June 1, 2011

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Review of Medicaid Personal Care Services Claims Submitted by Providers in North Carolina (A-04-10-04003)

Attached, for your information, is an advance copy of our final report on Medicaid personal care services claims submitted by providers in North Carolina. We will issue this report to the North Carolina Department of Health and Human Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Acting Deputy Inspector General for Audit Services, at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov or Peter J. Barbera, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750 or through email at Peter.Barbera@oig.hhs.gov. Please refer to report number A-04-10-04003.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

June 3, 2011

Report Number: A-04-10-04003

Mr. Lanier M. Cansler
Secretary
North Carolina Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-2001

Dear Mr. Cansler:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Personal Care Services Claims Submitted by Providers in North Carolina*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Mark Wimple, Audit Manager, at (919) 790-2765, extension 24, or through email at Mark.Wimple@oig.hhs.gov. Please refer to report number A-04-10-04003 in all correspondence.

Sincerely,

/Peter J. Barbera/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID PERSONAL CARE SERVICES CLAIMS SUBMITTED BY PROVIDERS IN NORTH CAROLINA

Daniel R. Levinson
Inspector General

June 2011
A-04-10-04003

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

In North Carolina, the Department of Health and Human Services (the State agency) supervises the administration of the Medicaid program. Within the State agency, the Division of Medical Assistance (DMA) administers the Medicaid program. DMA's Facility and Community Care Section manages the personal care services program. The beneficiary's physician authorizes personal care services, and Medicaid-enrolled home care agencies provide service delivery. During the period July 1, 2005, through June 30, 2007, the State agency claimed personal care services expenditures totaling approximately $613 million (approximately $391 million Federal share).

Pursuant to 42 CFR § 440.167, personal care services are generally furnished to individuals residing in their homes and not residing in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or institutions for mental diseases. Medicaid beneficiaries are authorized for personal care services by a physician in accordance with a plan of treatment or with a service plan approved by the individual State. Pursuant to North Carolina's administrative code: (1) the beneficiary of the service must have a medical diagnosis that warrants a physician's care and must be under the direct and ongoing care of the physician prescribing the services, (2) the beneficiary's medical condition must be stable, (3) services must be medically necessary, and (4) services must be provided by a State licensed home care agency approved to provide in-home aide services. Examples of personal care services include cleaning, shopping, grooming, and bathing.

OBJECTIVE

Our objective was to determine whether the State agency ensured that claims for Federal reimbursement of Medicaid personal care services complied with Federal and State requirements.

SUMMARY OF FINDINGS

The State agency did not ensure that all claims for Federal reimbursement of Medicaid personal care services complied with Federal and State requirements. Of the 100 sampled claim line items (items) in our random sample, 65 complied with Federal and State requirements, but 35 did not.

Of the 35 items that were not compliant, 8 contained more than 1 deficiency:

- For 30 items, services were not in accordance with the plan of care.
- For seven items, there were no nursing visits for supervision.
- For five items, there was a lack of required documentation.
- For two items, there was no physician order.
- For one item, the qualifications of the in-home care provider were not verified.

These deficiencies occurred because DMA did not have sufficient resources to adequately monitor the personal care services program for compliance with certain Federal and State requirements. The State agency has been working with the North Carolina legislature to develop new procedures and controls for the personal care services program. The North Carolina Current Operations and Capital Improvement Appropriations Act of 2009 funded an initiative effective July 1, 2009, that included mandated requirements for cost containment.

Based on our sample results, we estimated that the State agency improperly claimed $41,734,368 (Federal share) for unallowable personal care services during the period July 1, 2005, through June 30, 2007.

RECOMMENDATIONS

We recommend that the State agency:

- refund $41,734,368 to the Federal Government and
- continue its efforts to implement additional procedures and controls for monitoring the providers of personal care services for compliance with Federal and State requirements.

STATE AGENCY COMMENTS

The State agency concurred with our findings and recommendations. The State agency summarized the corrective actions that it had taken and the procedures that it is continuing to implement to better monitor and manage its Medicaid In-Home Personal Care Services Program.

