Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

North Carolina Focused Program Integrity Review:

Oversight of Medicaid Personal Care Services

August 2023

Final Report

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I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review of North Carolina's Medicaid Personal Care Services (PCS) program for Fiscal Years (FYs) 2019-2021 to assess the state's program integrity oversight efforts. This focused review specifically assessed the state's compliance with CMS regulatory PCS requirements within 42 CFR Parts 440 and 441. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in the delivery of these services.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to the CMS PCS review tool provided at the initiation of the review, and conducted in-depth interviews with the state Medicaid agency (SMA), as well as evaluated program integrity activities performed by selected agencies under contract to provide PCS to Medicaid beneficiaries.

This report includes CMS' findings and resulting recommendations, as well as observations, that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified two findings that create risk to the North Carolina Medicaid program related to PCS program integrity oversight. In response to the findings, CMS identified two recommendations that will enable the state to come into compliance with federal and/or state Medicaid requirements related to PCS program integrity oversight. These recommendations include the following:

State Oversight of Self-Directed Services

> **Recommendation #1**: CMS recommends the state develop and implement a process including written policies and procedures to conduct beneficiary verifications for self-directed care in accordance with § 455.20.

PCS Agency Oversight of Staff and Attendants

> **Recommendation #2:** CMS recommends DHHS implement oversight procedures to ensure the PCS agencies are compliant with the requirements of the Provider Administrative Participation Agreement to conduct federal database checks on a monthly basis. CMS further recommends DHHS amend the Provider Administrative Participation Agreement to include the requirement for provider agencies to include checking SAM on a monthly basis.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid program. CMS identified six observations related to North Carolina's PCS program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

State Oversight of PCS Program Integrity Activities and Expenditures

Observation #1: Consistent with § 455.13-17, CMS encourages North Carolina to implement more effective procedures and activities to monitor, audit, and investigate PCS providers and program integrity contractors to ensure that state and federal dollars are used to deliver health care services and are not misused for fraud, waste, or abuse.

Observation #2: CMS encourages North Carolina to require PCS agencies and/or adult care homes to use time sheets to verify hours of service rendered, as specified in the state's assessment and/or plan of care and PCS service plan.

Observation #3: CMS encourages North Carolina to amend the contract to require PCS agencies to train PCAs and staff on fraud, waste, and abuse.

Electronic Visit Verification (EVV) for PCS

Observation #4: CMS encourages North Carolina to consider utilizing GPS functions for PCS rendered by PCAs in residential homes.

Observation #5: CMS encourages North Carolina to consider additional PCS protocols, safeguards, alternative PCA supervision methods, procedures, or processes for residential aide verification of PCS services to minimize Medicaid fraud, waste, and abuse in residential facilities.

PCS Agency Oversight of Staff and Attendants

Observation #6: CMS encourages North Carolina to ensure that all PCS agencies have a policy addressing 10A NCAC 13F regarding qualifications of the administrator in charge as well as training materials mirroring section 6.1.2 of PCS Clinical Coverage Policy 3L.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts Focused Program Integrity Reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and PCS. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Personal Care Services

Medicaid PCS are services provided to eligible beneficiaries that help them to stay in their own homes and communities rather than live in institutional settings, such as nursing facilities. The PCS benefit is provided according to a state's approved plan, waiver, or demonstration and are optional Medicaid services, except when medically necessary for children eligible for early and periodic screening, diagnostic, and treatment (EPSDT) services. PCS are categorized as a range of assistance provided to persons with disabilities and chronic conditions to enable them to accomplish activities of daily living (ADLs) or instrumental activities of daily living (IADLs). An independent or agency-based Personal Care Attendant (PCA) may provide ADL services, which include eating, bathing, dressing, ambulation, and transfers from one position to another, and IADL services, which include day-to-day tasks that allow an individual to live independently but are not considered necessary for fundamental daily functioning, such as meal preparation, hygiene, light housework, and shopping for food and clothing.

