitted request, insufficient time remains to complete the process in the manner required by the regulation. Unless the contractor is able to provide the requested information in a shorter period of time, the 21-day processing limit is exceeded. Despite the regulatory 21-day limit, 22.5% of the listed deferred cases had apparently remained backlogged or in review for between 21 and 24 days before being deferred. Even if the contractors were to take only four calendar days to respond to each deferral and the Prior Authorization Unit were to complete processing within a day after receipt of requested information, resulting total processing time for those cases would run between 26 and 30 days after factoring in the untracked post-deferral processing days.

The data available for the Auburn office was inadequate to the point that it was not possible to develop similar processing time estimates for that office. However, the higher caseload average for Auburn suggests that processing times were unlikely to be substantially better than that of the Boston office.

In addition to the above-mentioned discrepancies in reporting information within the two Prior Authorization Unit offices, we also noted differences in information between the two offices.

For example, data for the Auburn office included useful information on consumer diagnoses, dates of birth, requested and approved service hours per week, and dates of referral to the program for new consumers, none of which had been included in data reported by Boston. However, unlike Boston, the Auburn data failed to include tracking of requests for extensions or cases where increases to previously authorized service levels had been requested. As described above, both offices provided data on deferrals. However, the Auburn data simply included a field coded “Y” or “N” for deferrals, with the field left entirely blank for 126 (31%) of the 405 consumer records. There were no reasons recorded for the deferrals. In contrast, the report for Boston provided a separate detail sheet covering deferrals, with reasons for each deferral and a graph summarizing the number of deferrals for each of 21 reason categories. Given the important nature of this prior authorization system’s related information, it would be reasonable to expect that managers would have implemented uniform data-gathering systems across both Prior Authorization Unit offices.

During our initial testing of this information, the Prior Authorization Unit Director informed us that significant changes were planned for the unit, including development and implementation of new guidelines, hiring two Nurse Specialists to work on perceived quality assurance and standardization issues for evaluations conducted by PCM agencies, and the conversion to an online Automated Prior Authorization System (APAS). Consequently, we conducted a follow-up site visit to the Prior Authorization Unit’s main office in Boston to obtain an update on the status of the system changes. As part of the follow-up review, we examined service management reports for July 2007 for comparative purposes, interviewed unit staff, observed APAS operations, and obtained printouts of PCA program-related APAS data. We analyzed this information to determine whether the APAS system had improved what Prior Authorization Unit officials had previously admitted to be a less than optimal information management system and to evaluate processing timeframes and adherence to applicable program performance criteria. Our review was supplemented by our analysis of additional information obtained directly from multiple PCM contractors and consumer advocates, including interview comments and data extracted from internal contractor management information systems. We conducted site visits to the offices of five PCM contractors, and contractor staff provided input and demonstrated internal information and reporting systems. At our request, the two largest PCM contractors (the Cerebral Palsy of Massachusetts Options PCM program and the Stavros PCM

program), together accounting for over one-third of the PCA program's 15,753 consumers in fiscal year 2007, provided data extracts from their information systems, including data elements such as consumer demographics (e.g., age, diagnosis, use of surrogates), requested service hours and hours approved by the Prior Authorization Unit, deferrals and associated reasons and processing dates, and information on actual service utilization by consumers. We analyzed this information as well as additional information obtained in conjunction with our review of PCA program contract-monitoring activity and background information obtained on prior authorization, evaluation, and other personal care service program arrangements existing both in Massachusetts and elsewhere in the nation.

**a. Implementation of the Automated Prior Authorization System Has Not Resolved Processing, Tracking, and Delay Problems**

The following statement received from one PCM agency Executive Director is an example of the comments provided to us by PCM contractors and consumer advocates, who generally asserted that prior authorization processing was only slightly faster using the APAS system than in the past and that the delay issues identified by our initial analysis remained largely unchanged:

- *The system is marginally, if at all, quicker on our end for processing documents . . . .*
- *Providers are not informed of various changes in the system, such as new fields or organization of information on the screen, making the system a bit user-unfriendly.*
- *Our staff found a marked increase in errors from MassHealth, ones presumably made by those doing rote data entry into the system.*
- *The system still needs some improvements and bug fixes. There are bugs in the program, which have not been resolved since its initial rollout.*
- *Providers would welcome an opportunity to provide feedback/make suggestions on APAS and its application (i.e. needs a new field to prompt someone to complete the process—if you log off the system before completing a task, it accepts the document but it is incomplete and eventually will be shot back to us with that indication).*

Our analysis of comments and documentation provided by both PCM contractors and the Medicaid Prior Authorization Unit found that the PCA management reporting systems were actually worse under APAS than they had been prior to the implementation of APAS. Significant problems with the generic prior authorization processing software package purchased for use by the unit appeared to exist as had been related to us by contractors, and

Prior Authorization Unit staff informed us that they had found it impossible to generate satisfactory tracking information from the software and were therefore continuing to use the manually entered and maintained Excel spreadsheet tracking system in use the prior year.

In reviewing the unit's report for July 2007 and comparing it to the July 2006 report that we had previously analyzed, we found that much of the limited date and processing category information available on reports for 2006 had been eliminated and that it was now not possible to estimate overall backlog information or the percentage of cases in delayed status at month-end at the Boston office for comparative purposes. However, some date information remained for 46 Boston office deferrals, and we were able to compute the time those cases had been backlogged or in review prior to the determination to defer decisions. While the median number of processing days for the cases in deferral status at month-end had decreased from the 19 days computed for July 2006 to 17.5 days a year later, the percentage of these cases that had been deferred only on the 21<sup>st</sup> day of processing or later actually increased from 22.5% to 37%. Processing delays clearly remained a significant program management issue even after implementation of the automated processing system. We also identified a variety of additional tracking, processing, and reporting-related issues:

- The manually prepared report provided to us omitted all case detail for the Auburn office but stated an implausibly low case total of 184 cases for Auburn on the report's cover page. We were initially told that report detail information was not available for the Auburn unit; however, we were eventually provided with limited July 2007 data for Auburn that was specially run for our use. That data omitted many of the data elements available the prior year and substantially exceeded the number appearing for Auburn on the cover page of the main report. In reviewing the data we noted problems such as duplicate consumer entries and eventually computed an unduplicated consumer count of 559 for Auburn that month. Duplications also appeared in the data detail for the Boston office and we determined that, on a consolidated basis across both offices, 352 more unduplicated consumer entries appeared in the report detail sections than had been entered on the report cover page. The combined total of review transactions stated on the cover page had been understated by over 26%.
- Nurse reviewers at the unit are simply assigned cases based on the consumer's county of residence and are expected to self-manage their review and processing activity. In addition, we observed that, despite the move to an automated software system, work by unit reviewers appeared to still be carried out on a manual basis. We observed that documents submitted electronically by PCM contractors were being printed out, edited by hand, and then given to unit clerical staff for data entry. We question the efficiency of these processing approaches, which may unnecessarily contribute to processing delays and resulting service delays for consumers.

- As had been the case a year previously, unit reports continued to reflect only partial information on processing, omitting information on many cases carried over from the prior month without resolution. The failure to implement appropriate APAS software controls or tracking systems to ensure that submission dates and elapsed processing days are accurately tracked and reported to system users and managers contributes further to the problem, particularly since user screens in the generic software application focus on a “Start Date” field with different data entry practices for new and ongoing consumers. That field is also subject to routine at-will modification by Prior Authorization Unit staff. It is therefore difficult to obtain reliable information for tracking purposes without examining either manually maintained records or software audit logs. These problems prevented a full audit analysis of processing time and delay issues. However, data we were able to obtain from reports and from APAS queries and a small sample of software audit log information provided to us suggested that the median number of elapsed days from submission to the initiation of review activity was approximately 18 days, with some cases going considerably longer without review despite regulatory time limits. Unit staff told us that, instead of fixing the regulatory time limit problem through software improvements or other systems changes, the unit had recently moved to address the compliance problem by simply voiding any request that appears to have run past an estimated 30 days of total processing (effectively allowing perhaps 10 days to resolve information requests made to PCM agencies by reviewers commonly made near, at, or even after the 21-day limit). The result of this practice can reasonably be expected to artificially inflate the total number of cases processed per month, further obfuscate existing information on service access delays and compliance problems, and increase inconvenience and workloads for both unit and contractor staff.
- No formal arrangements had been established for identifying and tracking special cases where expedited processing is needed. Instead, we noted only occasional informal comment field entries from reviewers regarding requests for expedited processing, with no evidence that such cases were actually being expedited or tracked. (Further details on this problem are provided in the section devoted to that issue in Audit Result No. 2.) Similarly, even though senior managers at EOHHS had identified the practice of deferring prior authorization decisions in order to obtain supplemental information from PCM agencies as a significant operational issue as early as January 2005, deferrals were not being fully tracked or analyzed. The Boston data for July 2006 continued to report only partial information covering only those deferred cases that remained unresolved at month-end, while the Auburn data eventually provided to us for that month contained no tracking information at all regarding deferrals. Yet, as described in our report, it appears that prior authorization deferral problems were increasing rather than decreasing at least through fiscal year 2007.
- The UMMS Commonwealth Medicine employee acting as director of the Prior Authorization Unit asserted to us that the number of PCA program consumers was growing at a rate of 30% per year at that time (fiscal year 2007), and stated that the unit had therefore moved to hire an additional reviewer, which would bring the total number of reviewers devoted to the PCA program from six to seven. However, our data analysis had not identified a volume increase of that magnitude, and the Medicaid OLTC Director of Community Services also questioned it, asserting that program growth was

only running at approximately 10%. We subsequently were provided with the statistical summary data appearing in the Introduction to our report, which suggests a fiscal year 2007 program growth rate of approximately 6%. As a result, it appears that inadequate prior authorization tracking and reporting systems may be significantly impairing management decision-making for the PCA program.

**b. Complicated and Inconsistent Submission Requirements and the Lack of Comprehensive Uniform Policies and Procedures Covering Application and Prior Authorization Processing May Be Causing Delays in the Process**

The 130 CMR 422.416(A) establishes requirements for prior authorization submissions, including the following:

*Requests for prior authorization for PCA services must include:*

*(a) the completed MassHealth Application for PCA Services and MassHealth Evaluation for PCA Services;*

*(b) the completed MassHealth Prior Authorization Request form;*

*(c) any documentation that supports the member's need for PCA services; and*

*(d) documentation that the member's physician or nurse practitioner has ordered PCA services. This documentation may be:*

*(i) the completed and signed physician/nurse practitioner sign-off page of the MassHealth PCA evaluation form; or*

*(ii) documentation that the nurse who conducted the evaluation obtained verbal authorization to initiate (or continue) PCA services from the member's physician or nurse practitioner. Such documentation must include the member's name and address, the name and telephone number of the nurse who obtained the authorization, the date the authorization was obtained, the number of PCA hours requested by the personal care agency and ordered by the physician or nurse practitioner, and the name, address, and telephone number of the physician or nurse practitioner who granted the authorization.*

This regulatory requirement has been supplemented by some additional guidance in the form of regulatory and PCM contract requirements and standardized application and evaluation forms.

During our audit, we asked the Director of the Prior Authorization Unit and her staff whether any additional written policies and procedures existed in addition to the aforementioned regulation regarding prior authorization submissions and processing. We were told that although none existed, efforts were underway to develop some additional guidance such as revised time-for-task information.



Contractors are required to complete application and evaluation processing and submit service approval requests to the Prior Authorization Unit within 45 days of receiving an initial request for PCA services from a new consumer. For ongoing consumers with expiring prior authorization approvals, requests for replacement authorizations are due at the Prior Authorization Unit at least 21 days prior to the expiration date of the existing authorization.

Using the previously described APAS software, each request is electronically submitted by a PCM agency on a single-page prior authorization request. In order to meet PCA approval processing needs, the PCM agency must then supplement this prior authorization request form by electronically scanning and uploading or separately faxing additional forms and materials, including:

- A four-page application form that must be completed in its entirety even for reevaluations, with no provisions for use of an abbreviated reauthorization application form. The computer-based version of the form contains 167 data entry points, many of which effectively require use of attachments such as copies of schedules for all proposed PCA services to the consumer and any other household residents, services provided by others in or out of the home, work and school schedules, and other attachments such as discharge summaries, service plans, medical histories, etc.
- A seven-page evaluation that must be completed and signed by an Occupational Therapist evaluator, a Registered Nurse evaluator, and the consumer's Physician or Nurse Practitioner, all attesting to the accuracy of review results and service hour recommendations, and the name and title, but not the signature, of the individual conducting the incorporated assessment of whether the consumer does or does not require a surrogate must be provided. The consumer or legal guardian and surrogate (if applicable) must also sign the document.

Our audit work identified existing requirements for sign-offs and submissions by medical providers and other third parties as a contributing factor in processing and service-access delays. For example, while the above-cited regulatory requirement for approval sign-off by the consumer's physician or nurse practitioner contains a provision for documentation of approval provided verbally, the process still appears to consume significant time making contact with the medical provider before paperwork can be processed with the Prior Authorization Unit and, even if the option for verbal approval is used, the validity of the approval is only temporary and Massachusetts Medicaid insists that formal written approval be obtained within 60 days, which consumes additional staff resources for follow-up and associated documentation tracking activities. However, we found that the sign-off

requirement is an artifact of CMS signature requirements that were repealed by Congress in the Omnibus Reconciliation Act (OBRA) of 1993. As documented by a 1996 US/HHS policy report and a long-term care program and policy review conducted by Louisiana in 2004, the medical provider sign-off requirement has been characterized as an unnecessary and unwanted "medicalization" of PCA services and a barrier to rapid establishment of functional ability status for eligibility determination and service initiation. Most states have now dropped the requirement from their own regulations. One physician we interviewed, a former Medical Director for Massachusetts Medicaid, also questioned the continued imposition of such requirements for the Massachusetts program and suggested that the program could instead reasonably rely on the expertise and judgment of PCM professional nurse evaluators, without additional sign-off by a consumer's primary care provider.

In addition to the time-consuming aspects of the process, our review noted that no instructions other than submission addresses accompany the above-described forms. Instructions do not appear either in written format or indirectly in the form of comment fields or data-entry validation and edit checks built into the electronic PDF file format versions of the forms. Instead, Medicaid simply includes the following statement at the top of the application form:

*The PCA Agency is to complete and submit this application to MassHealth with all relevant documentation, including the request for prior approval. MassHealth may defer or deny incomplete applications.*

Additional guidance appearing in separate PCM contract documents is minimal and somewhat inconsistent. For example, contract language requires completion of a separate written "Assessment of the Consumer's ability to manage PCA services in accordance with Subsection 2.2(B)" prior to submission of the prior authorization request. That assessment is required to be kept on file and to be made available to Medicaid upon request. Similarly, contract language contains somewhat confusing supplemental provisions regarding situations where a surrogate has been designated. While the submission of the executed service agreement between the consumer and the PCM contractor is not routinely required and service agreement submission requirements are not referenced in regulations or in the text included in the above-referenced prior authorization request, application, and evaluation forms, the contract requires that the service agreement be included as part of the prior

authorization submission package in cases where “the Service Agreement does not identify the Surrogate as being involved in the management of the PCAs.”

While some submission requirements are clear (e.g., the requirement for submission of medication lists), requirements for submission of various documents such as medical visit treatment notes and school Individual Education Plans (IEPs) are not specified. Some states such as Washington have implemented highly specialized automated software systems for conducting and documenting PCA program eligibility and functional evaluation assessments, with sophisticated built-in procedural steps and data-integrity checks. Other states, such as Maine, have promulgated detailed operational manuals for use by individuals responsible for evaluations and determinations regarding assistance levels. Massachusetts Medicaid PCA program arrangements stand in stark contrast with minimal use of specialized software, and almost no detailed written guidance is provided to either program contractors or state agency staff responsible for prior authorization reviews.

One PCM contractor with whom we spoke expressed concerns that in addition to the above-referenced complex, burdensome, and sometimes ambiguous submission requirements, unwritten submission requirements could informally be imposed by Prior Authorization Unit reviewers; that standards were not consistently applied, varying by Prior Authorization Unit office and even by individual reviewers; and that prior authorization expectations and submission requirements were often subject to change without notice, resulting in inconsistent demands for supplemental information and documents resulting in otherwise avoidable processing delays. Multiple PCM contractor representatives with whom we spoke voiced similar concerns, noting that explicit guidance should be provided so that all required information is gathered and submitted routinely and as expeditiously as possible in order to minimize delays arising from ad-hoc information demands. In reviewing these concerns and existing processing arrangements, we noted the following:

- The Prior Authorization Unit has not established formal procedures for prioritized processing of requests for new consumers. Instead, requests for both new and ongoing consumers are processed in the same queue for the assigned reviewer, and each reviewer is allowed to self-manage the processing of assigned cases. As a result, a request for an ongoing consumer that has been submitted on March 1<sup>st</sup>, six weeks prior to the required approval start date, may be processed before a March 2<sup>nd</sup> request for a new consumer needing services as “soon as possible.”