The State agency's comments are included in their entirety as Appendix D.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

North Carolina's Medicaid Program

In North Carolina, the Department of Health and Human Services (the State agency) supervises the administration of the Medicaid program. Within the State agency, the Division of Medical Assistance (DMA) administers the Medicaid program. DMA uses the Medicaid Management Information System, a computerized payment and information reporting system, to process and pay Medicaid claims, including personal care service claims. The Federal Government's share of costs is known as the Federal medical assistance percentage (FMAP). From July 1, 2005, to June 30, 2007, the FMAP in North Carolina ranged from 63.49 percent to 64.52 percent.

North Carolina's Personal Care Services Program

North Carolina's personal care services program (the program) is managed by DMA's Facility and Community Care Section. Although DMA is responsible for the program, each beneficiary's physician authorizes personal care services, and Medicaid-enrolled home care agencies provide service delivery. Title 10A § 13J.0901(29) of the North Carolina Administrative Code (NCAC) defines personal care services as including tasks that range from assistance to an individual with basic personal hygiene, grooming, feeding, and ambulation to medical monitoring and other health-care-related tasks. Pursuant to Title 10A NCAC § 22O.0120(a), such services must be medically necessary and the beneficiary must be under the direct and ongoing care of the physician prescribing the services. Further, the beneficiary of these services must have a medical diagnosis that warrants a physician's care, and the beneficiary's medical condition must be stable.

Under North Carolina's State plan (Attachment 3.1-A.1, 23.f), a Medicaid beneficiary may receive up to 3.5 hours of personal care service a day and not exceed 60 hours in a month. Those Medicaid beneficiaries who have personal care needs that exceed the service limitations may qualify to receive up to an additional 20 hours of service a month.

Providers of Personal Care Services

Title 10A NCAC § 22O.0120(b) requires personal care services to be provided by a Medicaid-enrolled home care agency that is located within North Carolina and is licensed to provide in-home aide services (providers). At the time of our audit, 993 providers participated in the program. The North Carolina Division of Health Services Regulation licensed the providers for 1 year upon qualification, and the licenses were renewable annually. Providers obtained clients from a variety of sources, including inquiries by beneficiaries or referrals from physicians, family, or social service agencies. The State agency's clinical coverage policy prohibited direct solicitation by the providers or their representatives.

Federal and State Requirements Related to Personal Care Services

The State agency and the providers must comply with Federal and State requirements in determining whether beneficiaries are eligible for personal care services. Pursuant to section 1905(a)(24) of the Act and implementing Federal regulations (42 CFR § 440.167), personal care services must be: (1) authorized for an individual by a physician in a plan of treatment or in accordance with a service plan approved by the individual State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) furnished in a home or, at the State's option, in another location.

Federal regulations at 2 CFR part 225 (incorporating Office of Management and Budget Circular A-87) establish principles and standards for determining allowable costs incurred by State and local governments under Federal awards. Section C.1.c. of Appendix A of 2 CFR part 225 provides that to be allowable, costs must be authorized or not prohibited by State or local laws or regulations.

Title 10A of NCAC § 22O.0120 establishes coverage requirements for North Carolina's program. These requirements include that personal care services must be authorized by a physician and meet the following criteria: (1) the beneficiary of services must have a medical diagnosis that warrants a physician's care and must be under the direct and ongoing care of the prescribing physician, (2) the beneficiary's medical condition must be stable, (3) services must be medically necessary, and (4) services must be provided by a State-licensed home care agency approved to provide in-home aide services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency ensured that claims for Federal reimbursement of Medicaid personal care services complied with Federal and State requirements.

Scope

Our audit period covered July 1, 2005, through June 30, 2007. During this period, the State agency claimed personal care services expenditures totaling approximately $613 million (approximately $391 million Federal share). We removed claim line items (items) submitted by one provider from the population of personal care services and performed a separate review (A-04-09-04041) of this provider. Our sampling frame consisted of 15,173,381 items, totaling $606,936,404 ($387,790,313 Federal share), taken from North Carolina's Medicaid paid claims submitted by providers.

We did not review the overall internal control structure of the State agency or the providers. Rather, we limited our internal control review to those controls related to our objective.