States administer their Medicaid programs within broad federal rules and according to requirements of the specific authority approved by CMS. Pursuant to 42 CFR Part 440, states can choose to provide PCS for eligible beneficiaries through their State Plan, a waiver, or a Section 1115 demonstration. Because PCS are typically an optional benefit, they can vary greatly by state and within states, depending on the Medicaid authority used to cover the benefit. Under federal statute and regulations, PCS must be approved by a physician or through some other authority recognized by the state. Beneficiaries receiving PCS cannot be inpatients or residents of a hospital, nursing facility, intermediate care facility for the developmentally disabled, or institution for mental disease. Services can only be rendered by qualified individuals who have met certain training and enrollment requirements, as designated by each state.

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

Overview of the North Carolina Personal Care Services Program and the Focused Program Integrity Review

The North Carolina Department of Health and Human Services (DHHS), Division of Health Benefits is responsible for the administration of the North Carolina Medicaid program. Within DHHS, the Long-Term Services and Supports Section, specifically the Personal Care Services Unit, provides program oversight. The Office of Compliance and Program Integrity (OCPI) is the organizational unit tasked with oversight of program integrity-related functions, including those related to PCS.

North Carolina administers Medicaid PCS to eligible beneficiaries under the Section 1905(a) State Plan and Section 1915(c) Home and Community-Based Services (HCBS) waiver authorities titled Community Alternatives Program for Children (CAP/C), Community Alternatives Program for Disabled Adults (CAP/DA), and Community Alternatives Program for Consumer-Directed (CAP/CD). HCBS are types of person-centered care delivered in the home and community, including PCS. Detailed descriptions of the North Carolina Medicaid PCS Programs and their applications can be found in Appendix C.

In Fiscal Year (FY) 2021, North Carolina's total Medicaid expenditures were approximately $18.1 billion, providing coverage to approximately 2.3 million beneficiaries. North Carolina's FY 2021 Medicaid expenditures for PCS totaled approximately $1.6 billion, and 165,550 beneficiaries received PCS. The DHHS offers both agency-based and participant-directed PCS options.

In September 2022, CMS conducted a virtual Focused Program Integrity Review of North Carolina's PCS program. This focused review assessed the state's compliance with regulatory requirements at 42 CFR Parts 440, 441, 455, and 456, as well as Sections 1905(a), 1915(c), and 1915(j) of the Social Security Act (the Act). As a part of this review, CMS conducted interviews with DHHS staff involved in program integrity and the administration of PCS to validate the state's program integrity practices, as well as with key personnel within four PCS agencies. CMS also evaluated the status of North Carolina's previous corrective action plan, which was developed by the state in response to a PCS focused review conducted by CMS in 2015, the results of which can be found in Appendix A.

During this review, CMS identified a total of five recommendations and five observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the six following areas:

A. **State Oversight of PCS Program Integrity Activities and Expenditures** – States share responsibility with CMS for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse. States must meet various statutory and regulatory requirements, such as program integrity safeguards in 42 CFR

Parts 455 and 456, to maintain effective oversight of their Medicaid programs.

B. Electronic Visit Verification (EVV) for PCS – Pursuant to Section 12006(a) of the 21st Century Cures Act, all states were required to implement an EVV system for PCS by January 1, 2020. Failure to meet this requirement results in incremental Federal Medical Assistance Percentage (FMAP) reductions of up to 1 percent, unless the state has both made a "good faith effort" to comply and has encountered "unavoidable delays."

C. Provider Enrollment and Screening – CMS regulations at § 455.436 require that the SMA check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the Department of Health and Human Services Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); and the National Plan and Provider Enumeration System (NPPES) upon enrollment and reenrollment, and check the LEIE and SAM no less frequently than monthly. In accordance with § 455.434, PCS agencies or attendants that enroll in Medicaid as providers are also subject to federal screening requirements found at § 455.410.