- Instead of conducting a thorough prescreening immediately upon receipt of a request, the Prior Authorization Unit simply assigns submissions to individual reviewers, relying on reviews to identify deficient submissions once the case was eventually reached in queue. As a result, submission deficiencies can remain unidentified until a reviewer finally examines the submission as it approaches the 21-day deadline for processing. At that point, too little time remains to correct the error and complete processing in a timely manner. The case is instead deferred pending submission of the missing information, further contributing to service access delays for consumers. We found that in July 2007, at least seven of the 46 deferrals recorded by the Boston office involved incomplete submission documents. For the seven cases listed as deferred for such reasons, one had had the problem identified on the 14<sup>th</sup> day after submission, one on the 18<sup>th</sup> day, and the remaining five only on the 21<sup>st</sup> day or later. The independent deferral data obtained from the two PCM contractors also included approximately a dozen similar deferral cases for each contractor. We also noted evidence that in some instances, cases can be subject to multiple consecutive deferrals when reviewers fail to fully review requests and identify all issues at the same time. For the PCM agency providing data on 395 deferrals over a 12-month period, 16 consumer cases were subjected to multiple consecutive deferrals where the Prior Authorization Unit had first raised one submission deficiency, waited for a response, and then raised a second deficiency rather than raising both matters at the same time. The adoption of formal internal Prior Authorization Unit operational standards requiring timely and comprehensive pre-screening reviews, in our opinion, would serve to minimize these deferral delays even without improvements to evaluation and APAS operations and software at the PCM contractor level.
- The lack of comprehensive written policies and procedures could result in the Prior Authorization Unit activities not being conducted in a consistent and efficient manner. In fact, we identified differences within and between review practices at Prior Authorization Unit offices. For example, we noted that in July 2006, one PCM agency (the Center for Living and Working) responsible for processing cases through both offices had a deferral rate of zero at the Boston office (i.e., none of its cases was classified as deferred) but a deferral rate of 29% for its cases processed through the Auburn office. Since the same set of staff members at the contractor carried out these operational activities, the distinctly different deferral rates could be attributable to variance in practices at the different Prior Authorization Unit offices. Similarly, while individual reviewers were not identified for transactions involving the Auburn office, data for the Boston office showed that for a total of 41 logged deferrals in July 2006, 37 of the deferrals had been made by just two of the four reviewers in the unit. One reviewer accounted for 19 deferrals involving 10 separate PCM contractors, while another accounted for 18 deferrals spanning five PCM contractors. We conducted a separate analysis of the above-referenced deferral data provided by the two largest PCM contractors, Stavros, the primary ILC contractor submitting cases to the Auburn office, and the Cerebral Palsy of Massachusetts (CPMA) Options PCM program accounting for the most requests processed through the Boston office. Using the 12 months of data for each contractor, we calculated deferral rates of approximately 16% for CPMA and 17% for Stavros. Deferral reasons also included repeated references suggesting that reviewers were applying unwritten approval criteria not stated in regulations or other policy documents. For example, in the case of submissions from Stavros to the Auburn Prior

Authorization Unit office, 45 (9%) of 498 deferrals carried reasons suggesting that reviewers were applying a standard that additional justifications must be provided whenever family members failed to provide at least half of all Instrumental Activities of Daily Living (IADL) assistance despite the fact that there was no regulatory basis for such a standard. Instead, 130 CMR 422.410 simply states an assumption that family members living in the consumer's home will provide assistance with IADLs but that individual circumstances will govern determinations regarding needed assistance levels. In contrast, deferral reasons for the CPMA Options program submissions offered no indication that such IADL family assistance expectations existed at the Boston office. Only a handful of 395 deferrals for CPMA made any reference whatsoever to family IADL assistance arrangements.

- Prior Authorization Unit monthly report data suggests that distinct differences exist between individual Prior Authorization Unit reviewers, which could also reflect inadequate standardization of review practices and the failure to establish detailed operational policies and procedures for the unit. For example, our analysis of the July 2007 monthly management report for the Boston office found that deferral rates for four individual reviewers varied from 1.8% of cases reviewed to 13%, with a single reviewer accounting for 51% of reported deferrals for the month. Similarly, a year earlier, two of the four Boston office reviewers accounted for 37 of 41 reported deferrals for the unit on the July 2006 monthly report. If individual reviewers were assigned to review the work of specific PCM contractors, such variations might be expected if poorly prepared requests from individual PCM agencies were disproportionately assigned to individual reviews. But since reviewers are not assigned to individual PCM contractors and instead review a cross-section of cases submitted by multiple contractors, review results such as decisions to defer approval action should be more uniform across reviewers. We also saw no documentation of any internal or external mechanisms for reviewing, standardizing, or otherwise ensuring the quality of review and determination activity by Prior Authorization Unit reviewers.

Some advocates and clinicians with whom we spoke asserted that they were concerned that the Prior Authorization Unit lacks a valid methodological basis for overruling function evaluation findings and resulting service-level recommendations made by the Nursing and Occupational Therapy professionals conducting face-to-face evaluations of consumers and that the evaluation and prior authorization review process was adversely affected by cost-containment pressures despite the federal mandate that service determinations be made on the basis of the best interests of consumers. Our background research also noted national best-practice policy guidance stressing the importance of keeping the evaluation and service level determination process independent from state agencies, which might be overly influenced by cost-containment considerations and, in the case of agency-directed service models, agency providers of PCA services. Consequently, in order to assess whether the program had adequate safeguards to ensure the objectivity and standardization of service

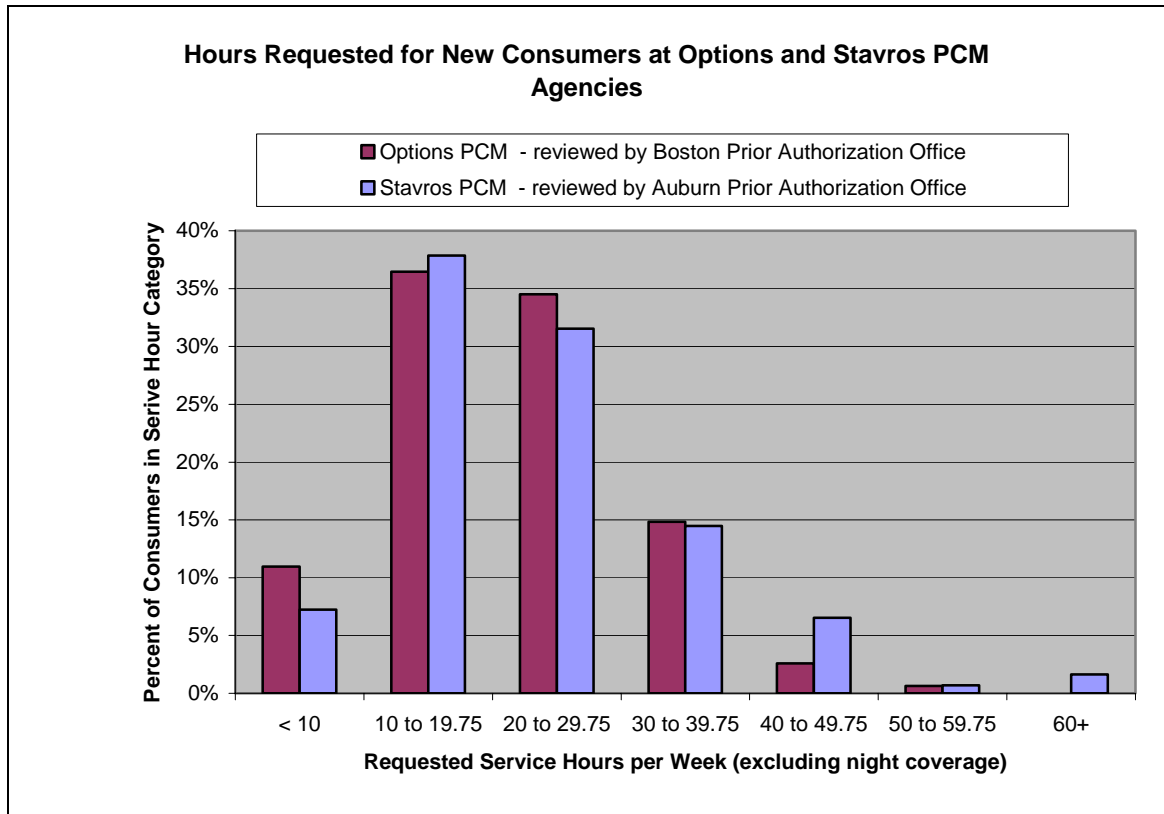
authorization procedures, we asked Prior Authorization Unit staff what clinical standards were used for making their decisions regarding service hour approvals and modifications. In response, the Prior Authorization Unit director said that her staff utilizes time-for-task guidelines for these Medicaid services developed in 1979 and “Medicaid Nursing Standards of Care.” In reviewing the time-for-task guidelines and proposed revisions then being developed by the program, we found that they simply provide general guidance regarding often-broad ranges of time periods than can be expected to be required by PCAs to perform individual Activities of Daily Living (ADL) and IADL activities. The guidelines in effect during our audit provided wide latitude to PCM agency evaluation teams. The document also expressly stated, “it is recognized that some persons may require more time, and others may require less time.” We noted that national best-practice information appeared to be consistent with this approach, documenting that service need is typically driven by individual circumstances rather than factors such as medical diagnosis or age and that standardized face-to-face evaluations by independent professionals are needed to appropriately make such determinations. We also noted advice suggesting that it should not be assumed that excessive variance or assessment quality issues will arise when face-to-face evaluations are conducted by appropriately trained nursing and occupational therapy professionals. However, when we reviewed the Medicaid Internet site that we had been told contained all applicable nursing standards used by Prior Authorization reviewers, we found various guidelines for Prior Authorization medical necessity determinations regarding a variety of non-PCA-related medical and nursing services but none pertaining to the PCA program. Nor did the Prior Authorization Unit provide us with any other documentation relative to the standards of care or medical necessity guidelines used by their staff to perform the Prior Authorization Unit’s desk reviews.

We then further assessed these standardization issues. We compared both the existing time-for-task guidelines and then-pending draft revisions to guidelines used in Maine and noted that the Massachusetts guidelines appeared to be generally more conservative than those in Maine, with lower time ranges established for many PCA activities. We also compared fiscal year 2007 service level recommendations made for consumers by the programs’ two largest PCM contractors, Stavros and the Cerebral Palsy of Massachusetts Options PCM program. One reason for selecting the two largest PCM agencies was that case-mix variances, while

not eliminated, could be expected to present less of an analysis problem than variances that might exist at smaller or more specialized PCM agencies such as those serving primarily elders, or consumers also receiving services from the Department of Mental Retardation. As shown in the following chart, which displays the percentage of new consumers for each PCM agency grouped by the number of service hours per week requested on their behalf by PCM evaluators<sup>41</sup>, there did not appear to be marked differences between the two PCM agencies in service request patterns. While requests from the Options program ran slightly lower than for Stavros, this may be attributable to the somewhat higher percentage of children in the Options case-mix and the fact that service requests for children are typically lower than for adults due to factors such as increased availability of non-PCA ADL and IADL assistance from parents and schools.

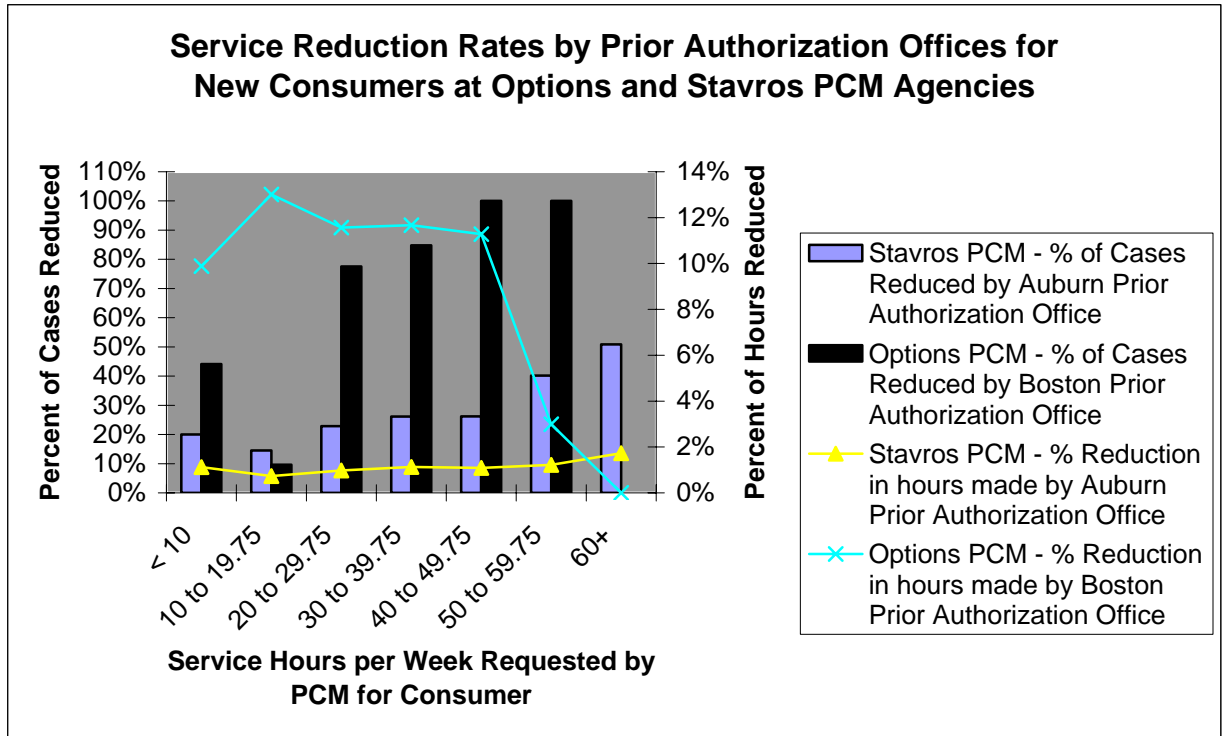
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<sup>41</sup> Since service hours are requested and approved in 15-minute segments, there are 0.25-hour gaps between range end and beginning points (e.g., 10 to 19.75 hours per week and 20 to 29.75 hours per week).



Since service requests prepared by Options are almost exclusively reviewed through the Boston Prior Authorization Unit office, while those prepared by Stavros are reviewed through the Auburn office, we compared the reductions made by unit reviewers to the two sets of requests. We analyzed both the percentage of cases reduced for Requested Service Hour range and the percentage reduction made by reviewers to the requested service hours for each grouping of requested service hours. The results appearing in the following chart suggest the existence of distinct variations in review practices and outcomes for the two groups of requests.





Despite the similarity in service hour request patterns for the two PCM agencies and the fact that the requests from Options tended to run slightly lower than those from Stavros, the Boston Prior Authorization Unit made far more reductions to the Options requests, both in terms of the percentages of cases and hours reduced, than were made by Auburn office reviewers to the requests from Stavros.

We also analyzed a subsample of 94 Stavros cases involving 52 new and 42 ongoing consumers for whom both requested and approved service hour data had been provided for two consecutive authorizations within the 12-month period (typically cases that were processed once near the start of the year and then again shortly before the end of the year). We compared requested and approved hours and changes occurring from one service authorization period to the next and obtained the results appearing in the following table:

### Reevaluation Results for 94 Stavros Consumers with Consecutive Request Data

	2nd submission resulted in increase	% of Total	2nd submission resulted in no change	% of Total	2nd submission resulted in decrease	% of Total
<b>New Consumers</b>						
First request approved without modification	21	60.0%	12	34.3%	2*	5.7%
First request reduced by reviewer	14	82.4%	1	5.9%	2*	11.8%
Total New	35	67.3%	13	25.0%	4	7.7%
<b>Ongoing Consumers</b>						
First request approved without modification	9	32.1%	17	60.7%	2**	7.1%
First request reduced by reviewer	7	50.0%	5	35.7%	2***	14.3%
<i>n = 14</i>						
Total	16	38.1%	22	52.4%	4	9.5%

Reduction comments:

\* Both reductions were requested by PCM agency, but the Prior Authorization Unit further reduced one.

\*\* Reductions were made by the unit despite PCM agency recommendations for no change in service level.

\*\*\* Reduction was requested by PCM agency.

Note that reported changes for second submission results are in relation to first submission approval levels rather than to actual request levels. Since PCM agency evaluators often requested increases in authorization levels while reviewers either granted smaller increases or no increases, the actual number of second submission requests that were reduced was 20 (38.5%) for the 52 new consumers and seven (16.7%) for the 42 ongoing consumers. Overall, 28.7% of second submissions were reduced from PCM agency requested levels.

For 13 (25%) new consumers and 22 (52.4%) ongoing consumers, approved service hours remained unchanged from the first submission to the second. However, 35 (67.3%) of the 52 new consumers required service increases at the time of their first reevaluation compared to only 16 (38.1%) of 42 ongoing consumers being re-evaluated after a prior reevaluation. Our background research revealed that it is not unusual for new consumers to themselves initially underestimate the assistance they will need and that relying on consumer self-reporting in evaluating functional status may underestimate disability in clinical evaluations, level-of-care determinations, and service planning. These results raise the possibility that, rather than over-assessing consumers, PCM agency evaluations may instead under-assess service needs, particularly for new consumers, and that additional reductions imposed by

Prior Authorization reviewers may further exacerbate such problems. Of the 35 new consumers where the Prior Authorization Unit approved service increased at the time of reevaluation, 14 (40%) were consumers for whom unit reviewers had initially made reductions to service time requested at the time the consumers entered the program. That pattern is not consistent with what would be expected to result from an oversight process focused on quality assurance. It is instead the type of pattern to be expected where reviews are focused on cost containment regardless of the true level of assistance needed by consumers. While the sample analyzed was small, the results appear to be consistent with assertions that new consumers are being underevaluated and underserved.

We also analyzed changes in Prior Authorization Unit service authorization reduction rates over time and found that both Prior Authorization Unit offices have increasingly imposed service reductions on cases. These changes were noticeable even over the course of a single year. For the above-described Options fiscal year 2007 cases with authorization period start dates between December 2006 and June 2007, the percentage of cases in which modifications were made by the Boston Prior Authorization Unit office increased from 37.5% in December 2006 to 57.5% in June 2007. The percentage reduction made to requested hours also increased from 4.9% to 5.5%. When broken down by type of evaluation, the results were even more distinct for initial evaluations for new consumers. For Options initial evaluation cases processed through the Boston office, the percentage of cases modified increased from 65.8% to 90.9% and the percentage reduction to requested service hours increased from 9.9% to 15.1%. For Options reevaluations processed through Boston, the percentage of cases modified increased from 33.1% to 45.7%, while the percentage reduction to requested hours varied from month to month, averaging 3.4% in both the first and second half of the period. We found similar although less sharply increasing trends for the Stavros initial and reevaluation cases processed through the Auburn office. It was also reported to us that the trend of an increase in modification rates had been encountered by other PCM agencies. For example, in July 2007 one PCM agency told us that modification rates by the Boston Prior Authorization office had significantly increased for its reviews and showed us copies of the 15 most recently processed requests, almost all of which involved new consumers. Of these, 12 (80%) had service hour reductions imposed by Prior Authorization Unit reviewers. Since we found no evidence that the changing approval

pattern was attributable to an underlying across-the-board deterioration in the quality and accuracy of PCM agency evaluations, the change in pattern appeared to corroborate assertions made by advocates and contractors that the increased case modification rates have been the result of changing review practices at the Prior Authorization Unit and may reflect implementation of unannounced and undocumented internal policy changes at the unit.