From January through October 2010, we conducted fieldwork at the State agency's offices in Raleigh, North Carolina; provider and physician offices; and beneficiary residences located throughout North Carolina.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws and regulations, as well as State policy;
- held discussions with State agency officials to gain an understanding of the program;
- created a sampling frame of 15,173,381 items of personal care services greater than $10.79 submitted by the remaining providers (Appendix A);
- selected a random sample of 100 items, for which we:
    - analyzed Medicare and Medicaid claims data to determine whether the beneficiary was residing in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases on the date of service;
    - analyzed Medicaid claims data to determine whether duplicate or prohibited services were performed on the date of service and whether daily or monthly service limits were exceeded;
    - reviewed provider documentation supporting the item;
    - reviewed documentation from the physician ordering the personal care services to confirm whether a medical professional had examined the beneficiary before the order was signed; and

- visited the beneficiary, if available, associated with the item to inquire about the personal care services he or she received;[1] and

- estimated the unallowable Federal Medicaid reimbursement paid in the population of 15,173,381 items of personal care services (Appendix B).

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 to provide 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 objective.

FINDINGS AND RECOMMENDATIONS

The State agency did not ensure that all claims for Federal reimbursement of Medicaid personal care services complied with Federal and State requirements. Of the 100 items in our random sample, 65 complied with Federal and State requirements, but 35 did not. Of the 35 items, 8 contained more than 1 deficiency. The table summarizes the deficiencies noted and the number of items that contained each type of deficiency. See Appendix C for the results for each item.

Summary of Deficiencies in Sampled Items

Type of Deficiency	Number of Unallowable Items[2]
Services not in accordance with plan of care	30
No nursing visits for supervision	7
Lack of required documentation	5
No physician order	2
Qualifications not verified	1

These deficiencies occurred because DMA did not have sufficient resources to adequately monitor the program for compliance with certain Federal and State requirements.

Based on our sample results, we estimated that the State agency improperly claimed $41,734,368 (Federal share) for unallowable personal care services from July 1, 2005, through June 30, 2007.

SERVICES NOT IN ACCORDANCE WITH PLAN OF CARE

Pursuant to section 1905(a)(24)(A) of the Act, implementing Federal regulations (42 CFR § 440.167(a)(1)), and 10A NCAC § 13J.1107(a), personal care services must be provided in accordance with a physician-authorized plan of care.

[1] Because of various reasons (i.e., the beneficiaries could not be located, declined to be interviewed, were too ill to respond, or were deceased), we were able to visit only 30 of the 100 beneficiaries.

[2] The total exceeds 35 because 8 items contained more than 1 error.

For 30 of the 100 items in our sample, the services provided were not in accordance with the beneficiary's authorized plan of care:

- For 29 of the 30 items, the providers failed to provide at least 1 of the tasks specified in the plan of care; however, the providers did not reduce their claims to reflect the actual services provided.

  For 2 of these 29 items, the providers also claimed more units of service than prescribed in the plan of care; however, there was no documentation to support the deviations from the plan of care.

- For the remaining item, the provider was unable to demonstrate that the tasks performed were the tasks specified in a plan of care.

NO NURSING VISITS FOR SUPERVISION

Pursuant to 10A NCAC § 13J.1110(d) and (f), an appropriate supervisor[3] must make a supervisory visit to each beneficiary's home at least quarterly, with or without the in-home aide present, and at least annually while the in-home aide is providing care to the beneficiary. The home care agency must maintain documentation of these visits.

Pursuant to 10A NCAC § 13J.1202, an appropriate professional must visit the beneficiary's home at least quarterly and assess the beneficiary's general condition, progress, and response to services provided and revise the plan of care if necessary based on the beneficiary's needs. Documentation of these visits shall be maintained in the beneficiary's service record. If the same professional is assigned responsibility for the quarterly assessment and supervision of the in-home aide, these functions may be conducted during the same home visit.

For 7 of the 100 items in our sample, the providers failed to provide documentation that demonstrated annual supervision of the in-home aide; in 1 instance, the provider also did not demonstrate that quarterly supervision of the in-home aide had been performed.

LACK OF REQUIRED DOCUMENTATION

Pursuant to section 1902(a)(27) of the Act and implementing Federal regulations (42 CFR § 433.32), Medicaid providers must maintain documentation that fully discloses the extent of the services provided to the beneficiary. The beneficiary's service records must contain a record of all services provided, including dates and times of the service, with entries dated and signed by the individual providing the service (10A NCAC § 13J.1402(a)(2)(C)).