D. State Oversight of Self-Directed Services –States may elect to cover self-directed PCS under a Section 1915(j) waiver, which allows participants or their representatives to exercise choice and control over the budget, planning, and purchase of self-directed PCS. CMS regulations at 42 CFR 441 Subpart J govern the use of this option.

E. State Oversight of Agency-Based PCS Providers – Beneficiaries may receive services through a personal care agency that oversees, manages, and supervises their care. Agency-based PCS are available under State Plan or waiver authority. In accordance with §§ 441.302 and 441.570, the SMA must assure that certain necessary safeguards have been taken to protect the health and welfare of individuals furnished services under the program and assure the financial accountability for funds expended for PCS provided through wavier or State Plan authority.

F. PCS Agency Oversight of Staff and Attendants – As defined by § 440.167, PCS must be provided by an individual who is qualified to provide such services, unless defined differently by a state agency for purposes of a waiver granted under part 441, subpart G. The conditions of participation for home health aides participating in PCS programs are further detailed at §484.36. In accordance with these standards, state law often requires PCS agency staff and attendants to be subject to enhanced screening and credentialing procedures at the date of hire and annually thereafter. As part of this review, CMS interviewed several PCS agencies to determine if they are exercising appropriate oversight of the quality and integrity of services provided to beneficiaries under the care of their agency, in accordance with state standards.

III. Results of the Review

A. State Oversight of PCS Program Integrity Activities and Expenditures

States share responsibility with CMS for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse. States must meet various statutory and regulatory requirements, such as program integrity safeguards in 42 CFR Parts 455 and 456, to maintain effective oversight of their Medicaid programs.

As required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and beneficiaries. In addition, Section 1902(a)(30) of the Act and federal regulations at 42 CFR Part 456 require the State Plan to provide for the establishment and implementation of a statewide surveillance and utilization control program that provides methods and procedures to safeguard against unnecessary or inappropriate utilization of care, services, and excess payments. States often meet these requirements through implementation of a surveillance and utilization review subsystem (SURS) within the Medicaid Management Information System (MMIS) and/or discrete SURS Units that are a part of larger program integrity efforts.

In North Carolina, the OCPI is primarily responsible for Medicaid program integrity activities. The OCPI identifies fraud and abuse within the Medicaid program through monitoring of PCS and in-home service providers by conducting ongoing data analysis/identification and through fraud detection solutions/systems. Analytics are conducted at the provider level, and prepayment review analytics are conducted at the provider and attendant level.

The DHHS has established PCS program participation and reporting requirements through state policy. North Carolina Medicaid Clinical Coverage Policy No: 3L, Section 6.0 covers the requirements for program participation, and Section 7.3 addresses reporting requirements. Section 4.14 of the approved State Plan addresses Utilization/Quality Control.

Despite these established policies and processes, North Carolina has not met these oversight and monitoring requirements. **During the review period, DHHS conducted minimal oversight of PCS, self-directed PCS, and program integrity contractors and did not conduct any post-payment audits, reviews, preliminary investigations, and/or full investigations.**

In addition, some of the state's PCS agencies and/or adult care homes (i.e., Mocksville and Mint Hill) do not require PCAs to use time sheets to verify hours of service rendered, as specified in the state's assessment and/or plan of care and PCS service plan. The state also does not require PCS agencies to train PCAs and staff on fraud, waste, and abuse. It was noted that Mocksville does not conduct fraud, waste, and abuse training. In addition, Mocksville does not have a policy on training materials mirroring Section 6.1.2. of the North Carolina Medicaid State Plan PCS Clinical Coverage Policy 3L.

Observation #1: Consistent with § 455.13-17, CMS recommends that North Carolina implement more effective procedures and activities to monitor, audit, and investigate PCS providers and program integrity contractors to ensure that state and federal dollars are used to deliver health care services and are not misused for fraud, waste, or abuse.

Observation #2:CMS encourages North Carolina to require PCS agencies and/or adult care homes to use time sheets to verify hours of service rendered, as specified in the state's assessment and/or plan of care and PCS service plan.