Although we do not question Medicaid's authority to promulgate appropriate guidelines for standardizing both the functional evaluation process and the quality review of evaluation results and service recommendations prepared by PCM agency professional staff, we found that the program currently lacks appropriately detailed written documentation needed to ensure that both evaluation and Prior Authorization Unit review activities are appropriately standardized and administered in an equitable manner. The absence of relevant guidelines in this area can allow Prior Authorization staff to substitute their own judgments for the results of face-to-face evaluations conducted by independent professional evaluation teams. As evidence of the flaws in judgment that may occur in this process, during our audit we were also shown copies of appeal decisions by hearings officers where hearings officers had overruled Prior Authorization Unit decisions, going so far as to state that there was "no evidence" supporting conclusions reached by unit reviewers, that reviewer assertions regarding the illegality of PCAs performing certain health care assistance activities were incorrect, and that reductions in service time made based on assertions that requested time exceeded time customarily needed for certain activities were improper when the need for assistance was clearly greater for the consumer. Considering this input and the absence of adequate written guidelines covering Prior Authorization Unit reviews, we obtained and analyzed Medicaid Hearing Board summary reports covering all Medicaid appeal activity, not just that related to PCA services, for the eight months from January 2007 through August 2007. While the summary material did not provide case-specific information or even a broad summary of appeal issues, it did categorize appeals by service type and 10 separate outcome categories. We noted that PCA appeal volume appeared to be significant, totaling 212 closed cases over an eight-month period, an average of approximately 1.3 appeals received per workday. As shown in the table below, our analysis of the data also established that, compared to non-PCA service appeals, PCA appeals are disproportionately likely to be

resolved by a hearing decision rather than by dismissal prior to decision, and that appeal decisions for PCA cases disproportionately are made in the consumer's favor.

### Medicaid Appeal Outcomes

#### January 2007 through August 2007

	ALL		PCA		ALL Non-PCA	
	Number	% Total Closed Cases	Number	% Total Closed Cases	Number	% Total Closed Cases
Closed by Dismissal Prior to Decision	10,124	88.6%	121	57.1%	10,003	89.2%
Closed by Decision	1,303	11.4%	91	42.9%	1,212	10.8%
Total Closed Cases	11,427	100.0%	212	100.0%	11,215	100.0%
Information was not available on how many pre-decision dismissals resulted from settlements at least partially in the consumer's favor. Outcome data for only those cases closed by decision appear below:						
Closed by Decision at Least Partially in Consumer's Favor	337	25.9%	50	54.9%	287	23.7%
Closed by Decision to Fully Deny or Dismiss	966	74.1%	41	45.1%	925	76.3%

In our opinion, this appeal data, together with the other Audit Results described above in this section, indicate that in many cases Prior Authorization Unit decisions to reduce or deny PCA service requests prepared by PCM agency professional nursing and occupational therapy evaluators may not be based on standard and accepted criteria, and that the absence of comprehensive standards and appropriate quality assurance controls for the Prior Authorization Unit review process may be resulting in questionable review outcomes.

#### c. Regulatory Provisions for Expedited Processing of Certain Cases Are Not Routinely Used

The 130 CMR 422.416(D) provides for expedited processing in certain situations where "special conditions" exist, such as where consumers are transitioning out of nursing facilities. The regulation requires the PCM agency receiving the service request to notify Medicaid within 24 hours so that Medicaid can, if it so chooses, assume responsibility for conducting the evaluation and expedite prior authorization processing. However, we noted no evidence that Medicaid routinely uses the regulations to conduct evaluations or otherwise expedite

processing for these consumers. In fact, according to the PCA contractors with whom we spoke, even though contractors continue to notify Medicaid of service requests for consumers leaving nursing facilities, Medicaid has not exercised its option to conduct those evaluations for several years. During our interviews with officials at the Medicaid Prior Authorization Unit, officials told us that, if necessary, they can expedite the processing of such cases and can complete processing on a same-day basis. However, there was no documentation to substantiate this assertion, since the Prior Authorization Unit data provided to us for review lacked information needed to track such cases. Further, our review of Prior Authorization Unit records produced no confirmation that cases were being effectively expedited, requests for expedited processing were being logged or tracked, or compliance of PCM agencies with the 24-hour notification requirement was being monitored. PCM contractors and advocates with whom we spoke stated that delayed processing of nursing home discharge and other special cases remains an issue; even when notified of a facility transition situation, Medicaid rarely takes action to expedite processing; and even when the PCM agency expedites its own evaluation and processing activity and the Prior Authorization reviewer processes a request ahead of queue order, processing still typically takes several weeks. These assertions were consistent with the results of our review of transaction data provided by the Prior Authorization Unit, which documented multiple cases in which requests for transitioning consumers, rather than being expedited, were instead deferred for reasons such as failure of the nursing facility to provide a projected discharge date. This situation effectively creates a “Catch-22” situation for consumers where facilities are reluctant to establish discharge dates until PCA service arrangements have been completed and at least some Prior Authorization reviewers are unwilling to approve the PCA services until a planned discharge date has been established. For example, one PCM agency told us of four cases where expedited processing had been requested for consumers being discharged from nursing facilities. However, the PCM agency Program Director reported that the “expedited” prior authorization processing time at the Boston office for the four cases was an average of 41 days, not counting additional “deferral days” for two of the cases. For the two cases involving deferrals, it was reported that, despite the regulatory 21-day limit on Prior Authorization Unit processing time, one case had been processed at the unit for 34 days before the reviewer decided to defer action in order to obtain supplemental information, and the other was processed by the unit for 22 days before further processing

was deferred. As noted in the Background section of this report, Medicaid nursing facility rates in Massachusetts average approximately \$180 per day. As a result, nursing facility charges incurred for the combined 164 days associated with Prior Authorization Unit processing of just those four cases could well have exceeded \$29,000. Discharge delays also may result in compounded problems, such as loss of housing or pre-existing community support arrangements resulting in additional discharge delays and barriers even after state Medicaid authorities have granted service approval. Clearly, the need for effective provisions for expedited processing of such cases is widely recognized and should be addressed.

**d. PCA Regulations and Prior Authorization Unit Practices May Not Adequately Address Federal Requirements Applicable to Services for Children**

The nation's Medicaid Act, first established in 1965, was amended by Congress in 1989 to include special provisions of 42 U.S.C. §1396d(a)(4) designed to ensure that no Medicaid-eligible child will go without care deemed medically necessary by the child's clinician. As incorporated into federal regulations and interpreted by the courts, this requirement mandates the provision of so-called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. The scope of those services must include medically necessary services needed to "correct or ameliorate" physical or mental illnesses and conditions in a child so long as the services are permitted by CMS to be delivered on either a mandatory or optional Medicaid state plan basis. Services must be furnished without limiting the amount, duration, and scope of medically necessary services to children regardless of the limitations that CMS allows states to apply to adults. According to legal advocates we interviewed and information available on legal interpretations of this matter made elsewhere in the nation, this requirement extends to PCA services provided to children. For example, a National Health Law Program document on Children's Personal Care Services under Medicaid quotes past federal guidance as stating:

*Under EPSDT requirements, a State must cover any medically necessary services that could be part of the basic Medicaid benefit if the State elected the broadest benefits permitted under federal law (not including HCBW [home and community-based waiver] services, which are not a basic Medicaid benefit). Therefore, EPSDT must include access to case management, home health, and personal care services to the extent coverable under federal law.*

If this guidance is accurate, it means that even if a state chooses to exclude certain permissible PCA activities from the service package provided to adult consumers, these

services must still be made available to children. Unfortunately, as documented in a July 2001 Government Accountability Office (GAO) report<sup>42</sup>, although the extent to which children in Medicaid across the country are receiving these services is not fully known, the available evidence indicates that many are not receiving these services. At the time of the study, GAO identified 28 states in which lawsuits had been filed alleging that the states had failed to adequately provide these mandated services.

During our audit, we noted that PCA program regulations and materials made no reference to the special federal provisions covering children and that the content of Medicaid regulations and materials (as well as the content of program materials in use by PCM contractors) did not address these federal requirements. For example, 130 CMR 422.412 identifies seven categories of activity as non-covered services, including:

*(C) assistance provided in the form of cueing, prompting, supervision, guiding, or coaching*

While Massachusetts Medicaid is permitted by federal Medicaid rules to exclude coverage of these cueing and related activities for adults, the exclusion is not permitted for children. Yet the regulation makes no provision for exceptions involving PCA services to children. We found that not even informal exceptions to the regulatory prohibitions were being made for children in Massachusetts.

**e. Prior Authorization Adjudication Notifications and Due Process Guarantees Could Be Improved**

PCM contractors with whom we spoke told us that they were concerned with the fact that consumer appeal rights to their authorized PCA services may be impaired by the PCA program's use of what was, in their opinion, confusing, untimely, and inadequate notification practices. For example, these PCM contractors stated that Prior Authorization Unit determination notices, which are computer-generated, were often confusing due to complexities regarding service authorization issues, request documentation requirements, and mathematical and data-entry errors, and that often even PCM agency staff familiar with a particular request had to review details of case files in order to decipher the meaning of decision notices. We were also told that notice provisions were presented in language that

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<sup>42</sup> GAO-01-749, Medicaid, Stronger Efforts Needed to Ensure Children's Access to Health Screening Services, available at <http://www.gao.gov/new.items/d01749.pdf>.



was difficult to comprehend for many consumers and that, particularly in the case of consumers with surrogates, problems can arise when appeal deadlines pass. For example, in the case of consumers with surrogates, decision notices are mailed only to the consumer, without a copy being sent to the surrogate, further exacerbating such problems. During our audit, we spoke with a public health professional who was a parent and surrogate for a 19-year old consumer in the PCA program. She provided us with a copy of a Medicaid notification received by her child, which contained complex information covering a determination involving regular approved time during school weeks, separate approved time during vacation weeks, approved holiday time, two processing extensions of 30 days each, an adjustment made to calculated holiday service hours due to an unexplained calculation error that was asserted to have been corrected by the Prior Authorization Unit, and an entry that “Personal care ser per 15 min” had been “Modified,” but with the corresponding “Reason Code” field left blank. This information was accompanied by a multi-paragraph appeal rights notice listing a street address and fax number to be used in requesting a hearing and a statement that “If you have any questions regarding this notification, please contact your provider.” The notice bore a simple letterhead with the agency name and Internet site address but no street address or phone number, and the notice was unsigned and failed to identify the responsible reviewer by name. The parent stated that in her opinion, the explanation in such notices needed to be more concise and be written in a more understandable form. She stated that even she had a difficult time understanding the notice.

During our audit, we asked officials from the Prior Authorization Unit to provide us with sample service notification notices. In response, officials provided us with examples of PCA program prior authorization “Adjudication Letters” sent to the consumer and to the responsible PCM and FI contractors whenever a determination is made. (No notification is sent to a consumer’s surrogate, who is expected to obtain the information through the consumer.) The content of these three computer-generated notifications is essentially identical, except that the document sent to the consumer is labeled as a “Member Adjudication Appeal Letter” and contains information regarding appeal rights that is omitted from the letters sent to the PCM and FI contractors. The Prior Authorization Unit also provided us with a printout of 98 separate boilerplate “Action Codes” used to generate text content in the notification letters regarding the reasons for any adverse actions taken by unit

reviewers. These Action Codes (44 denial codes, eight termination codes, and 46 modification codes), which are reprinted on decision notices, are not individually tailored to the consumer's particular circumstances. Rather, they simply break assistance needs into categories such as mobility, medications, bathing/grooming, dressing, range-of-motion, eating, toileting, IADL, transportation, and adaptive equipment maintenance. Adverse decisions are then justified with broad reason statements such as time requested being "longer than ordinarily required." For example, code 1476 reads:

*MassHealth has modified your request for prior authorization for personal care services because the time you requested for assistance with mobility is longer than ordinarily required for someone with your physical needs. See 130 CMR 422.410(A)(1) and 130 CMR 450.204(A)(1).*

No individually based explanation is provided on details such as which aspects of mobility assistance have been deemed to take too long or on the length of time that has been determined to be "ordinarily required." In addition, we noted that one code (1462), used to deny assistance to recipients of Emergency Aid to the Elderly, Disabled, and Children (EAEDC), references a nonexistent regulation. In order to get a general understanding of the complexity of the language used in these notifications, we subjected the Massachusetts Medicaid decision notices we received to a simple readability analysis available as a tool option in Microsoft Word software. The analysis reported that the notices had been written at a 12th grade reading level. This can be interpreted as indicating that readers with less than a 12th grade reading level cannot reliably be expected to fully comprehend the notices. In our research, we noted that accepted readability standards for similar notices are generally far lower. For example, numerous studies on the readability levels of rights notifications used by insurance companies indicate that many states require that insurance company notices be presented at eighth-grade or lower reading levels. Such requirements are based on studies documenting that reading levels for the general population typically run three to five grade levels below the actual highest grade levels attained by consumers. One resource on this issue available through the Privacy Rights Clearinghouse cites 1998 data showing 41% of the total adult population with no higher than high school degrees; hence, reading levels are likely to be at or below junior high school grade levels. For some population groups, such as elders, statistics report even lower education and literacy levels. For example, the same report documented that 68% of the population aged 65 and over have no more than a high

school degree, suggesting that over two-thirds of elders may read at or below junior high school reading comprehension levels. Similar reading-level issues exist for many Medicaid consumers, and the majority of PCA program consumers can reasonably be expected to read significantly below the 12<sup>th</sup>-grade reading level associated with prior authorization adjudication notices. In contrast, we noted the existence of federal litigation, such as the “Alberto N.” case covering personal care services in Texas, where a court-approved settlement required that notices to consumers in that state’s PCA program be written at sixth-grade reading levels, that explanations address the particular circumstances of the consumer, and that the appeal process be made more accessible through measures such as the use of toll-free telephone numbers and provisions for written and telephonic appeals, not just in-person appeals. Also, a 1997 audit report (A-02-96-61000), issued by the Office of the Inspector General for the Social Security Administration, expressed concern regarding the readability of similar rights notices sent to Social Security/Medicare recipients, recommending that, if at all possible, notices be written at the fifth-grade level and that notices include enhancements such as contact names and toll-free phone numbers.

In summary, existing PCA service notification and due process provisions could be improved in that:

- Notifications are written in unnecessarily complex language, well above recommended readability levels and probable reading comprehension levels for the majority of program consumers.
- Notifications use generic explanatory statements and do not appear to reasonably address each consumer’s specific circumstances. This problem is compounded by the lack of formal written guidelines for medical necessity determinations involving the program.
- Appeal arrangements do not include reasonable accessibility provisions such as toll-free telephone numbers for assistance and options for telephonic or written appeals. Also, an individual’s existing PCA service arrangements remain in effect pending appeal only in cases where appeals are submitted within 10 days of the determination. Consequently, the failure to ensure that surrogates are promptly notified of adverse determinations creates significant risk that appeal requests may not be filed on behalf of cognitively impaired consumers in time to ensure that existing assistance levels will be continued pending the outcome of the appeal.

In our opinion, these issues raise concerns regarding the adequacy of the program’s arrangements for ensuring that PCA program participants understand any adjustments that

are made to their level of service and are provided a meaningful opportunity for fair hearings.

**f. Special Prior Authorization Processing and Service Arrangements Established for Certain Categories of Consumers May Result in Inconsistencies in the Treatment of Some PCA Consumers**

Despite the previously described federal Medicaid principles regarding comparable service arrangements for all program participants, we found certain situations where different groups of consumers are subject to different prior authorization and PCA service delivery arrangements, as detailed below:

***Arrangements for Department of Mental Retardation Consumers***

As described in a 1997 Urban Institute report entitled Health Policy for Low-Income People in Massachusetts, even though Medicaid regulations were changed in 1988 to open the PCA program to individuals requiring surrogates, as of 1997, PCA service access barriers continued to exist for these consumers:

*While the DMA [Medicaid] argues that most PCA services for people with cognitive impairments constitute a form of respite and are, therefore, not "medically necessary," disability advocates argue that people with cognitive impairments unfairly face limited access to these services.*

Although participation by consumers with cognitive impairments gradually increased after issuance of the Urban Institute report, with the referral of significant numbers of DMR clients to the PCA program, we were told by advocates that the enrollment process for DMR clients was characterized by conflicts between Medicaid and DMR regarding responsibility for provision of ADL and IADL assistance. A special pre-Prior Authorization Unit submission review process, also administered by UMMS Commonwealth Medicine, was eventually established to address these issues. However, we were told that problems continued despite the additional pre-submission review process.