[3] North Carolina's State plan requires that in-home aides work under the supervision of a registered nurse (Attachment 3.1-A.1, 23.f).

For 5 of the 100 items in our sample, the providers lacked evidence that they had complied with 1 or more of these requirements. In all 5 items, at least 1 of the following deficiencies occurred:

- The service log for the date of service could not be located.
- The service log did not support the number of hours claimed.
- The employee time record did not support the number of hours claimed.

NO PHYSICIAN ORDER

Pursuant to section 1905(a)(24)(A) of the Act, implementing Federal regulations (42 CFR § 440.167(a)(1)), and 10A NCAC § 22O.0120(a), personal care services must be authorized by a physician. Orders for personal care services must be signed by a physician, but care may commence in the interim with a verbal order. The home care agency must obtain the physician's signature within 60 days from the date of the verbal order (10A NCAC § 13J.1302(a) and (d)).

For 2 of the 100 items in our sample, the providers did not obtain the proper physician's authorization. The providers initiated personal care services before obtaining either a written or verbal order from the physician.

QUALIFICATIONS NOT VERIFIED

Pursuant to section 1905(a)(24)(B) of the Act and implementing Federal regulations (42 CFR § 440.167(a)(2)), personal care services must be provided by an individual who is qualified to provide such services. In-home care providers who are not subject to occupational licensing laws may be assigned only care activities or tasks for which they have correctly demonstrated competency to an appropriate individual. The demonstration of competence must be documented by the home care agency (10A NCAC § 13J.1110(b)).

For 1 of the 100 items in our sample, the provider did not verify the qualifications of the individual who provided in-home care. There was no evidence that the in-home aide had demonstrated competency for all of the services provided.

CAUSE OF UNALLOWABLE ITEMS

These deficiencies occurred because DMA did not have sufficient resources to adequately monitor the program for compliance with certain Federal and State requirements. In June 2006, the State agency began limited onsite monitoring visits (15 home care agencies each month) to review the case records for compliance with Federal and State requirements. The monitoring visits also included beneficiary interviews and quarterly regional training. However, because of the substantial growth in North Carolina's program, the State agency's limited monitoring efforts were inadequate.

The State agency has worked with the North Carolina legislature to develop new procedures and controls for the program. The North Carolina Current Operations and Capital Improvement Appropriations Act of 2009 (Session Law 2009-451) funded an initiative (effective July 1, 2009) that included mandated requirements for cost containment. At the outset of this initiative, an independent contractor reassessed and reauthorized personal care services for approximately 37,600 program participants. The restructured program included involvement by the beneficiary's physician, independent assessments, and independent review of the plans of care to ensure the appropriate utilization of personal care services. The program uses automated tools to ensure consistency among the assessments, service authorizations, plans of care, provider service logs, and claims for reimbursement.

ESTIMATE OF THE UNALLOWABLE AMOUNT

Of the 100 personal care services items sampled, 35 items were not in compliance with Federal and State requirements. Based on our sample results, we estimated that the State agency improperly claimed $41,734,368 (Federal share) for unallowable personal care services during the period July 1, 2005, through June 30, 2007. The details of our sample results and estimates are shown in Appendix B.

RECOMMENDATIONS

We recommend that the State agency:

- refund $41,734,368 to the Federal Government and

- continue with its efforts to implement additional procedures and controls for monitoring the providers of personal care services for compliance with Federal and State requirements.

STATE AGENCY COMMENTS

The State agency concurred with our findings and recommendations. The State agency summarized the corrective actions that it had taken and the procedures that it is continuing to implement to better monitor and manage its Medicaid In-Home Personal Care Services Program.

The State agency's comments are included in their entirety as Appendix D.

OTHER MATTER

We interviewed 30 of the 100 beneficiaries in our sample to determine whether quality-of-care or service-related issues existed. We did not interview the remaining 70 sampled beneficiaries because they could not be located, declined to be interviewed, were too ill to respond, or were deceased. Of the 30 beneficiaries interviewed, 29 rated the quality of daily care as good or very good and 1 rated it as average.