Observation #3: CMS encourages North Carolina to amend the contract to require PCS agencies to train PCAs and staff on fraud, waste, and abuse.

B. Electronic Visit Verification (EVV) for PCS

EVV is a technology used to verify that PCS visits occurred, and systems include telephonic verification, verification through a fixed or mobile device in the home, verification through a GPS-enabled mobile application, or a combination of these. Pursuant to Section 12006(a) of the 21st Century Cures Act, all states were required to implement an EVV system for PCS by January 1, 2020. Failure to meet this requirement results in incremental FMAP reductions of up to 1 percent, unless the state has both made a "good faith effort" to comply and has encountered "unavoidable delays."

Currently, North Carolina does utilize an EVV system for in-home scheduling, tracking, and billing for agency-directed PCS providers. North Carolina utilizes an open vendor model approach to EVV that allows the state to contract with a single EVV vendor, Sandata Technologies, but allows providers to utilize their own third-party vendor or an alternative EVV solution. The DHHS EVV system began statewide on January 1, 2021, and is compliant with Section 12006(a) of the 21st Century Cures Act.

However, the state does not require PCS agencies/aides to utilize GPS functions for PCS rendered by PCAs in residential homes. The state is also not aware of GPS mileage capability, minimizing verification of PCA's presence, and PCS services performed, in the home. The state also does not require any additional PCA verification of services rendered to beneficiaries in 24-hour adult care homes, which are not required to use the EVV. Specifically, Mocksville and Mint Hill do not require beneficiaries to verify services rendered in any manner and residential aides only self-report information.

Observation #4: CMS encourages North Carolina to consider utilizing GPS functions for PCS rendered by PCAs in residential homes.

Observation #5: CMS encourages North Carolina to consider additional PCS protocols, safeguards, alternative PCA supervision methods, procedures, or processes for residential aide verification of PCS services to minimize Medicaid fraud, waste, and abuse in residential facilities.

C. Provider Enrollment and Screening

CMS regulations at § 455.436 require that the SMA verify the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the HHS-OIG's LEIE; SAM; SSA-DMF; NPPES upon enrollment and re-enrollment and check the LEIE and SAM no less frequently than monthly.

Any agency employing or billing caregiver services to Medicaid beneficiaries must enroll in North Carolina Medicaid. These agencies are required to list licensure, certification, and permit information on the enrollment application and sign the Provider Administrative Participation Agreement disclosing that information. Each agency must recertify every 5 years to ensure they meet the enrollment criteria to maintain their eligibility.

For agency-directed services available under the State Plan and Section 1915(k) waiver authorities, DHHS contracts with General Dynamics Information Technology, Inc. (GDIT) to perform the provider enrollment process in accordance with federal and state regulations, as well as specifications and requirements of the contract. A LexisNexis Background Report is run monthly to screen current and previously enrolled providers deceased records, expired licenses, license sanctions, federal exclusions, and criminal background to ensure providers follow compliance with North Carolina state regulations. All North Carolina Licensing Boards and DHHS Divisions are monitored for any actions against professional providers that affect their licensure. Criminal background checks are completed, including fingerprint based. Fingerprint-based Criminal Background Checks (FCBCs) are received from the North Carolina State Bureau of Investigation. The GDIT conducts criminal background checks on all owners, managing employees, and providers listed on the application.

All providers enrolled in North Carolina Medicaid must fulfill all screening and credentialing requirements prior to participation in the program. As part of the screening process, the following databases are checked by GDIT: NPPES; SSA-DMF; LEIE; SAM; and the North Carolina PPTD. The PPTD tracks providers who have violations that have resulted in penalties or serious administrative actions against their license.