During our audit, one DMR consumer advocate described an example of the potential adverse consequences of these special arrangements applicable to DMR consumers. Specifically, a consumer served by the DMR contracted provider agency with which the advocate was associated had been able to independently live alone in an apartment with 84 hours per week in day and evening PCA time plus two additional hours per day of nighttime

PCA coverage. These arrangements were successful in part due to the unpaid surrogacy assistance provided by the consumer's elderly parent. When the aging parent's own ability to provide required surrogacy assistance decreased, DMR and the contractor agreed to provide limited additional supports with the express understanding that the supports were designed not to conflict with or replace already approved PCA services. Consistent with those arrangements, the assigned PCM agency recommended at the next reevaluation of the consumer that PCA services be continued at the same level. However, we were told that reviewers at the Prior Authorization Unit had overruled the PCM evaluators, instead determining that PCA services should be reduced to 21 hours per week with no additional nighttime assistance. The rationale for this determination was reported to be that since the consumer was now receiving at least some DMR-contracted supports, DMR and its contractor were now responsible for ADL and IADL even though the assistance was not required or funded by the contract between DMR and the service provider. The consumer appealed the determination but only succeeded in winning back some of the needed hours. Our review of limited PCA program data available to us documented prior authorization service reductions from the requested levels, at least partially corroborating the representations made by the advocate regarding the reduction of service levels to this consumer. According to the advocate, the resulting level of approved PCA hours was insufficient to allow the consumer to continue living independently, and DMR then stated that it lacked the resources needed to offset the PCA service cuts. As a result, the consumer was forced to move into less independent congregate-type living arrangements. We were told that such situations are a common problem for DMR consumers and that acceptance of increased DMR supports intended to maintain community living arrangements, even those that do not constitute ADL or IADL assistance, can actually jeopardize those independent living arrangements if PCA services are used by the consumer.

At the start of fiscal year 2007, Medicaid and DMR took further action to resolve such service responsibility disputes by transferring responsibility for PCA services provided to several hundred consumers receiving contracted full-time residential program services through DMR. Under this arrangement, the consumers are now required to obtain all personal care ADL and IADL assistance from employees of DMR residential service contractors. The contractors are reimbursed for these services using PCA program funds

transferred from Medicaid to DMR through an Intergovernmental Service Agreement (ISA) for this purpose. However, consumer advocates with whom we spoke stated that in their opinion, this service delivery model cannot provide the same level of independence and consumer direction as the consumer-employer service model used by non-DMR consumers in the state's PCA program. These advocates stated that unless consumers need legal control over the hiring and firing of direct care staff, "captives of the DMR service system."<sup>43</sup> However, under the transfer arrangements, PCAs are the employees of each DMR service contractor and are no longer employees of individual consumers. Consequently, as consumer service needs change, DMR employees, rather than independent PCM agency evaluation teams, determine the level of PCA assistance to be provided to each consumer. Also, under this arrangement a DMR consumer must accept restrictions on the availability and use of regular Medicaid state plan PCA services in order to obtain access to DMR agency services, which run counter to long-recognized principles of consumer choice and control within the PCA program.

In order to assess what negative effects, if any, this PCA service model has had on DMR consumers, we analyzed the utilization rates of services by consumers in this program as reported by DMR to PCA program managers. In total, utilization was reported to be only 77.35% during fiscal year 2007. While in a handful of cases underutilization was explained by notations such as references to consumer deaths, the overall utilization results also appeared to be somewhat distorted by the fact that utilization was reported to exceed 100% for 83 of the 518 consumers covered by the report. This suggested that underutilization issues for a significant number of consumers were greater than might be assumed based on the overall 77% utilization statistic. In addition to the 83 consumers with greater than 100% utilization (an apparent violation of the ISA's prohibition on the provision of services in excess of those deemed necessary by Medicaid), 28 consumers were reported to have received exactly 100% of their authorized services, while the remaining 408 listed consumers (78.8%) were reported to have received less than 100% of the service hours to which they were entitled. Sixty consumers (14.7%) received less than 50% of their service hours and 38 (9.3%) were reported to have not received any of their approved hours. Although the

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<sup>43</sup> This assertion is consistent with the philosophy behind provisions of the recently enacted Deficit Reduction Act, which in the case of "Cash and Counseling"/Individual Budget-type PCA services, actually prohibits agencies responsible for housing consumers from also providing their PCA services.

median utilization for the 408 consumers with less than full utilization was 83.9%, the average (mean) utilization was only 69.6%. Similarly, extreme variances were also documented for consumers with significant underutilization. For example, one consumer authorized for 156 hours per month averaged only 53% utilization for the year, with monthly service hours varying from 36.5 hours to 120 hours. The extent of utilization variance should be of concern to EOHHS, since the PCA services transferred to DMR for delivery through its contractor system are now being rendered through an agency-employer model rather than a consumer-directed model. Consequently, if services are not being received, it cannot be assumed that responsibility rests with a consumer/employer who may have failed to appropriately manage his or her own PCAs. In fact, in light of the asserted cognitive impairments for these consumers and the shift of PCA recruitment responsibility to DMR and its contractors, one might reasonably expect that utilization variances would be minimized under these service arrangements and that all services would be provided in full as required by the ISA, perhaps in some ways offsetting the adverse consumer choice and control shortcomings associated with the service transfers.

#### ***Arrangements for Transitional Living Service Consumers***

As described in the Introduction to our report, Medicaid personal care regulations provide for a special program component providing Transitional Living Services (TLS) for certain consumers. The TLS program is defined along with other personal care service-related definitions in 130 CMR 422.402 as:

*a program of services that may be offered by an organization in a structured group-living environment, for persons with severe disabilities who demonstrate an aptitude for independent living, but who can clearly benefit from functional skills training and supervised experience in management of health care, PCA services, and community activity in gaining the ability and confidence necessary to achieve independent living.*

Specific regulations covering TLS activity appear in 130 CMR 422.431 through 441, and TLS providers are also required to adhere to all other provisions of Medicaid's Personal Care Manual. These regulations provide for approval of an appropriate personal care agency provider and its proposed living facility and the delivery of PCA and related services designed to assist consumers in transitioning to independent living arrangements where consumers are not initially able to live independently and manage their own PCA services.

TLS includes PCA assistance, evaluation, service planning, skills training, transportation, and other support services. During the period covered by our audit, these services were provided at two facilities, Warren House and McLaughlin House, which were operated by New England Rehabilitation Hospital in Woburn, Massachusetts, a for-profit service provider working in partnership with Supportive Living, Inc., a nonprofit housing corporation that has developed and manages the facilities with funding from a combination of federal, state, and charitable sources for the purpose of providing supportive living arrangements for individuals with brain injuries. (Early in fiscal year 2008, responsibility for the Medicaid-funded direct services provided by the hospital was transferred to Advocates, Inc., a major nonprofit contracted human services provider in the DMR service system, whereas the facilities continue to be owned and maintained by the housing corporation.) During our review of various documents associated with the operation of these program sites, we noted the following:

- Services under the TLS component are in fact really long-term, non-transitional community residential-type services. Consumers were not being transitioned out of the program and consumers were not employing and directing their own PCAs as provided by the above-cited personal care TLS regulations. Instead, all services were performed by agency-employed PCAs.
- TLS services, including cueing/supervision and various health tasks, were not available to regular PCA program consumers. The provider controls the screening and admission process and public relations materials indicate it maintains a waiting list of approximately 150 individuals, all with brain injuries. These arrangements appear to conflict with both Massachusetts Medicaid personal care TLS regulations and applicable federal standards requiring that Medicaid state plan services be made available on an equal basis and in a timely manner to all consumers eligible under the state Medicaid plan.

**g. The PCA Program Prior Authorization System Does Not Routinely Take Advantage of Regulations That Allow Reevaluations of Consumers with Stable Medical Conditions to Be Conducted Less Frequently**

The 130 CMR 422.422(D)(2) states:

*The MassHealth agency may, at its discretion, grant prior authorization beyond the usual one-year period for services requested in a reevaluation in cases where the member:*

*(a) is aged 22 through 60;*



*(b) had no significant change in medical condition, functional status, or living situation within the previous year that may increase or decrease the member's need for PCA services, and no significant change is anticipated; and*

*(c) is not requesting an increase in the number of PCA hours provided per week.*

Despite this regulatory provision, our analysis of Prior Authorization Unit data and our interviews with PCM contractors and advocates indicated that this regulatory provision in fact is rarely used. Even the largest PCM agencies serving over 2,000 consumers each have only a small number (e.g., from 5% to as low as 0.3%) of consumers for whom the Prior Authorization Unit has approved authorization periods in excess of one year. This pattern is surprising, since the program expressly serves only consumers with long-term “chronic” disabilities and approximately half of all consumers are age 22 through 60. When we raised this issue with Prior Authorization Unit staff, they acknowledged that the number of extended duration approvals is low and is currently running at approximately 12 per week (approximately 4% of all program consumers). However, contractors and advocates asserted that the proportion of consumers for which extended duration approvals were warranted was much higher than 4%. Contractors and advocates asserted that in their opinion, Prior Authorization Unit reviewers were over-interpreting the “no significant change” provision of the regulation by refusing approval where there had been any change whatsoever, even if the change had no effect on required total service hours per week.

We reviewed the previously described sample of 94 cases where consecutive prior authorizations had been processed through the Auburn office for authorization start dates during fiscal year 2007 to analyze total requested hours and total approved hours for each case. We found that for 59 of the 94 cases, approved hours changed from one request to the next by no more than 1.75 hours per week (15 minutes per day). Five cases involved minor decreases, 19 cases involved minor increases, and for 35 cases there was no change whatsoever in approved hours. Yet none of these 59 cases, or the other 35 cases in the sample, received approvals for durations in excess of one year. 28 of the 59 cases with little or no change to approval levels involved consumers aged 22 through 60, 15 of whom had no change in total approved hours. We noted no apparent reason under the existing regulations why at least these 15 consumers should not have received extended duration approvals. Seven of the 59 cases involved child consumers, four of whom had no change in total approved hours; 24 consumers were age 61 or older, including 19 age 66 or older; and

16 of the consumers aged 61 or older had no change in their total approved hours. The 16 included the oldest consumer in the 94-consumer sample, an individual who was over age 90. If not for the age restriction included in the current Medicaid regulation, the total number of consumers potentially eligible for extended duration approval under a “no change” standard would have been 35 out of the 94 (37.2%). Even factoring in the existing age restriction, 15 of the 94 consumers (16%) appeared eligible for extended duration approvals under current regulations, a percentage four times higher than the estimated 4% extended duration approval rate reported by Prior Authorization Unit staff. Were the age restrictions to be dropped and “no significant change” to be defined as plus or minus 1.75 hours per week, 59 consumers (62.8% of the sample) might have been determined to be eligible for long-duration service authorizations. The results of our analysis are presented in the following table:

Age	Under 22		22 through 60		61 through 65		66+		All Ages	
	Number	% of Age Group	Number	% of Age Group	Number	% of Age Group	Number	% of Age Group	Number	% of Total
No Change in Approved Hours	4	40.0%	15	32.6%	2	25.0%	14	46.7%	35	37.2%
1.75 Hour Decrease or Less	1	10.0%	4	8.7%	0	0.0%	0	0.0%	5	5.3%
1.75 Hour Increase or Less	<u>2</u>	<u>20.0%</u>	<u>9</u>	<u>19.6%</u>	<u>3</u>	<u>37.5%</u>	<u>5</u>	<u>16.7%</u>	<u>19</u>	<u>20.2%</u>
Total with No Change Greater than 1.75 Hours per Week	7	70.0%	28	60.9%	5	62.5%	19	63.3%	59	62.8%
Decrease > 1.75 Hour	0	0.0%	2	4.3%	0	0.0%	1	3.3%	3	3.2%
Increase > 1.75 Hour	<u>3</u>	<u>30.0%</u>	<u>16</u>	<u>34.8%</u>	<u>3</u>	<u>37.5%</u>	<u>10</u>	<u>33.3%</u>	<u>32</u>	<u>34.0%</u>
Total in Sample	<u>10</u>	<u>100.0%</u>	<u>46</u>	<u>100.0%</u>	<u>8</u>	<u>100.0%</u>	<u>30</u>	<u>100.0%</u>	<u>94</u>	<u>100.0%</u>

While our sample was relatively small, the results suggest that extended duration prior authorizations are being significantly underutilized. The results also indicate that even when service need changes do occur from one evaluation to the next, they are often small for perhaps 60% of consumers, regardless of age group. We also noted that when changes do occur they overwhelmingly involve the need for service increases, even as judged by Prior Authorization Unit reviewers. The policy implication of this pattern is that the risk of a

change in status going unidentified due to the use of longer periods between reevaluations is minimal. Where service needs increase, consumers or their surrogates, case managers, or other involved service providers are likely to address the issue and seek a change in approved service levels. Even in those instances where service requirements decrease, the decreases tend to be less than 15 minutes per day, and there is minimal risk to the Commonwealth that significant losses will be incurred due to any failure by the consumer to report a decreased need for service. Also, since the direct and indirect costs associated with conducting and processing reevaluations are significant, it appears that a shift to reduced reevaluation frequency is likely to more than offset any losses arising from unreported reductions in service need.

**h. The Consumer Evaluation and Service Authorization Process Could Be Enhanced by Use of Laptop-Based Software Systems**

We noted that, in contrast to the Massachusetts evaluation and prior authorization process, other states have established effective automated processes to conduct evaluations and authorize PCA services. For example, the state of Washington has a far more streamlined and automated evaluation and approval process where evaluations are conducted and documented by local evaluators using a sophisticated laptop computer software application and are then uploaded to the state agency for processing and finalization. One study reported that Washington's expedited process has reduced the average time required to make authorization decisions from 37 days to 17 days.

Evaluation software can also be used to enhance the standardization, uniformity, and equity of determinations based on decentralized reviews performed by multiple individuals across a state. For example, our audit work identified numerous inconsistencies in practice across the two Prior Authorization Unit offices and even from one reviewer to the next, including apparent differences in regulatory interpretation and expectations regarding the extent to which family or other household members can be expected to provide assistance to reduce the need for paid PCA hours. We observed that, in contrast to this nonstandardized approach, the state of Washington's software system utilizes a widely accepted clinical assessment tool called the Zarit-Burden Interview to objectively measure the extent to which family members and other informal caregivers can reasonably be expected to provide such assistance.

In addition to efficiency and standardization improvements, the use of software-based evaluation systems where data is routinely uploaded to state program units for processing can be expected to reduce processing errors, such as those reported to us by Massachusetts system users as occurring when Prior Authorization Unit determination results are entered into the separate REVS system used by FI contractors to verify PCA payroll expenditure compliance with Prior Authorization limits. The ready availability of standard format evaluation data can also facilitate program evaluation studies and quality management activities such as screening for atypical evaluation patterns warranting visits by quality assurance staff.

### ***Recommendation***

In order to address the many issues presented in this Audit Result, we recommend the following:

The Commonwealth should amend PCA program regulations and contract arrangements to routinely rely on PCM contractor evaluation results and service assistance recommendations without the requirement for further approval processing through the UMMS Prior Authorization Unit. That streamlined approach would also be consistent with systems used in other states where results of such evaluations directly serve as the “prior authorization” used by state management systems to control payment in excess of approved service limits. Where concerns exist regarding standardization issues across PCM contractors, such concerns should be addressed through more appropriate quality assurance systems rather than by substituting the judgment of desk-reviewers with an inadequate basis for making such determinations without themselves conducting face-to-face evaluations in a methodologically standardized manner.

Information technology improvements should be implemented, such as the use of laptop-based software systems used in other states such as Washington to conduct and document evaluations and service approvals. Further, automated uploading of information to program databases should be implemented to expedite processing, share information efficiently, and facilitate standardization and quality assurance activity.

The feasibility of developing more comprehensive shared evaluation and assessment procedures should be explored so that multiple assessments of the same consumer for different but related or similar service programs are minimized.

The approval process should be modified to permit use of expedited “fast track” temporary service approval arrangements where needed to initiate services on an emergency basis or to facilitate the timely transfer of consumers from hospitals, rehabilitation facilities, or other settings to independent living arrangements. Regulatory and operational changes should also be implemented to reduce service access time for all consumers to the two-week average typical in many other states.

Existing regulatory provisions permitting use of reevaluations conducted less frequently than annually for consumers with low-risk stable situations should be expanded to provide greater

flexibility, and should be effectively implemented. Consideration should be given to establishing a presumption that less frequent reevaluations will be conducted for low-risk consumers with typically stable situations or where service needs can be expected to gradually increase over time as underlying impairments progress, but can reasonably be expected to be reported by consumers or their surrogates as changes occur. Exclusions from eligibility for extended duration approvals should not be based on age or other criteria for which there is no objective documented basis for assessing higher risk.

Detailed written policies and procedures should be developed to ensure that service need and assistance determinations are made in a consistent, fair, and equitable manner in conformance with appropriate standards and that inappropriate disparities in treatment and service access are eliminated.

Policy and procedure changes should be implemented to ensure adherence to special federal rules applicable to the scope and approval of PCA services for children.

Notification and appeal procedures should be modified to ensure that all parties receive timely notice in clear language that is readily understandable by individuals with limited reading comprehension levels.

### **3. THE MONITORING AND EVALUATION OF PCA PROGRAM SERVICES COULD BE IMPROVED**

We found that the monitoring activities conducted by PCA program staff at FI and PCM agencies could be improved. For example, Medicaid's monitoring activities focus on compliance with various organizational and operational contractual requirements and place less emphasis on the collection, distribution, and analysis of information that could facilitate better program planning and decision making. Further, the contract monitoring activities that are being conducted could be improved to better ensure that PCA program services are being provided in a manner consistent with applicable regulations and the requirements of the contracts that fund these services.

Our review of national studies on PCA program services throughout the nation identified common "best-practice" themes, including:

- The importance of consumer control and the principle that the views of personal assistance service users must be paramount in the design, delivery, and evaluation of personal assistance service programs;
- Flexibility;

- A holistic focus on person-centered problem solving to facilitate independent living arrangements; and
- The development of evidence needed for informed decision making by all stakeholders; including consumers, providers, state and federal managers, legislators, etc.