Of the 30 beneficiaries interviewed, 4 stated that they had experienced issues with the performance or professionalism of in-home aides at some point while receiving care from the providers; however, the providers resolved these issues to the satisfaction of the beneficiaries.

APPENDIXES

APPENDIX A: SAMPLING METHODOLOGY

POPULATION

The population consisted of Medicaid paid claims for personal care services rendered by the providers in North Carolina during the period July 1, 2005, through June 30, 2007, that the North Carolina Department of Health and Human Services claimed for Federal Medicaid reimbursement.

SAMPLING FRAME

The sampling frame consisted of 15,173,381 claim line items totaling $606,936,404 ($387,790,313 Federal share) for personal care services rendered by providers during our audit period.

SAMPLING UNIT

The sampling unit was a personal care service claim line item.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 claim line items.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used OIG/OAS statistical software to estimate the amount of unallowable payments.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Frame Size	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Items	Value of Unallowable Items
15,173,381	$387,790,313	100	$2,589	35	$417

ESTIMATES

Estimated Value of Unallowable Items (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	$63,262,897
Lower Limit	$41,734,368
Upper Limit	$84,791,426

APPENDIX C: RESULTS FOR EACH SAMPLED ITEM

Legend

A	**Services Not in Accordance With Plan of Care**
B	**No Nursing Visits for Supervision**
C	**Lack of Required Documentation**
D	**No Physician Order**
E	**Qualifications Not Verified**

OIG Review Determinations for the 100 Sampled Items

Item Number	A	B	C	D	E	Number of Errors
1						0
2						0
3						0
4						0
5						0
6						0
7	X				X	2
8						0
9						0
10			X	X		2
11						0
12						0
13						0
14						0
15						0
16						0
17						0
18						0
19	X	X	X			3
20						0
21	X					1
22	X					1
23	X					1
24						0
25						0
26						0
27	X					1
28						0
29						0
30						0

Item Number	A	B	C	D	E	Number of Errors
31						0
32	X					1
33						0
34	X					1
35	X					1
36	X					1
37	X					1
38						0
39						0
40	X					1
41						0
42			X			1
43	X					1
44						0
45						0
46	X					1
47						0
48	X					1
49						0
50						0
51	X					1
52						0
53						0
54						0
55	X					1
56						0
57						0
58						0
59						0
60	X	X				2
61						0
62						0
63						0
64	X					1
65				X		1
66						0
67	X					1
68						0
69						0
70						0
71						0
72						0

Item Number	A	B	C	D	E	Number of Errors
73						0
74						0
75						0
76	X					1
77	X	X				2
78						0
79						0
80	X		X			2
81						0
82						0
83						0
84						0
85						0
86	X					1
87	X					1
88						0
89						0
90		X				1
91	X					1
92	X	X	X			3
93						0
94		X				1
95	X	X				2
96	X					1
97						0
98	X					1
99						0
100						0
	30	7	5	2	1	
Total With Errors						35
Total With More Than One Error						8

APPENDIX D: STATE AGENCY COMMENTS

North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel: 919-733-4534 • Fax: 919-715-4645

Beverly Eaves Perdue, Governor

Lanier M. Cansler, Secretary

March 28, 2011

Peter J. Barbera
Regional Inspector General for Audit Services
United States Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW
Suite 3T41
Atlanta, GA 30303

RE: Report Number: A-04-10-04003
Draft *Review of Medicaid Personal Care Services Claims Submitted by Providers in North Carolina*

Dear Mr. Barbera:

This letter acknowledges receipt of the above-referenced draft report. I understand that this report, along with Report Number: A-04-09-04041 *Review of Federal Reimbursement Claimed by North Carolina for Medicaid Personal Care Services Claims Submitted by Shipman Family Home Care, Inc.* dated October 1, 2010 completes the Office of Inspector General's review of North Carolina Medicaid's In-Home Personal Care Services Program for the period July 1, 2005 through June 30, 2007.

Validity of Facts

Representatives of the Office of the Internal Auditor of the North Carolina Department of Health and Human Services met with Lorraine Forrest and Jaffer Ballard of OIG's Raleigh office on February 24, 2011. These internal state auditors reviewed the audit methodology, sampling procedures, and the audit findings and concluded that the audit findings were both valid and reasonable. The State therefore accepts the findings of fact described in pages 4 through 7 of the draft report.