In accordance with § 455.434, PCS agencies or attendants that enroll in Medicaid as providers are subject to federal screening requirements found at § 455.410. SMAs must require providers, as a condition of enrollment in Medicaid, to consent to FCBCs when required to do so under state law, or by the level of screening based on fraud, waste, and abuse risk as determined for that category of provider, in accordance with § 455.450. High risk and moderate risk providers are subject to enhanced screening. Any providers enrolled in North Carolina Medicaid are screened based on their categorical risk. Screening is conducted during provider enrollment to determine the provider's categorical risk level. Limited categorical risk requires licensure verifications and database checks. Moderate categorical risk requires site visits, licensure verifications, and database checks. High categorical risk requires fingerprinting, site visits, licensure verifications, and database checks. In North Carolina, PCS providers are considered high-risk.

CMS determined that DHHS has met federal screening requirements. CMS did not identify any findings or observations related to these requirements.

D. State Oversight of Self-Directed Services

A self-directed PCS state option allows beneficiaries, or their representatives, if applicable, to exercise decision-making authority in identifying, accessing, managing, and purchasing their PCS. In accordance with § 441.464, a state offering a self-directed option must assure that certain necessary safeguards have been taken to protect the health and welfare of individuals furnished services under the program and assure the financial accountability for funds expended for self-directed services. These safeguards must include provisions for prevention against the premature depletion of the beneficiary directed budget, as well as identification of potential service delivery problems that might be associated with budget underutilization.

North Carolina has a process in place to ensure the requirements of § 441.464 are met. The state provides self-directed PCS under the Section 1915(c) HCBS Waiver CAP/CD. To be considered for enrollment in the self-directed option, the individual must complete a self-assessment questionnaire about their readiness to self-direct. If there is an indicator that the waiver participant does not have the skills necessary to self-direct, additional training and support are offered. Before enrollment in the self-directed PCS program, each waiver participant or their representative must participate in training, including what is self-direction, key players and their roles, how to hire, recruit, and train workers, and the identification of fraud, waste, and abuse. Upon enrollment in the self-directed option, waiver participants or their representatives are referred to as the employer of record. The employer of record is responsible for recruiting, hiring, supervising, evaluating performance, and firing workers. Other responsibilities include negotiating wages, training, approving timesheets, keeping all parties informed of the provision of services, and creating schedules that include days/hours and tasks/duties.

Financial intermediary support is provided to waiver participants through Financial Management Services (FMS). The providers of these services submit claims on behalf of the waiver participant. Their core responsibilities include: meeting with the waiver participant to provide an overview of self-directed PCS and their roles and responsibilities; collecting and processing timesheets of the participant's workers; processing payroll, and withholding, filing, and payment of applicable federal, state, and local employment-related taxes and insurance; maintaining a separate account for each participant's budget; providing participants periodic reports of expenditures and the status of the approved service budget; and tracking and reporting disbursements and balances of participant funds. During the development of the plan of care, the waiver participant or the representative must validate the competency of their hired worker(s) using a validation worksheet. Once the competency is validated and shared with the case advisor, the FMS initiates the hiring process.

Timesheets approved by the employer of record are reconciled by the FMS for payment using the authorized units of services. Each month the FMS provides an updated copy of the budget to the waiver participant and care advisors to assist with monitoring expenditures and the status of the approved service budget. A care advisor is required to engage monthly with the FMS provider to monitor the provision of services and the expenditures of the personal care payments,

as well as the FMS' performance in managing these funds. Concerns are addressed, if applicable, or reported to the DHHS for follow-up. The care advisor engages monthly and quarterly with the waiver participant to monitor the successes/concerns of consumer services. The DHHS meets quarterly with the FMS providers to monitor their performance, provide program updates as needed, and reconcile billing issues. These quarterly meetings are intended to ensure that self-directed funds outlined in the service plan are managed and distributed as intended.

North Carolina does not have a process or procedures in place to conduct beneficiary verifications for self-directed care in accordance with § 455.20. The state does have policies and procedures for other provider types, but the process is not inclusive of self-directed PCS.

> **Recommendation #1:** CMS recommends the state develop and implement a process including written policies and procedures to conduct beneficiary verifications for self-directed care in accordance with § 455.20.