These quality management considerations encompass, but also go well beyond, traditional fiscal accountability and regulatory compliance-oriented contract-monitoring activities. When public agencies elect to purchase services, they have an obligation to both the individuals being served and the public at large to conduct appropriate monitoring and oversight activities. The Federal Center for Medicare and Medicaid Services (CMS), within the U.S. Department of Health and Human Services, promotes state Medicaid programs to use a Quality Management and Continuous Quality Improvement (CQI) system and has adopted a uniform CQI tool for CMS regional office use in monitoring state Medicaid waiver programs. While CMS does not mandate the use of such approaches, the Commonwealth's Operational Services Division (OSD) and the Office of the State Comptroller (OSC), the state agencies that oversee the procurement of all commodities and services, including Medicaid services, have issued guidance regarding contract administration practices, including monitoring and evaluation activities. Current guidance reiterates principles previously set forth in an OSD Procurement Policies and Procedures Handbook, which states,

*The Commonwealth has a responsibility to conduct monitoring and evaluation of the commodities and services it purchases. These activities can assist in identifying and reducing fiscal and programmatic risk as early as possible, thus protecting both public funds and clients being served. Contract managers are responsible for monitoring contractor performance and other issues that arise during the life of the contract. In developing monitoring and evaluation procedures, the Commonwealth, through its departments or PMTs [Procurement Management Teams], should strive for methods which rely on, among other things, national or industry standards and which are coordinated, cost efficient and appropriate to the level of risk to the Commonwealth in the purchase of the commodities or services.*

As noted in the Background section of this report, EOHHS contracts with multiple nonprofit organizations to provide PCA program services. The number of contracted organizations, which include FI and PCM agencies, has steadily increased to 30 participating contractors during fiscal year 2008. As part of the PCA program, PCM agency activities must be coordinated with contracted FI activities and with the activities of multiple state-operated program units associated with the PCA program. The complexity of the PCA program presents a variety of management challenges for both PCA program managers and contracted service providers.

These challenges make it particularly important that PCA program managers implement appropriate monitoring and control systems to ensure that the PCA program operates as intended.

During our audit, we reviewed the monitoring and program evaluation procedures established by EOHHS relative to PCA program services. In addition to an assessment of the PCA program's monitoring activities, our analysis also included a comparative review of the monitoring activities being conducted by PCA programs in other states and the above-summarized best practice themes. We first asked PCA program officials to provide us with copies of all the policies and procedures EOHHS has established relative to monitoring PCM and FI activities. In response to our request, these officials told us that they have not established any formal written policies and procedures for these purposes, but rather conduct monitoring activities as required by Medicaid regulations and the terms and conditions of the Commonwealth's contracts with PCM and FI agencies.

We then reviewed a judgmental sample of 10 of the monitoring files being maintained by PCA program staff for the 27 PCM agencies that provided PCA program-related services to the Commonwealth during fiscal years 2005 through 2006. In addition, we reviewed four of the monitoring files relative to monitoring activities conducted by PCA program staff at the four FI agencies that were involved in the PCA program during fiscal years 2005 through 2006. In addition to records for the 10 selected PCM agencies and four FIs, we reviewed electronic files provided by PCA program managers that contained monitoring information on all PCM agencies that were under contract with the Commonwealth during our audit period. Finally, we also reviewed various other related documents such as minutes of meetings between PCA program managers and various PCM and FI contractors.

In addition to reviewing the aforementioned documents, we conducted research as described in the Audit Scope, Objectives, and Methodology section of our report to obtain the above-described PCA program monitoring and quality management best practice information. Based on our research, we identified a number of areas in which we believe EOHHS's monitoring of PCA program-related activities could be improved, as detailed in the sections below.

**a. PCA Program Monitoring Is Not Designed to Assess the Overall Quality and Effectiveness of the PCA Program**

Under their contracts with the Commonwealth, PCM agencies are obligated to submit four separate reports (Functional Training, Consumer Complaint, Intake & Orientation, and Prior Authorization Tracking reports) twice a year to PCA program managers. In addition, these contractors are also required to annually submit a self-report on contract performance standards and measures and a copy of the Uniform Financial Statements and Independent Auditor's Report (UFR) that they are separately required to submit to the Commonwealth's Operational Services Division. EOHHS/Medicaid's responsibilities under contracts with FIs and PCM agencies include, among other things, carrying out program evaluation and other contract-management activities such as the monitoring and auditing of contract compliance, and applying sanctions and financial recoupment measures for noncompliance. Contract provisions also allow EOHHS/Medicaid to conduct various discretionary activities such as on-site monitoring visits and consumer satisfaction surveys.

Medicaid managers have implemented a monitoring approach that focuses on ensuring that PCM and FI contractors are in compliance with certain terms and conditions of their contracts. This monitoring focuses on four contract standards:

- Standard One: the contractor must develop a program that is sensitive to the needs of the consumer it serves, pursuant to the contract.
- Standard Two: the contractor must respond to consumers' requests for all prior authorizations in the timeframes specified in the contract and conduct the evaluation process in accordance with the requirements of the contract.
- Standard Three: the contractor must recognize the importance and need for establishing and maintaining the integrity and validity for its claims and reporting submissions.
- Standard Four: the contractor must establish and maintain a cooperative working relationship with the fiscal intermediary.

Each standard is associated with between one and seven specific performance measures, such as having 100% of evaluations "accurately reflect the consumer's functional abilities." Program managers evaluate compliance on each measure through a combination of techniques, including compiling data from periodic contractor self-reports; gathering data



from the Prior Authorization Unit on cases and surveys; and periodically conducting site visits to PCM agencies.

However, our review determined that these monitoring activities do not assess whether PCA program service providers are achieving desired outcomes, identifying and resolving problems and barriers to success, and identifying and promoting implementation of programmatic improvements. System-wide PCA program evaluation activity in the Massachusetts PCA program is limited, and is not designed to identify various cross-contractor issues that may exist within the PCA program or to provide information needed for an evidence-based approach to planning, policy, operations management, and oversight. In contrast, PCA programs elsewhere in the nation (e.g., Washington, California, and Texas) utilize monitoring activities that focus more on identifying best practices, critical incident monitoring and analysis, and include quality assurance visits aimed at improving service quality and not just assessment and enforcement of regulatory and contractual compliance. We found that Massachusetts PCA program monitoring and evaluation activities, unlike those of many other states, do not significantly address qualitative program activities such as program outreach, coordination, and referral issues and their potential impact on the success of the program. Our review in this area identified numerous issues, as follows:

- PCA program staff did not provide documentation to substantiate that they were tracking the number of consumers entering the program from institutional settings or cases where the PCA program was used to divert consumers from nursing homes or other less appropriate or less desirable long-term care arrangements.
- The PCA program is not monitoring the efficiency and effectiveness of its own PCA prior authorization process, which could result in unnecessary delays in the provision of PCA services or compliance issues involving the requirement in Section 1902(a)(19) of the Social Security Act that state programs “provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients.”
- There has been no significant monitoring of utilization patterns and underutilization problems or attention paid to identifying contributing factors and possible approaches to resolving such problems. The only significant utilization focus has been on controlling overutilization for the purpose of cost containment. In contrast, we noted that California documentation demonstrates additional uses made of overutilization tracking information. There, PCA activity time is reported to be tracked not just for compliance with service authorization limits but also to identify situations where individual PCAs

work more than 300 hours per month, whether for individual consumers or multiple consumers, so program staff can be alerted to spot situations where quality of service may suffer due to excessive PCA workloads. The monitoring of service underutilization is of obvious importance both for assisting consumers and surrogates in self-managing their PCA services and for assessing operational arrangements such as the prior authorization process, the adequacy of PCA compensation and referral and backup service arrangements, as well as the impact of special initiatives such as the DMR service transfer. However, with the exception of extremely limited monitoring on underutilization for DMR service transfer consumers, which has not examined individual details such as reasons for underutilization, PCA program managers do not monitor underutilization.

- PCA turnover issues have not been examined by PCA program managers even though data is maintained at the FI contractor level that could be used for such analysis.
- Little attention has been paid to demographic trends for the program and their implications or to issues of underserved consumer groups (whether by age, disability/functional issues, or other categories such as cultural/language grouping).
- Other than periodically identifying percentages of consumers with surrogates, information relative to surrogates is not tracked or analyzed to identify any surrogacy-related issues such as consumer problems in securing surrogacy assistance or the need for such things as paid surrogacy assistance or background checks for surrogates where desired by consumers.
- There is no documentation to substantiate that PCA program staff are compiling information regarding other consumers' needs that have not been met, such as problems securing assistance with skilled nursing, housing, transportation, employment, or other needs that if not adequately addressed can seriously impair independent living arrangements or result in institutional placement even where PCA recruitment and retention issues do not result in underutilization of the program.
- PCA program staff does not make independent direct contact with PCA program participants to assess consumer satisfaction with the PCA program as a whole. Rather, PCM contractors are expected to conduct their own consumer satisfaction surveys on an annual basis, a quality assurance practice that may be useful to contractor management staff but may be of limited value for statewide quality assurance and program evaluation purposes. This limitation is due to a number of factors, including inadequate standardization, lack of anonymity, and failure of Medicaid to ensure that surveys cover program issues other than PCM agency intake and orientation, evaluation, and skills training activities. Since Medicaid mandates that surveys cover those three service areas, the result is that consumers are repeatedly asked the same questions year after year, producing little in the way of new, useful information for managers at either the contractor or Medicaid. Also, this repetitive survey approach predictably results in reduced response rates over multi-year periods. Yet Medicaid managers required PCM agencies to do whatever was necessary to ensure that survey responses are received from at least 20% of the PCM agency's consumers, regardless of the number of consumers

using the PCM agency or the number of responses needed to provide a statistically valid basis for determining whether or not the contractor had met the performance standard of at least 95% consumer satisfaction levels. As a result, even PCM agencies with over 3,000 consumers may need to survey 100% of consumers each year in order to ensure that the required percentage of responses are received. During our audit we noted that in other states the state Medicaid agency independently evaluates consumer satisfaction in a standardized statistically valid manner for all aspects of the program. For example, in California, state managers measure consumer satisfaction and concerns on an independent basis through such means as meetings with consumer groups and face-to-face visits to appropriately selected samples of program participants. Such well-designed monitoring practices could produce more useful and reliable results than the process mandated by Massachusetts Medicaid PCA program managers<sup>44</sup>.

We also noted that significant elements of each PCM agency's responsibilities as specified in their contracts are not addressed by EOHHS program monitoring activities. For example, approximately 10% of the language in the contract between each PCM agency and the Commonwealth is devoted to personnel issues such as staffing levels, including staff availability, training and qualifications, use of contracted staff or consultants, and record-keeping and staff-change notification requirements. However, we found that with limited exceptions, the PCA program's monitoring and evaluation systems do not assess these areas. Details regarding the inadequate scope of monitoring for utilization, compliance, and financial issues are discussed in the subsections below.

**b. PCA Service Provider Site Visits May Not Be Conducted with Adequate Frequency**

PCM and FI contract provisions state that program managers may conduct annual on-site monitoring visits to each contractor. Although there are no formal written policies and procedures relative to these monitoring activities, PCA program staff told us that site visits had regularly been conducted on an annual basis up until the end of fiscal year 2006, but that these PCM monitoring arrangements were in the process of being changed so that a site visit by program staff to each PCM contractor will only be conducted once every two years. However, our review of tracking sheets maintained by program managers revealed that regular annual site visits had not been conducted even prior to 2006.

During our audit, PCA program managers provided us with what they referred to as a tracking sheet that detailed PCM agency site visits and follow-up activity they had conducted

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<sup>44</sup> Subsequent to our audit work, the PCA Quality Home Care Workforce Council initiated its own independent survey of consumers regarding certain aspects of the program during 2008. However, that survey is not an integral component of program monitoring activity.

between May 2004 and November 2006. This tracking sheet documented a total of only 36 visits to 26 of 27 PCM contractors and made reference to only three prior site visits conducted since October 2002. Our separate review of agency records covering 10 of the 27 contractors documented an additional three site visits to two contractors between August 2003 and November 2005 that were not included in the tracking sheet provided to us by PCA program staff. As detailed in the table below, based on the documentation that was provided to us, we were able to confirm only 43 PCM agency site visits conducted from October 2002 through November 2006, as opposed to the 96 or more reviews that should have been conducted if visits were conducted annually.

### Monitoring Site Visits Per PCM Contractor

#### October 2002 through November 2006

Number of Contractors	Number of Visits Each over 4-Year Period	Total Visits Conducted	Number of Visits to Have Been Conducted under Annual Visit Standard *
14	Visited once	14	44
10	Visited twice	20	40
<u>3</u>	Visited three times	<u>9</u>	<u>12</u>
<u>27</u>		<u>43</u>	<u>96</u>

\* Not all 27 PCM contractors were in the system from the start of the contract period, so the actual number of site visits that should have been performed using a frequency of once a year was less than 108. We conservatively estimated that a minimum of approximately 96 visits should have been performed over the period, ignoring considerations such as the need for follow-up visits where serious problems were identified.

This apparent lack of regular monitoring is of particular concern given the fact that the majority of the PCM contractors that appeared on the tracking sheet were determined by PCA program staff to be significantly out of compliance with various contractual performance measures. For example, for 13 contractors that had not been visited since November 2004, nine were cited during their most recent site visit as not being in compliance with more than 20% of the established contract performance measures. At least four of the nine had been determined to be in less than full compliance on over one-third of the performance measures, and in one case performance data had not even been tracked,

apparently due to the failure of the PCM contractor to comply with reporting requirements over an extended period.

**c. PCM Agency Monitoring May Not Accurately Assess Actual Program Activity**

Prior to conducting a PCM monitoring site visit, PCA program monitoring staff require the contractor to self-assess its compliance with each of the above-described contract standards and performance measures. Then, as part of the site visit process, Medicaid program staff use a three-page consumer file review form to assess adherence of each consumer file with compliance requirements such as consumer eligibility, surrogate assessment, evaluations and requests for prior authorization, service agreements, and functional skills training. The results of these file reviews are used in conjunction with the contractor's self-assessment and other information such as input from the FI and the Prior Authorization Unit to characterize performance on each measure as having been Met, Partially Met, or Not Met. Medicaid then sends the results back to the contractor to enter planned corrective measures on items identified by Medicaid as being not met or only partially met and uses the results to determine the matters to be reviewed at any follow-up visit. Typically where items have been characterized as met as the result of a prior visit, the same items are then left un-reviewed at the follow-up visit. It is important that sample records selected for review at site visits be of sufficient size to identify problems that may occur infrequently but may still be of a serious nature. Samples must also be large enough to produce results that are reasonably representative of what would be found in an examination of all records. Also, the assumption of "once in compliance, always in compliance" should be validated by revisiting un-reviewed items at least periodically.

However, no policies or procedures had been established regarding either the use of these review tools or the sampling methodologies that should be used (e.g., statistical sampling, judgmental sampling, etc.) during these site visits. Further, based on the PCM monitoring records we reviewed, we believe that in many cases the samples reviewed by Medicaid staff during monitoring visits may be too small to provide a reasonable basis for valid conclusions regarding overall quality management and compliance at each contractor visited. For example, for one contractor serving approximately 1,700 consumers per year, PCA program monitoring staff examined only 24 consumer files. Our review of other site review records

indicated that sample sizes typically were only eight to 15 cases per PCM agency regardless of whether the contractor served 45 consumers a year or 3,000 consumers a year.

We also found that the monitoring process assesses compliance with the performance requirement that 100% of evaluations “accurately reflect the consumer’s functional abilities” by employing the assumption that if Prior Authorization reviewers have modified a service request submitted on behalf of a consumer, the contractor has failed to meet the performance standard. Given the questions that exist regarding whether the prior authorization desk review process has a reasonable basis for modifications made to service authorization requests, it is not clear that this contract-monitoring assumption is valid. The use of a “100%” standard for performance on that measure also effectively causes every contractor to be less than fully in compliance with the standard.

In addition to the issues of sample size and underlying assumptions for drawing conclusions regarding the accuracy of consumer evaluations, we noted that PCA program staff do not sample either contractor or Medicaid billing data to assess trends that could indicate a problem in service delivery. For example, our review of PCA billing data for the program indicated that for fiscal year 2005, over 50% of persons applying to some PCM contractors apparently had never received an initial evaluation, the overall average was in excess of 45%, and the median percentage by PCM contractor was over 25%. This data raises questions such as whether ineligible consumers are being referred to the program; whether they are eligible but so unstable that they are entering nursing homes or making other long-term care arrangements even before initial evaluations can be conducted; or whether program arrangements are inadequate to meet their needs due to problems such as unavailability of personal care attendants, surrogates, or other essential supports such as service coordination or housing assistance needed to make community-based living arrangements a viable option.

We also observed that PCM agency site visits were conducted by PCA program monitoring staff on a single-day basis regardless of the number of consumers served by the PCM contractor or the extent of issues already identified for the contractor.

PCM monitoring visits identified numerous instances of noncompliance by PCM contractors. In fact, data maintained by Medicaid program managers for site visits conducted

during fiscal years 2004 and 2005 showed that no contractor had been found by PCA program reviewers to be in full compliance on all established performance measures. Every site visit conducted by PCA program staff during this period had resulted in a determination by PCA program managers that a formal Corrective Action Plan (CAP) was required. For example, on one program manager's spreadsheet tracking 29 visits to 24 contractors during 2004 and 2005, there was not a single visit reported where the contractor had been deemed to be at as high as a 90% compliance level. Eighteen of the 29 were rated at less than 75% compliant, with some as low as 25%. In addition, we noted information on this spreadsheet that reported performance results on certain measures that were lower than the contractually established thresholds, yet some contractors were characterized as being in full compliance on those measures. For example, under Performance Standard 2, Measure 1, at least six contractors had been characterized as having fully met the requirement that at least 95% of their initial evaluations of consumers were submitted to Medicaid's Prior Authorization Unit within 45 days from referral date. However, the spreadsheet data we reviewed showed that contractors submitting as few as 72% of their initial evaluations within the required timeframe had been characterized as being in full compliance. In addition, all compliance data for one visit to a contractor, Independence Associates, Inc., had been left blank without explanation, and no other visits had been documented for that contractor despite the fact that other records maintained by the unit documented a history of complaints regarding the contractor and performance issues such as failure to submit the period reports mandated by contract. Other documentation for that contractor revealed that it had been determined by PCA program managers to have Not Met three performance measures and had only Partially Met a fourth measure.