Recommendations

The OIG auditors recommend that the State: (1) refund $41,734,368 to the Federal Government and (2) continue with its efforts to implement additional procedures for monitoring the providers of personal care services for compliance with federal and state requirements. The State concurs with each of these recommendations.

As indicated in the following corrective actions taken, the State has been focused on improving personal care services compliance even before the audit was initiated. While the State is unable to extrapolate the results of this OIG audit and recoup on the basis of this audit from individual providers, individual provider audits have resulted in disallowances by the State and recoupments will help offset the $41,734,368 recommended recoupment. Future personal care services audit recoupments for the same time period will also help offset the State repayment.

Corrective Actions

The State has initiated and is continuing to implement procedures to better monitor and manage its Medicaid In-Home Personal Care Services Program. Beginning in April of 2007, the State initiated a wide variety of PCS reviews to evaluate PCS and introduced a number of program changes designed to reduce medically unnecessary, inappropriate, and excessive utilization of personal care services. These actions include:

- Conducting, between April 2007 and March 2009, reviews of 347 home care agencies and 4,273 recipients receiving PCS from these agencies. This review documented substantial non-compliance with program requirements and excessive amounts of services delivered to individuals with low levels of functional disability.
- Implementing an independent assessment program that provides assessment of the need for PCS by an entity that does not provide home care or home health services.
- Automating key aspects of the PCS administration process including physician referrals, assessments, recipient notifications, recipient choice of providers, and recipient tracking tools. In the near future, the recipient's plan of care will be automated and submitted by each PCS provider to the Independent Assessment Entity for review and approval.
- Establishing an electronic interface with the state's Medicaid Management Information System (MMIS) to ensure claims are paid in accordance with the service authorization.
- Submitting a State Plan Amendment (SPA) to terminate the existing In-Home Personal Care Services Program and establishing separate In-Home programs for children and adults that contain additional mechanisms for the State to monitor, evaluate, and manage program cost, quality, utilization, and compliance.

The Governor has initiated a series of aggressive measures to curb Medicaid fraud, waste, and abuse. The measures include stronger investigation and prosecution of potential abusers, increasing the number of on-site investigations, and utilization of technology to detect and prevent abuse. Examples of these measures implemented to date include:

- Increasing Program Integrity reviews by authorizing three additional review teams to conduct PCS post payment provider audits.
- Implementing a pre-payment audit to include PCS providers who have previously demonstrated high levels of program non-compliance.
- Implementing analytical software that reviews claims for irregular or aberrant billing patterns that, in turn, triggers referral to Program Integrity Recovery Audit Contractor for review.

- Utilizing the Fraud and Abuse Management System (FAMS) software that summarizes claims data to identify PCS providers that fall outside of norms for indicators such as total dollars paid per recipient, hours of service provided, and service duration.
- Contracting with a vendor to conduct on-site and desktop reviews that monitor PCS programs for compliance with federal and state statutes, rules, regulations, clinical coverage policies, and administrative requirements.
- Suspending payments to providers that have outstanding recoupment balances owed to the state and, when necessary, termination of provider agreements with Medicaid.

Successful efforts to identify and terminate Medicaid recipients who do not qualify for PCS is evidenced by the fact that program enrollment decreased from 37,226 in January of 2010 to 28,436 in January of 2011. Concurrently, the program continued to provide appropriate levels of services to individuals who demonstrated legitimate needs for personal assistance.

The North Carolina Department of Health and Human Services is committed to improving the state's Medicaid program and continues to take steps to make Medicaid more efficient and effective in meeting the needs of qualified individuals within the state. Be assured, we will address the issues contained in these two reports and continue to move forward with changes to identify and correct problems in this program.

Lastly, we would like to express our appreciation for the manner in which the HHS OIG auditors conducted this audit. They were very professional in all our interactions and cooperative in answering our questions. Their findings were well-documented as evidenced by our internal review.

Sincerely,

Lanier M. Cansler

cc: Dr. Craigan Gray, State Medicaid Director
Michael Watson, Deputy Secretary for Health Services
Dan Stewart, Assistant Secretary for Finance and Business Operations
Eddie Berryman, Director of the DHHS Office of the Internal Auditor