On a variety of other compliance measures, multiple contractors appeared to be cited as being deficient due to the fact that PCA program staff conducting the site visits were less than satisfied with forms developed internally by contractors. These included documents such as consumer satisfaction surveys, surrogacy-related forms, telephone logs, service agreements between consumers and the PCM agencies, and consumer handbook/orientation materials, even where the materials had previously been submitted to program managers and approved at the time the organizations were approved as PCM contractors. As a result, each contractor was frequently being required to "reinvent the

wheel” by independently developing document modifications to be submitted to PCA program managers for approval. Where efficiencies can be expected from the use of standardized documents and procedures across multiple contractors, the most efficient, cost-effective way to implement such changes is to develop them on a statewide basis with stakeholder participation rather than by requiring each contractor to do its own development work, much of which may duplicate work already done by others.

**d. Sanctions for Noncompliance with Contractual Terms Are Not Standardized and Are Administered in an Inconsistent Manner**

Appropriate contract administration practice requires that contract compliance and performance be accurately and fairly assessed and that identified problems be addressed through the implementation of corrective measures and, where appropriate, sanctions administered in a fair and standardized manner. As previously described in Audit Result No. 3, we identified significant questions regarding contract-monitoring practices used to characterize contractor performance. During our audit, we noted that PCA program managers also had not developed standardized graduated sanctions for instances in which they concluded that a PCM agency was noncompliant with contractual terms and conditions or performance standards. Appropriately or not, PCA program managers characterized numerous contractors as being noncompliant with contractual requirements and performance measures for extended periods of time. Yet, as of March 2008, program staff had formally sanctioned only three contractors since October 2002. In each case, regardless of the nature of the noncompliance, the sanctions involved suspending the contractor’s intake activity (ability to take on new consumers) for a period of time while corrective actions mandated by PCA program managers could be implemented by the PCM agencies. However, we found a number of instances in which PCA program staff appeared to have inconsistently administered sanctions against PCM agencies. For example, one contractor for which only 62.5% of EOHHS program performance measures had been met had been sanctioned; yet similar action had not been taken for the contractor with missing compliance statistics and for at least four other contractors with apparently worse compliance statistics than the sanctioned contractors. For the four non-sanctioned contractors with compliance statistics, compliance rates computed by PCA program staff ranged from a high of only 56% to a low of 38%. Nor were sanctions implemented in a timely manner, as evidenced by the



case of one contractor with a reported performance measure compliance rate of only 25% in 2004 that remained unsanctioned for over a year until sanctions were finally initiated during fiscal year 2006. Also, in the case of the contractor for which performance statistics had been left blank on the tracking sheet maintained by PCA program staff, we found site visit documentation indicating that the contractor had not met three performance measures and had only partially met a fourth measure. Other documentation indicated that this contractor had failed to finalize corrective action requirements and had also failed to file key reports required by its PCA contract over an extended period.

**e. PCA Program Monitoring Activities Should More Effectively Track and Analyze the Underutilization of PCA Program Services**

Underutilization of PCA program services can be attributable to factors such as PCA recruitment problems and temporary hospitalizations of consumers rather than authorizations of unnecessary services. National policy studies emphasize the importance of monitoring not just over utilization of authorized service levels, but also underutilization. For example, a 2006 report commissioned by HHS/CMS, entitled “Individual Providers, Employing Individual Providers Under Participant Direction,” includes the following guidance:

*In some states, the support coordinator reviews monthly billing submissions to identify under utilization and the possibility that providers are not doing the work (Vermont). Over billing can also be a cause for concern since it could indicate that the individual may need more support than is identified in his or her support plan or that the provider is taking advantage of the person. South Carolina has an automated billing system called Care Call whereby providers call-in when they arrive and leave. On an individual/provider level, the support coordinator may review monthly billing submissions to determine that services are delivered as authorized. Billing systems can also be used to detect statewide or sub-state trends in use of individual providers by types of services (e.g., types of services provided, usage in different areas of the state, type of living arrangement).*

Another study published by the AARP Public Policy Institute in 2006, “Health Care Quality: Emerging State Strategies to Deliver Person-Centered Services,” also notes the importance of monitoring service delivery utilization and the advantages of real-time information, such as that generated by the South Carolina system for ensuring that service problems for consumers in high-risk situations are promptly identified.

Such studies, together with comments made to us by consumer advocates during our audit, suggest the existence of significant concerns regarding the underutilization of PCA services for at least some consumer populations due to factors such as PCA recruitment and turnover problems. Clearly, it is important to identify, track, and address underutilization situations.

In response to our initial document requests made early in fiscal year 2007, Medicaid managers provided us with only a single summary of utilization statistics. The summary, which covered only fiscal year 2004, reported that only 79% of authorized PCA service units were actually used, that 22% of consumers used less than 50% of their authorized service units, and that 5% of consumers had not made any use of their authorized services. We then asked the Medicaid Office of Long Term Care's (OLTC) Director of Community Services about the department's underutilization tracking activities and were told that the department was conducting no ongoing tracking or analysis of service utilization. In fact, the aforementioned data for 2004 had been generated on an ad hoc basis and was not an integral component of PCA program monitoring and information management systems. The Director told us that she hoped to be able to address the issue in the future.

Due to the absence of current summary data, we conducted our own analysis gathering available fiscal year 2007 data directly from Cerebral Palsy of Massachusetts, since that organization operated both FI and PCM agency services and was able to cross-match FI billing data with PCM program data, such as requested and approved service hours for approximately 1,767 consumers served by its own PCM program. The purpose of our analysis was to evaluate the validity of the many concerns expressed by advocates regarding issues such as the impact of PCA recruitment and retention problems on consumer services and to identify any noticeable utilization trends or associations with other program operations that had not been identified by Medicaid managers. Given the fact that it was not possible to utilize a random sampling methodology to develop definitive statistical projections of statewide utilization averages for the PCA program, the results of our analysis might vary somewhat from statewide patterns.

The results of our own analysis are presented in the tables and accompanying text below:

**Utilization Summary for 1,767 Consumers at Fiscal Year 2007 Year-End**

Utilization	New Consumers	Ongoing Consumers	All Consumers
	% of Consumers	% of Consumers	% of Consumers
0%	18.6%	2.1%	4.8%
0% to 50%	<u>11.4%</u>	<u>3.8%</u>	<u>5.0%</u>
Total under 50%	<u>30.0%</u>	<u>5.9%</u>	<u>9.8%</u>
50% to 80%	10.3%	9.2%	9.4%
80% to 90%	<u>8.0%</u>	<u>6.8%</u>	<u>6.5%</u>
Total under 90%	<u>48.3%</u>	<u>21.9%</u>	<u>25.7%</u>
Over 90%	51.7%	78.1%	74.3%

Based on our review of this data, we found that approximately 26% of all consumers and 48% of new consumers underutilized prior authorization approved service hours by 10% or more, while 10% of all consumers and 30% of new consumers underutilized approved service hours by 50% or more. Some degree of underutilization is inevitable due to temporary consumer hospitalizations and unavoidable PCA turnover and sick time. Underutilization can also be expected to be somewhat higher for new consumers due to the start-up time needed after the prior authorization approval date to set up PCA payroll arrangements and complete the first payroll period before timesheets are submitted. However, the data in the previous table suggests that significant underutilization issues appear to exist for perhaps 20%-25% of the program's consumers<sup>45</sup>.

We also noted that underutilization problems disproportionately involved consumers under age 22 and, to a lesser extent, those over age 65 – the two most rapidly growing age groups

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<sup>45</sup> Our analysis did not include the individual record reviews that would be required to determine whether termination situations such as death, institutionalization, or moving out of state accounted for a material portion of reported underutilization. However, terminations in general appear to be infrequent due to the stable nature of the program, which serves consumers with permanent, chronic disability issues, and the currently low level of participation by elderly consumers, the group most likely to leave the program in any given year. We therefore had no reason to believe that terminations, rather than other factors, account for the significant underutilization patterns identified by our review.

in the PCA program. However, these differences could not be attributed simply to differences in the proportion of new consumers by age group. Even for new consumers, the pattern persisted by age group with 36.1% of new consumers under age 22 and 34.4% of new elder consumers utilizing less than 50% of their approved service hours during the year, compared to 28.2% of new adult consumers aged 22 through 65.

Further, as summarized in the following table, underutilization problems are disproportionately worse for consumers with fewer approved service hours per week and for consumers whose requested service hour levels have been reduced by the Prior Authorization Unit. These patterns are related to each other, since approved service hours per week are lower for a consumer whose services have been reduced by the Prior Authorization Unit than the approved hours would have been had no reduction occurred.

#### Underutilization by Prior Authorization Action and Approved Service Hours

Approved Hours per Week	Request Not Reduced by Prior Authorization Unit		Request Reduced by Prior Authorization Unit		All Consumers	
	Number of Consumers	% under 50% Utilization	Number of Consumers	% under 50% Utilization	Number of Consumers	% under 50% Utilization
At Least 27.25 Approved Hours*	432	4.9%	442	8.8%	874	6.9%
Under 27.25 Approved Hours	497	11.3%	396	14.6%	893	12.8%
Total All Approved Hours	929	8.3%	838	11.6%	1767	9.8%

\*The median number of approved service hours per week for the 1,767 consumers was 27.25 hours, with 15 consumers all approved for 27.25 hours. As a result, it was not possible to divide the 1,767 consumers into two groups on the basis of approved hours with exactly the same number of consumers in each group.

Most notably, our analysis indicated that extreme underutilization cases were not uncommon and that 4.8% of the 1,767 consumers had failed to utilize any of their prior authorization approvals in place at year-end. In order to factor out those consumers whose failure to utilize approved services might be attributable to having had prior authorizations approved close to year-end, we compared utilization data for those consumers with prior authorization periods in place for three months or less at year end to data for those consumers with prior authorization approval periods starting between January 1, 2007 and March 31, 2007. For the consumers with approval periods starting only at April 1, 2007 or later, 8.1% still did not

utilize any approved hours prior to year-end. The percentage for those with approvals issued from January through March was lower, but still significant. Approximately 3.7% had no service utilization reported whatsoever through at least the end of June 2007 – a period of three to six months for each consumer. For children, we calculated an even higher zero utilization rate of 5.4% over that period. This was not surprising, since the median requested and approved service hours per week for children are far lower than for adults or elders (e.g., median requested hours were 15.75 for children, compared to 30.25 for adults, and 31.25 for elders over age 65), and underutilization is more common for consumers with fewer service hours.

Prior Authorization Unit staff told us that they sometimes review individual utilization information at the time of reevaluation/reapproval. However, they stated that they only do this because they regard past underutilization as an indication that the consumer did not really need the level of services approved, and the unit considers this a reason to make reductions to future service hours requested by PCM evaluators. However, according to advocates and professionals we interviewed, the result can be a self-fulfilling prophesy with adverse consequences for the consumer.

In January 2008, as we were completing the above analysis, Medicaid PCA program managers provided us with their own review of underutilization. It consisted of a simple breakdown of stated utilization rates by age group for fiscal year 2006, as follows:

**Fiscal Year 2006 Utilization Data Provided by Medicaid PCA Program Managers**

Age group	# Members	Units Authorized	Units Used	% Used
Age 0 - 21	1826	9,789,686	7,815,897	80%
Age 22 - 64	5880	49,963,123	45,093,444	90%
Age 65 And Over	2107	15,894,705	14,249,462	90%
Total, All Ages	9813	75,647,514	67,158,803	89% *

\* Medicaid actually incorrectly reported the Total All Ages percentage as 87%. We have corrected the error for presentation in this report. We also noted that the total number of consumers reported in this utilization summary (9,813) does not fully account for all 14,828 consumers separately reported by Medicaid to be in the PCA program for fiscal year 2006, as shown in the summary table appearing in the Introduction section of this report.

In comparing the 2006 data generated by Medicaid to the results reported above for the 2007 sample we analyzed, we noted some similarities. For example, both the statistics

reported by Medicaid and the results of our analysis showed that utilization rates for children ran approximately 10% below the rates for adults. However, our analysis calculated an overall average utilization rate of 91% for the sample, 2% higher than the 89% rate calculated from the data provided by Medicaid. Since our sample covered only consumers served through a single PCM agency in southeastern Massachusetts, we could not rule out the possibility that utilization patterns may be different elsewhere in the state.

Consumer advocates and PCM contractors repeatedly voiced concerns to us regarding underutilization problems and stressed the importance of reliably maintaining available PCA services for consumers as a factor in reducing avoidable nursing home placement and temporary hospitalization for acute care issues. When consumers go without adequate PCA assistance, the results can be more than a mere inconvenience and in fact can be either life-threatening or can increase the incidence of a wide variety of health problems. When the consumer's independent living arrangements are also dependent in part on assistance provided by family members and other informal care givers, underutilization of PCA services can stretch informal care arrangements to the breaking point and sometimes generate stress-related health or living problems at significant cost to the individuals. PCA program managers should implement better systems for monitoring utilization and devote greater attention and resources to underutilization issues.

**f. PCA Program Staff Should Routinely Utilize Financial Statements Submitted by PCM Agencies to the Commonwealth in Monitoring Their Activities**

The Division of Health Care Finance and Policy uses PCA program contractor financial filings for pricing purposes, as described in Audit Result No. 4 on pricing issues. Those financial filings are made in the form of Uniform Financial Statements and Independent Auditor's Reports (UFRs) prepared in accordance with specifications established by the Commonwealth's Operational Services Division. The UFR is an annually submitted financial report comprised of financial statements audited by an independent certified public accountant along with unaudited organizational and program-specific information on budgeted and actual revenue and expense, supplemented with details on program staffing arrangements and service statistics.

However, while PCA program managers asserted that they annually gathered UFR copies from program contractors, they acknowledged that they didn't have the expertise required to fully understand and interpret UFR filings and that when attempting to review the filings in the past they had had to seek assistance from state managers outside the program. We noted that all employees conducting monitoring activity and their supervisors had clinical degrees (e.g., social work) rather than financial management backgrounds. In reviewing contract administration records, we saw only limited evidence that UFRs were reviewed or that UFR filings were even verified on an annual basis by Medicaid other than for the FI contractors, where financial report information is used for the limited purpose of reconciling actual administrative costs with reimbursement payments as discussed in the Introduction section of our report. There were only a few instances where program staff appeared to have utilized UFRs in the monitoring process. We believe that the information being submitted by PCM and FI agencies in their UFRs should be routinely used by appropriately qualified reviewers during their monitoring activities. Using this financial information to perform simple analytical assessments could provide meaningful information relative to the contractors' performance in providing PCA program services. For example, during our review of PCM agency monitoring records we noted that during a fiscal year 2005 site visit, PCA program staff documented that one PCM agency, Toward Independent Living and Learning, Inc. (TILL), only met 25% of EOHHS's performance measures. Monitoring staff identified performance problems associated with understaffing in the program, reporting that there was "little evidence of functional skills training or intake and orientation being provided to consumers," there was only a single skills trainer providing services to an average of 332 consumers per month, data in periodic program reports submitted by the contractor was not substantiated by underlying documentation, and the contractor had improperly billed Medicaid \$6,013.74 for consumer services where required prior authorization had not been granted by Medicaid. Despite these serious monitoring results, Medicaid took no significant action other than to require the contractor to prepare a corrective action plan that, when submitted over three months after the monitoring visit, asserted that the staffing and other identified deficiencies had been corrected. No further action was taken until a follow-up monitoring visit was conducted 12 months after the original visit. While PCA program managers at that time accepted the assertion of the contractor that staffing issues had been addressed, they noted that documentation of skills

training activity was still absent and that various supervisory and other programmatic deficiencies had remained uncorrected. Only then were restrictions imposed on new consumer intake, and even those limited restrictions were lifted in July 2006 without first verifying that corrective measures had actually been implemented.

We reviewed UFRs submitted by TILL for fiscal years 2002 through 2006 and found that information in the UFR submissions conflicted with assertions the contractor had made to PCM program managers and that, had program managers reviewed the contractor's UFR filing for fiscal year 2004, they would have seen that by the contractor's own admission, the program had been operating with far less than even one full-time equivalent (FTE) staff position. According to the contractor's UFR, the program had expended only \$2,132 in salary payments for the entire year for a total of only 0.07 FTE caseworker staff, the equivalent of just 2.8 hours per week in staff time for a program serving over 300 consumers. Even though they noted that service documentation was absent, program monitoring staff accepted the contractor's representation that a full-time skills training caseworker was in place without seeking verification from timesheets, payroll records, or UFR filings. As a result, the monitoring staff did not identify the full extent of the understaffing. Similarly, a careful review by PCA program staff of UFR filings for 2004 and subsequent fiscal years would have produced evidence that significant staffing issues for both direct care and supervisory and clinical positions continued to exist in the contractor's PCM program through fiscal year 2006. In fact, our own review of the UFRs noted evidence that the contractor may have actually been spending approximately 41 cents of each dollar received in program revenue, incurring only \$263,271 in expenses over the three-year period while reporting the receipt of \$643,569 from Medicaid for the program's services over those years.

For fiscal years 2002 and 2003, during which time the contractor was also operating the PCM program for Medicaid, it failed to discretely report the program on its UFR filings, thereby making it impossible to determine staffing arrangements and financial results for the program. It instead appeared that program activity and associated staff, revenues, and expenses may have been misreported as being in other non-PCA programs purchased by state agencies. Also, on January 7, 2002, the Office of the State Auditor publicly issued an audit report on this organization's non-Medicaid human service contracts. That audit found



that the contractor had engaged in numerous contracting violations with unallowable, questionable, and undocumented costs totaling in excess of \$4.4 million dollars for the period from July 1, 1997 through December 31, 2000. Despite the deficiencies identified in the audit, we found no evidence that PCA program managers had given adequate consideration to these issues in either awarding the PCM contract to the organization later in 2002 or in monitoring the contractor's activities, which were not reviewed by a site-visit team until two years later.

In our opinion, PCA program managers are not routinely making appropriate use of available UFR information and similar financial information publicly available through public charity and Internal Revenue Service Form 990 tax filings, which could enhance their ability to more effectively monitor PCM and FI activities.

**g. Site Visit Review Materials and Proposed Corrective Action Plans Submitted by Contractors Not Processed in a Timely Manner**

As previously noted, PCA program managers have not established any written policies and procedures governing their monitoring activities. As a result, no standards have been established for completing Corrective Action Plans (CAPs) in a timely manner. During our analysis of PCA program monitoring data, we noted significant delays in the processing of CAPs. Specifically, we reviewed the data relative to 31 monitoring visits that were conducted by EOHHS program staff at 23 PCM contractors between May 2004 and November 30, 2005. Based on our analysis, we determined that for 25 of the 31 visits, the amount of time it took to develop and finalize CAPs ranged from 127 days to 279 days. For five other visits, we were unable to calculate the number of days it took to develop a CAP due to the lack of accurate record processing dates maintained on the tracking sheet by Medicaid reviewers. Further, the resolution for a sixth visit conducted in November 2004 remained outstanding due to noncompliance of a PCM contractor in regards to the resolution requirements and the lack of appropriate contract sanctions initiated by PCM program managers or other enforcement action in a timely manner. We noted that many of the delays were attributable to PCA program staff not sending monitoring results and correction request notices to PCM contractors until one to three months or longer after site visit dates, as well as similar delays in notifying contractors of the need to modify their

proposed CAPs after they had been submitted to PCA program staff for review and approval.

We also noted that similar problems exist with FI organizations. For example, Medicaid reviewers conducted a site visit to one contractor on May 31, 2006 to follow up on issues identified by the spring 2005 review conducted by a contracted CPA firm. The program did not notify the contractor of required corrective action until June 28th, when it gave the organization until July 14 to develop and submit a draft CAP. The draft plan was submitted; however, PCA program managers did not respond to the draft until December 1, 2006 – six months after the site visit date.

***Recommendation***

In cooperation with consumer advocates and other stakeholders, EOHHS and the PCA Quality Home Care Workforce Council should restructure the existing approach to managing quality for the PCA program in an administratively simple manner, maximizing use of routinely generated electronic information, participation by consumers and other stakeholders, and a holistic approach to addressing PCA program issues in the wider context of meeting the community-based long-term care assistance needs of consumers. Specific detailed recommendations are not provided here due to the complexities and uncertainties involving resolution of the many other issues identified by our audit. For example, if as recommended in Audit Result No. 2 on the prior authorization process, EOHHS eliminates existing prior authorization review arrangements, the nature of restructured arrangements would alter the quality management procedures that might otherwise be recommended were that system to continue. Resulting quality management arrangements should be appropriately documented along with associated resource requirements, since implementation of an appropriate quality management system can reasonably be expected to require significantly different staffing, information technology, and contractual resource arrangements than presently exist. Of particular concern is the importance of developing appropriate quality management systems to ensure that issues involving unmet need, inadequate service coordination, inadequate or delayed service access, and underutilization are promptly identified and addressed.

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**4. COMPENSATION ARRANGEMENTS FOR FI AND PCM AGENCIES SHOULD BE REEVALUATED ON A REGULAR BASIS AND ADJUSTED TO ENSURE THAT FAIR BUT NOT EXCESSIVE COMPENSATION IS PROVIDED FOR PCA PROGRAM SERVICES**

We found that the rates that the Commonwealth pays to FI and PCM agencies are not routinely evaluated and adjusted to ensure that these organizations are provided with fair but not excessive compensation. As a result, we found that during the period covered by our audit, FI agencies were allowed to realize significant surplus revenues under their PCA program contracts, one in excess of 19%, while many PCM organizations incurred significant losses that needed to be funded by the PCM agency's other revenue sources. The specific problems we identified in the areas of FI and PCM agency compensation are discussed in the sections below:

**a. The Compensation the Commonwealth Provides to FIs May Be Excessive**

As mentioned in the Background section of this report, since 1998 FIs have been reimbursed for PCA payroll and tax and related expenses at rates established by Medicaid and the Division of Health Care Finance and Policy. As of January 2008, this rate was \$10.84 per hour for direct payroll wages, with an additional \$1.44 per hour employer expense component add-on for taxes and worker compensation costs (increased to \$1.48 per hour effective April 1, 2008). All other direct and indirect costs associated with each FI's operations are reimbursed by the Commonwealth through an Administrative Task rate negotiated between Medicaid and the FI contractors. This rate is a consumer per diem rate paid for each day that a consumer is enrolled with the FI and has a prior authorization in place. Prior to October 2003, the rate was paid on a consumer-enrolled monthly basis. Initially, the monthly rate was \$61.30 per enrolled consumer, which is the equivalent of \$2.02 per day. However, this rate was reduced in April 2003 to \$55.37 per month, the equivalent of \$1.82 per day. Effective October 2003, the rate was converted to a daily rate of \$1.72, where it remained through our audit period.

The established Administrative Task rate is subject to a year-end process where each FI is required to reconcile the amount paid to them to the contractor's actual costs for conducting FI administrative tasks. In accordance with contract terms, this reconciliation process uses a "cost corridor" process. Prior to 2003, no adjustment was made as long as the FI's actual costs were between 80% and 120% of the Administrative Task revenue amount. If the FI's actual costs were outside this cost corridor, Medicaid would either make a supplemental

payment to cover losses in excess of 20% of revenues or the FI would be obligated to repay Medicaid for any surplus revenue received above the corridor limit. So for example, if an FI were paid \$1 million and its actual costs were between \$800,000 and \$1.2 million, no adjustment would be made, allowing contractors to generate as much as a 25% \$200,000 surplus on \$800,000 in actual expense. Effective April 1, 2003, Medicaid negotiated a contract amendment to change the permitted cost corridor to a range of 85% to 115% of revenue, effectively permitting up to a 17.6% surplus of revenue over expenses (i.e., if contract revenue is \$100 and actual cost is \$85, then surplus revenue over expense is \$15, which is 17.6% of the \$85 cost amount). In November 2006, the corridor range was further reduced to between 90% and 110%, still permitting the generation of up to 11.1% excess revenue over expense.

In reviewing the Uniform Financial Statements and Independent Auditor's Reports (UFR) data for years 2006 and 2007 for the three FI organizations with available FI Administrative Task revenue and expense information, we found that all three continued to report substantial excesses of revenue over expenses for both years, with a cumulative total of \$1,636,722 excess revenue over \$13,867,987 expense for the two-year period, as detailed in the following table:

### Fiscal Intermediary Administrative Tasks Excess Revenue over Expense

#### Fiscal Years 2006 and 2007

Contractor *	2007		2007 Excess		2006		2006 Excess	
	Revenue	Expense	Revenue over Expense	Revenue over Expense%	Revenue	Expense	Revenue over Expense	Revenue over Expense%
North Shore ARC	\$1,445,067	\$1,211,105	\$233,962	19.3%	\$1,206,843	\$1,092,930	\$113,913	10.4%
Cerebral Palsy of MA	\$3,549,979	\$3,234,278	\$315,701	9.8%	\$3,299,294	\$2,877,586	\$421,708	14.7%
Stavros	\$3,218,807	\$2,918,379	\$300,428	10.3%	\$2,784,719	\$2,533,709	\$251,010	9.9%

\* Although the Center for Living and Working provided FI services prior to a December 2005 contract termination, it failed to discretely report financial information for administrative task activity in its financial statements for fiscal year 2006.

Since the fiscal year 2007 reconciliation process had not yet been completed at the time of our audit work, it was not possible to determine whether appropriate recovery action was

initiated for the contractor realizing a 19.3% excess of revenue over expense, substantially above the limit in effect for that year.

While CMS allows states considerable latitude in establishing pricing arrangements for Medicaid services, Medicaid law establishes certain fundamental requirements in Section 1902(a)(30)(A) of the Social Security Act, requiring that states establish methods and procedures "...to assure that payments are consistent with efficiency, economy, and quality of care...." We noted that the December 2007 CMS regulatory change notice, referenced in Audit Result No. 1 on case-management service enhancement issues included reference to this payment standard and provided detailed guidance regarding the shortcoming associated with certain payment mechanisms such as capitated per diem rates, weekly rates, monthly rates, or other "bundled" payment approaches such as the ones being provided by the Commonwealth to FIs that are not reflective of the actual types or numbers of services provided or the actual costs of providing the services. CMS characterizes such mechanisms as not being consistent with the above statutory provision since they result in payments that are not accurate or reasonable, may be higher than necessary, and contribute to inefficient use of resources and require substantially more federal oversight resources to establish the accuracy and reasonableness of state expenditures.

In our opinion, the payment mechanism established by Medicaid for its Fiscal Intermediary services results in payment amounts that can substantially exceed the costs and operating margins reasonably necessary for operation of these services. We believe reimbursement arrangements should be re-evaluated for Fiscal Intermediary services. Even though some or all of the FI contractors may use excessive surpluses generated on Administrative Task activities to ameliorate the PCM agency rate deficiencies described below, they are not obligated to do so and we believe these resources should be redistributed across a broader group of PCM contractors to address identified program-wide resource issues for PCM services.

**b. PCM Agency Funding Appears to Be Inadequate**

While administrative burdens placed on PCM contractors have increased, reimbursement rates have not even kept up with the annual rates of inflation, and many PCM agencies are now incurring losses in providing PCM program services. During our audit, Medicaid

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officials told us that the Division of Health Care Finance and Policy (DHCFP) was preparing to conduct a pricing review for the purpose of making PCM service pricing adjustments. During the 1990s, DHCFP had at Medicaid's request changed the pricing basis for skills training from a price for a 15-minute service unit to a capitated per-consumer-per-month price. However, the change was made without conducting an analysis of case-mix differences that could reasonably be expected to result in significant variances in cost-per-consumer patterns across different PCM agencies such as those disproportionately serving adults with physical disabilities but no cognitive impairments and adults utilizing surrogates, elders, and children. Further, no attempt has been made to gather and analyze such case-mix data in recent years. Similarly, while DHCFP has reviewed historical cost data reported by PCM contractors in their UFR filings, PCM agencies have not been asked to provide supplemental schedules that identify costs by pricing unit types (i.e., initial evaluations, reevaluations, skills training, and intake and orientation) as has been required for other Medicaid class rate providers such as outpatient mental health clinics. Nor have PCM contractors been asked to conduct substitute staff time or workload studies, which might provide a sound methodological basis for pricing decisions. During our audit, we analyzed certain rate information relative to PCM services and then compared these rates to inflation-adjusted rates for these same services, as indicated in the following table:

### Personal Care Management Rate Changes

1999 through 2008

	Effective Date					
	February 1, 1999	April 1, 2003	August 3, 2003	Proposed March 1, 2008 **	Adopted March 1, 2008	1999 rates adjusted for inflation ***
Initial Evaluation	\$177.63	\$177.63	\$177.63	\$214.00	\$214.87	\$231.55
Reevaluation	\$102.48	\$102.48	\$102.48	\$123.00	\$123.49	\$133.59
Skills Training	\$53.30	\$37.31	\$47.76	\$45.85	\$47.76	\$69.48
Intake and Orientation	N/A *	\$39.98	\$47.76	\$97.37	\$97.90	N/A

\* A separate service unit for Intake and Orientation activity during the first three months of consumer enrollment was established in 2003. Prior to that time activity during the first three months was paid through the skills training rate.

\*\* Rates as proposed by DHCFP at a January 31, 2008 public hearing prior to adjustments made in response to public testimony.

\*\*\* Calculation based on the US Bureau of Labor Statistics Northeast Consumer Price Index-Urban (CPI-U) change from January 1999 through December 2007.

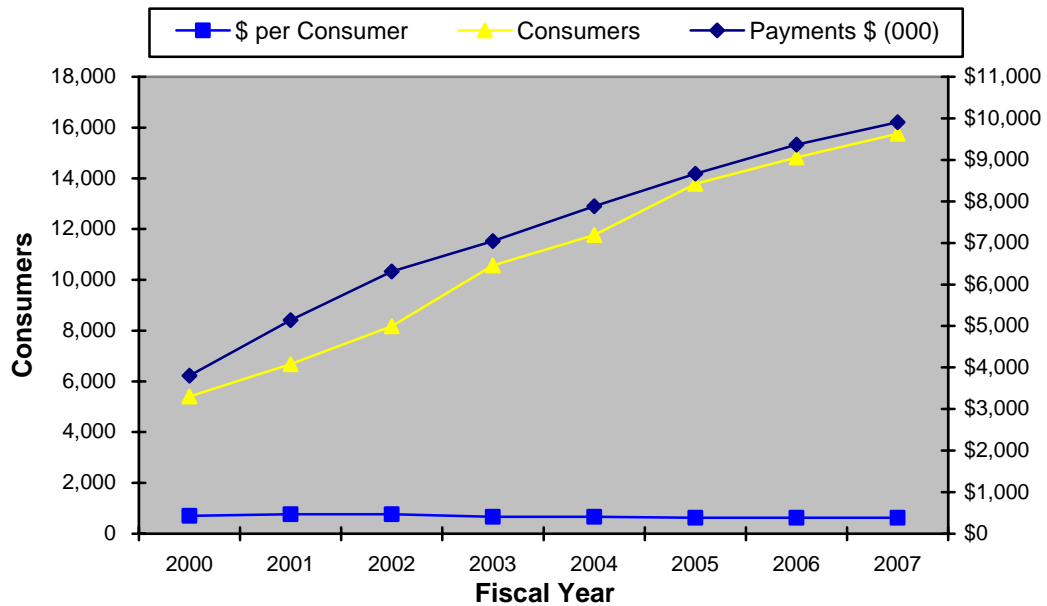
As can be seen in the table above, the recently adjusted PCM rates are not even equal to the inflation-adjusted PCM rates that were in effect during 1999. DHCFP has asserted that the rate adjustments promulgated for March 1, 2008 include a 7% inflation adjustment factor; however, the adjustment was calculated only from 2005 and does not factor in the cumulative impact of inflation during the multi-year period shown in the previous table, which has exceeded 30% over the nine-year period from January 1999 through December 2007. Since then, the inflation rate just for the 12 months ending in July 2008 has been reported by the US Bureau of Labor Statistics to be approximately 5%. PCA program officials stated that analyzing the reasonableness of these rates based on inflation is unfair because the Division's analysis was based on provider-reported costs allocated across service types in consultation with the providers. However, that assertion was inconsistent with separate statements made to us by DHCFP staff that inflation and labor market changes are appropriate factors to be considered in addition to historical costs when making pricing

determinations. In addition, PCM contractors and consumer advocates with whom we spoke told us that PCM providers have generally not been able to provide needed levels of service within the rates established by Medicaid and DHCFP, particularly as the PCA program has evolved to serve disproportionately more consumers with greater requirements for skills training assistance. These contractors pointed out that labor costs for nursing professionals required to perform evaluations have also increased in excess of overall inflation. In support of this assertion, we noted that U.S. Bureau of Labor Statistics data documents a 38.4% increase in the Massachusetts median hourly wage for registered nurses in just six years, from \$23.75 in 2000 to \$32.88 in 2006. Furthermore, PCM contract specifications and rates fail to address outreach activities, which have been identified as an important component of national efforts to expand PCA and related services in order to minimize use of institutional care. As described in Audit Result No. 1 on case-management issues, similar concerns exist regarding the adequacy of case-management assistance provided by PCM agencies to consumers.

Although Medicaid PCM expenditures have increased 161% in terms of absolute dollars, unadjusted for inflation, from \$3.8 million in fiscal year 2000 to \$9.9 million in fiscal year 2007, the increase has been largely driven by a 192% increase in the number of consumers in the program from 5,401 in fiscal year 2000 to 15,753 in fiscal year 2007. However, the average expenditure per consumer actually declined 11% in non-inflation-adjusted dollars, from \$703.72 in fiscal year 2000 to \$628.89 in fiscal year 2007, as indicated in the following table:



### PCM Service Historical Expenditure Trends



Given the significant increase in inflation over this same period (22.5% in the Northeast Consumer Price Index - Urban (CPI-U) from January 2000 through January 2007), it is difficult to conceive how PCM service activity could not have been significantly impaired by the failure to make inflation adjustments to rates over that period. Just for the period 2000 through 2007, the average expenditure per consumer dropped approximately 27% in terms of real inflation-adjusted dollars. One indication of a decline in the quality of PCA program services may be reflected in the fact that the ratio of consumers to PCM skills trainers in Massachusetts is significantly higher (a median of 136.5 for the PCM data reviewed) than that documented for apparently similar activity in other states, such as Oregon (69:1) and Washington (75:1). The 7% inflation adjustment factor used by DHCFP to estimate cumulative cost increases from fiscal year 2005 through the present, with no further rate adjustment planned for an additional two years, appears inadequate to prevent a further decline in the quality of PCM services. For example, the previously referenced federal data on changes in the Massachusetts median hourly wage rate for registered nurses documented an increase of over 5.1% in just the single year between May 2005 and May 2006. These circumstances suggest that PCM services have not historically been overpriced and will remain significantly under-priced even after the March 1, 2008 rate adjustments.

PCM contractor UFR filings for fiscal years 2002 through 2007 show an overall decline in operating results over that period. Approximately 25% of contractors reported an operating loss on the PCM program in 2002 compared to approximately 50% or more in more recent years. Consolidated operating results also declined to the point where the excess of revenue over expense reported for fiscal year 2006, even including charitable contributions and other supplemental sources of support, was only 0.88%. For fiscal year 2007, the consolidated operating results had declined even further to a 0.29% deficit for all PCM programs.

Information contained in the DHCFP pricing analysis and additional data we analyzed from UFRs and PCM contractor service statistics point to wide variations in cost patterns across contractors. For example, the PCM contractors associated with the DMR human service provider system disproportionately reported excess PCM program surpluses, while the ASAP PCM contractors reported losses on their PCM programs. In fiscal year 2006, the four DMR-type PCM agencies reported a consolidated surplus of 15.37%, despite one of the four having reported a 38.7% loss on its PCM program. In contrast, the 14 reporting ASAP PCM agencies that year reported a consolidated loss of 12.24% on PCM operations, with eight of the 14 reporting losses. Results for ILC-type PCM agencies and other PCM organizational types were mixed. These results appear to corroborate concerns raised by both PCM contractors and DHCFP managers that significant case-mix variations exist across PCM agencies that have not been adequately factored into PCM reimbursement arrangements. PCM program officials stated that they did not believe that this was necessarily an issue of case mix differences not being factored into rate calculations. Rather, these officials stated that different providers are at different stages in building up their case loads and that those providers with greater longevity are generally in a better fiscal condition with respect to their PCM program. However, during our audit work DHCFP staff told us that in their opinion it would have been desirable to factor in case-mix variances for price determination purposes and, as described above, distinct case-mix differences exist across PCM contractors. Caseload size and program longevity alone do not account for the variances we found in individual program financial outcomes.

As described above, DHCFP did not gather sufficient information to perform an adequate and authoritative pricing review. Yet it proceeded to perform a complex multi-stage cost-allocation and cost-adjustment analysis to assign costs by unit type and exclude what it

believed to be excessive costs. The result was an analysis suggesting that rates should actually be \$258.46 for Initial Evaluations, \$148.07 for Reevaluations, \$157.99 for Intake and Orientation, and only \$28.17 for Skills Training. Those rates represent median values derived for each unit type after application of various productivity factors and other cost exclusions, followed by application of an inflation factor to recognize an anticipated 7% increase in costs subsequent to the fiscal year 2005 base year for the analysis.

If rates were accurately developed, the expected result would be that approximately half of the contractors would realize surpluses or deficits on each type of service so long as they successfully reduced excess costs deemed to exist by DHCFP staff. In practice, since not all contractors could be expected to successfully implement all of the required operational adjustments, the result to be expected would be losses by a majority of contractors on each unit type, with some contractors offsetting losses on some unit types through gains realized on other unit types. However, the overall result might well be that even after the rate adjustment, a majority of contractors would experience operating deficits on their PCM programs. For this reason, sound class-rate pricing approaches often set rates at a level above the median, so that the majority of service providers that operate in an efficient and economical manner will be able to generate reasonable modest operating margins, while more inefficient and uneconomical program operators will experience deficits and either change their operating arrangements or eventually leave the market. However, DHCFP did not price the services in this manner. Even when done properly, this across-the-board class-rate pricing approach only works appropriately where services are highly standardized with minimal variances in case-mix, staffing arrangements, productivity rates, or other cost factors. High levels of standardization often exist for some Medicaid class-rate reimbursement model services such as licensed mental health outpatient clinics where, for example, costs per hour of individual therapy may be relatively uniform across providers. As PCM contractors have pointed out, that is not the case for PCM services where unit costs appropriately vary significantly across providers.

When DHCFP developed the above-referenced initial rates, the results would have seriously disrupted PCM operations, resulting in overall revenue declines for some contractors, generally favoring those with large operating scale efficiencies and higher percentages of new consumers rather than smaller stable operating bases of ongoing consumers. In an attempt

to address this issue, DHCFP modified the calculated rate results, reducing the computed Initial Evaluation, Reevaluation, and Intake and Orientation rates to levels 45% of the way between existing rates and the calculated rates, while increasing the calculated skills training rate to a level 4% below the existing rate. DHCFP effectively proposed 20% rate increases for both types of evaluations, while the rate for Intake and Orientation was proposed to be increased by 104% and the Skills Training rate accounting for the vast majority of service activity and billings was to be reduced by 4%. The result of this adjustment was to establish a rate pattern that DHCFP calculated would ensure that each PCM agency received at least a net increase in consolidated PCM service revenues. No calculations were documented regarding the anticipated impact on individual program operating results. We asked DHCFP for an explanation of the 45%/4% adjustments and received the following written response through the Medicaid Director of External Audit:

*The DDHCFP and EOHHS determined that using the cost estimates in and of themselves as the rates would impose too dramatic a change at once and be counterproductive. So the rates for the three services where FY05 cost + inflation was higher than the current rate were increased by 45% of the difference between the rate and the cost. For the fourth, skills training, we reduced the rate by 4% to reflect costs below the current rate.*

In our opinion, the response was an inadequate explanation of the adjustments made, since it simply restated what had been done without providing a rationale for using the selected adjustment approach rather than some other approach.

We also analyzed the pricing and cost allocation methodology employed by DHCFP in the new rates calculation. We confirmed that there was no evidence of an examination of case-mix issues. Arbitrary cost allocations were made. Initially, direct staff costs were allocated on a simplistic all-or-nothing basis to one of two categories covering combined evaluation activity and combined skills training and intake and orientation activity. This allocation disregards the reality that some staff divide their work time between both sets of activities. Other costs, such as tax and fringe and administrative and support costs, were then pro-rated on the basis of the initial direct staff allocations, without any consultation with contractors or other apparent evaluation of the reasonableness of that methodology. Since evaluation staff are disproportionately higher paid professionals such as nurses, the effect is to over-allocate other costs to the evaluation activity center. For example, fringe costs such

as health insurance are better allocated either on a direct expense basis for each employee or on an average per employee position basis rather than in proportion to payroll. The resulting allocated costs were then subjected to various “productivity” and administrative cost cap adjustments. However, those adjustments were subject to distortion due to the questionable accuracy of the underlying allocated cost data.

Each of the two activity groups was then subdivided into separate centers for each unit type. For the evaluation centers, all Occupational Therapists were assumed to devote their time exclusively to initial evaluations despite the fact that regulations call for these professionals to also be used on an as-needed basis for reevaluations. Then all other evaluation costs were pro-rated to initial evaluation or reevaluation cost centers in proportion to the number of billed initial evaluations and reevaluations. This methodology relies on the highly questionable assumption that, other than Occupational Therapist time, both types of evaluations require equal staff and other resources. PCM contractors told us that this assumption is incorrect and that considerably more resources are required to conduct initial evaluations.

For the Skills Training and Intake and Orientation activities, an allocation of costs in proportion to billed units would have produced identical monthly rates for each service. Instead, DHCFP obtained data from Medicaid PCA program managers on the number of 15-minute consumer contact units reported by each PCM agency. These contact units, characterized as Face-to-Face, Telephone, and Other, are an artifact from reimbursement arrangements in the 1990s when billing was done on that basis rather than on a capitated monthly rate basis. We noted that both contractors and Medicaid managers have characterized these statistics as being tracked and reported in an un-standardized manner across contractors and as being of doubtful accuracy. For example, the expectation that contractors will accurately track every single telephone call regarding a consumer and the length of each call when doing so is not required as an integral part of the billing process is clearly unreasonable. Even the DHCFP analysis calculated implausible variances in the average number of reported units per consumer for each contractor. Averages ranged from 2.0 to 17.25 units per consumer related to Intake and Orientation and between 1.04 and 27.3 units per consumer related to Skills Training. In addition, the implicit assumption that costs for each 15-minute unit are equal is questionable, since face-to-face contacts involve extra

cost elements such as staff transportation expense. This allocation methodology disproportionately allocated costs to Intake and Orientation activity, resulting in calculation of what would have been a highly questionable 231% Intake and Orientation rate increase and a 41% Skills Training rate decrease.

In contrast to the allocation methodologies used by DHCFP for PCM pricing, other cost allocation approaches are less burdensome and often more accurate. As DHCFP has done for other Medicaid rates such as outpatient mental health services, providers can be asked to perform standardized time and activity sampling studies to be used for pricing allocation purposes and to validate the results of program modeling estimates. For example, a sample of staff can be required to record and time activity for a one-week period once every two years when prices are being reviewed and adjusted. We also noted that the pricing process used, with inadequate up-front participation by advocates and contractors, contrasts markedly with approaches used in other states such as Pennsylvania, where comprehensive studies of compensation arrangements have been conducted with more inclusive participation of all interested parties.

As previously noted, Medicaid requires that payments be consistent with efficiency, economy, and quality of care. The same section of the law also requires assurance that payments “are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” This federal payment standard strikes a balance between cost-minimization efficiency and economy considerations and the need to reimburse providers sufficiently to ensure reasonable quality of care and access to service. As detailed above, we found that DHCFP could make modifications to the existing FI and PCM pricing arrangements to better ensure adherence to these federal standards and that necessary services of reasonable quality are adequately available to consumers.

### ***Recommendation***

Compensation arrangements for both FI and PCM services should be reevaluated with meaningful participation by contractors and consumer advocates and third-party representatives with independent expertise necessary to ensure that compensation is sufficient to provide the resources necessary to provide quality services needed for effective program operation

conducted in an efficient and economical manner, with appropriate adjustments to cover variations in resource requirements warranted by factors such as case-mix and volume differences across contractors. Audit Result No. 1 also indicates the need to fully engage consumers and advocates regarding programmatic modifications that might enhance services and impact on issues such as independent living barriers and inappropriate utilization of institutional long-term care facilities. Since substantial time may be required to address those issues, temporary pricing adjustments may be necessary pending the development of a more comprehensive resolution of contractor compensation issues.

**APPENDIX I****PCA Program Fiscal Intermediary Agencies****Fiscal Year 2006**

North Shore ARC  
6 Southside Road  
Danvers, MA 01923  
978-762-8307

Cerebral Palsy of Massachusetts  
43 Old Colony Avenue  
Quincy MA 02170  
617-479-7443  
Stavros  
210 Old Farm Road  
Amherst, MA  
413-256-0473

Center for Living and Working<sup>46</sup>  
484 Main Street  
Denholm Building  
Worcester, MA 01608  
508-363-1226

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<sup>46</sup> The Center for Living and Working ceased providing Fiscal Intermediary services effective December 31, 2005.



## APPENDIX II

### PCA Program PCM Agencies

PCM Agency	Selected Fiscal Intermediary <sup>47</sup>
Ad Lib, Inc. 215 North Street Pittsfield, MA 01201 413-442-7047	Stavros
Boston Center for Independent Living 60 Temple Place, 5 <sup>th</sup> Floor Boston, MA 02111 617-338-6665	Cerebral Palsy of Massachusetts
Bristol Elder Services 182 North Main Street Fall River, MA 02720 508-675-2101	Cerebral Palsy of Massachusetts
Center for Living and Working 484 Main Street Worcester, MA 01608 508-755-1746	Stavros
Coastline Elderly Services 1646 Purchase Street New Bedford, MA 02740 508-999-6400	Cerebral Palsy of Massachusetts
Elder Services of Berkshire County 66 Wendell Avenue Pittsfield, MA 01201 413-236-1718	Cerebral Palsy of Massachusetts
Elder Services of the Merrimack Valley 360 Merrimack Street Lawrence, MA 01843 978-683-7747	North Shore ARC
Family Service Association of Greater Fall River 101 Rock Street Fall River, MA 02720 508-677-3822	Cerebral Palsy of Massachusetts

<sup>47</sup> Fiscal Intermediaries are those in place during the second half of fiscal year 2006 and later, after Fiscal Intermediary services previously provided by the Center for Living and Working were transferred to other FI contractors.

Franklin County Home Health Care Corporation 330 Montague City Road Turners Falls, MA 01376 413-773-5555	Cerebral Palsy of Massachusetts
Greater Lynn Senior Services 8 Silsbee Street Lynn, MA 01901 781-599-0110	North Shore ARC
Greater Springfield Senior Services 66 Industry Avenue Springfield, MA 01104 413-781-8800	North Shore ARC
Independence Associates, Inc. 141 Main Street, 1 <sup>st</sup> Floor Brockton, MA 02301 508-583-2166	Stavros
Montachusett Home Care Corp. 680 Mechanic Street Leominster, MA 01453 978-537-7411	Cerebral Palsy of Massachusetts
Mystic Valley Elder Services 300 Commercial Street Malden, MA 02148 781-342-7708 (Terminated participation effective May 2008)	North Shore ARC
Northeast Independent Living Program 20 Ballard Road Lawrence, MA 01853 978-687-4288	Stavros
North Shore ARC 6 Southside Road Danvers, MA 01923 978-624-2365	North Shore ARC
Old Colony Elderly Services 144 Main Street Brockton, MA 02303 508-584-1561	Cerebral Palsy of Massachusetts
Cerebral Palsy of Massachusetts Options PCM Program 30 Taunton Green, Unit 8 Taunton, MA 02780 508-880-7577	Cerebral Palsy of Massachusetts

Preparatory Rehabilitation for Individual Development and Employment, Inc. d.b.a. PRIDE 3 Maple Street Taunton, MA 02780 508-823-7134	North Shore ARC
Somerville Cambridge Elder Services 61 Medford Street Somerville, MA 01243 617-628-2601	North Shore ARC
South Shore ARC 371 River Street North Weymouth, MA 02191 781-413-2222	Cerebral Palsy of Massachusetts
Southwest Boston Senior Services – d.b.a. Ethos 555 Amory Street Boston, MA 02130 617-522-6700	Cerebral Palsy of Massachusetts
Stavros Center for Independent Living 210 Old Farm Road Amherst, MA 01002 413-256-0473	Stavros
Toward Independent Living and Learning – d.b.a. TILL 20 Eastbrook Road Dedham, MA 02026 781-302-4833	Cerebral Palsy of Massachusetts
Tri Valley Elder Services 10 Mill Street Dudley, MA 01571 508-949-6640	Cerebral Palsy of Massachusetts
United Cerebral Palsy Association of Metro Boston 71 Arsenal Street Watertown, MA 02472 617-926-5480	Cerebral Palsy of Massachusetts
West Massachusetts Elder Care 4 Valley Mill Road Holyoke, MA 01040 413-538-9020	Cerebral Palsy of Massachusetts
BayPath Elder Services 33 Boston Post Road West Marlborough, MA 01752 508-573-7200 (Enrolled fiscal year 2008 – not included in audit review)	Cerebral Palsy of Massachusetts

Minuteman Senior Services  
24 Third Avenue  
Burlington, MA 01803  
781-272-7177  
(Enrolled fiscal year 2008 – not included in audit review)

Cerebral Palsy of Massachusetts

Springwell  
125 Walnut Street  
Watertown, MA 02472  
617-926-4100  
(Enrolled late fiscal year 2007 with no significant activity until fiscal year 2008 –  
not included in audit review)

Cerebral Palsy of Massachusetts

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**APPENDIX III****Listing of Services to Be Provided by PCM  
Agencies as Detailed in 130 Code of  
Massachusetts Regulations (CMR) 422.000**

1. Maintaining a communication system that is accessible to members on a 24-hour basis;
2. Responding to member inquiries about the MassHealth agency's prior-authorization decisions within the timeframes specified in the contract and in 130 CMR 422.000;
3. Maintaining records in accordance with 130 CMR 422.446 and the PCM contract;
4. Conducting a formal, written assessment of the member's ability to manage the PCA program independently in accordance with 130 CMR 422.422(A) and the PCM contract, and in a standard format approved by the MassHealth agency;
5. Performing evaluations and reevaluations of members who are eligible for personal care services in accordance with 130 CMR 422.422(C) and (D) and the PCM contract;
6. Submitting to the MassHealth agency all requests for prior authorization for PCA services in accordance with the procedures and timelines identified in the PCM contract, 130 CMR 422.416(A), (B), and (C), and 422.418;
7. Developing in conjunction with the member and the member's surrogate, if any, a formal, written service agreement for the member in accordance with 130 CMR 422.423 and the PCM contract, and in a standard format approved by the MassHealth agency;
8. Providing intake and orientation services to determine a member's initial eligibility for PCA services, and to instruct the member in the rules, policies, and regulations of the PCA program in accordance with 130 CMR 422.421(A) and the PCM contract;
9. Providing functional skills training to instruct the member and the surrogate, if necessary, in the basic requisites of an effective program of personal care services in accordance with 130 CMR 422.421(B) and the PCM contract;
10. Maintaining policies and procedures for the receipt and timely resolution of member complaints in accordance with the PCM contract;
11. Providing written information to members in a language and format that is understandable to them;
12. Providing PCM services that are culturally sensitive;

13. Seeking out and including member input and feedback into the PCM services provided by the personal care agency;
14. Educating members and surrogates about the tools available to promote PCA services that are safe, such as the availability of Criminal Offender Record Information (CORI), Disabled Persons Protection Commission (DPPC), the sex offender registry, and the Elder Services hotline;
15. Working with the member to establish a list of PCAs who can be contacted when an unforeseen event occurs that prevents the member's regularly scheduled PCA from providing services;
16. Developing creative methods to assist members in the recruitment of PCAs;
17. Establishing a cooperative working relationship with the fiscal intermediary by:
  - a. Choosing one fiscal intermediary for all members served by the personal care agency and notifying the MassHealth agency of the choice;
  - b. Informing new members of the fiscal intermediary and assisting them to enroll with them before hiring personal care attendants;
  - c. Educating members about the role of the fiscal intermediary;
  - d. Assisting members to select one of the employer options in 130 CMR 422.419(B)(1);
  - e. Working with the fiscal intermediary to resolve member and PCA complaints;
  - f. Sharing information with the fiscal intermediary, as needed, about the status of a member's prior-authorization decision, including, but not limited to, the member's name, address, and date of birth;
  - g. Providing the fiscal intermediary with the name, address, and phone number of the member's surrogate, if any, and any changes in the surrogate information.