E. State Oversight of Agency-Based PCS Providers

Beneficiaries enrolled to receive services through a personal care agency have their care overseen, managed, and supervised by the agency. Agency-based PCS are available under the State Plan and waiver authority. In accordance with §§ 441.302 and 441.570, the SMA must assure that certain necessary safeguards have been taken to protect the health and welfare of individuals furnished services under the program and to assure the financial accountability for funds expended for agency-based PCS provided through waiver or State Plan authority.

North Carolina ensures these requirements are met through VieBridge, a vendor contracted to administer a case management IT system (e-CAP/C and e-CAP/DA) to process referrals, level of care decisions, assessments, service plans, critical occurrences, and notices. VieBridge's responsibilities include processing the results of the level of care and assessment decisions, creation of a plan of care that identifies the PCS by units in the amount, frequency, duration, and authorized rendering provider, assurance of a freedom of choice document, generation of the service authorization to the freely chosen provider, and transmittal of prior approval record to DHHS's MMIS to assist with processing claims. There are edits and audits in the MMIS to deny units over the authorized amounts or without an EVV visit record.

In addition, DHHS is supported by statewide local non-governmental entities, known as case management entities. These entities manage the day-to-day oversight of the waiver participants through case management services. There is at least one case management entity in each of the 100 counties in North Carolina. Case managers are staffed by nurses and human services workers. There are over 500 case managers statewide. The case management entity's responsibilities include assessing the waiver participant to identify service needs, planning consisting of the creation of the service plan/plan of care and authorization of the PCS provider, referrals, and monitoring/follow-up, which includes monitoring the provision of the PCS monthly and quarterly face-to-face meetings.

Applicable policies and procedures (Clinical Coverage Policy No: 3K-1 for CAP/C and Clinical Coverage Policy No: 3K-2 for CAP/DA) are posted on the DHHS's website. The policies

provide information on when services are covered, when services are not covered, requirements and limitations, provider eligibility for billed services, and service definitions and requirements.

The case management entities are trained on new processes and procedures at each waiver renewal. Each quarter, the waiver assurance area focuses on training with the case managers. Annually, a statewide webinar is held for all providers to provide updates on the waiver program, state Medicaid initiatives, and to reiterate policies and procedures. Regularly scheduled weekly meetings are held with the IT case management vendor and quarterly meetings are scheduled with the case management entities and financial management providers.

Additionally, agency-based PCS providers are subject to audits, reviews, and data mining conducted by OCPI to identify any aberrant billing patterns, etc.

CMS did not identify any findings or observations related to these requirements.

F. PCS Agency Oversight of Staff and Attendants

As defined by § 440.167, PCS must be provided by an individual who is qualified to provide such services, unless defined differently by a state agency for purposes of a waiver granted under part 441, subpart G. The conditions of participation for home health aides participating in PCS programs are further detailed at § 484.36. In accordance with these standards, state law often requires PCS agency staff and attendants to be subject to enhanced screening and credentialing procedures at the date of hire and annually thereafter. As part of this review, CMS interviewed several PCS agencies to determine if they are exercising appropriate oversight of the quality and integrity of services provided to beneficiaries under the care of their agency, in accordance with state standards.

The DHHS does not require individual aides or caregivers providing PCS services to be enrolled in North Carolina Medicaid; therefore, it is the responsibility of the employing agency to perform the appropriate database checks. When a provider enrolls in North Carolina Medicaid, they sign a Provider Administrative Participation Agreement that outlines various requirements for participation in the program. In accordance with the Provider Administrative Participation Agreement, Section 6.e., the provider is required to screen all its employees, contractors, and contractor's employees monthly using the LEIE database to determine whether any of its employees, contractors, and contractor's employees are excluded from participation in Medicare, Medicaid, or other federal health care programs. The provider shall promptly notify DHHS upon discovery of any excluded employee, contractor, or contractor's employees.

As part of the review, CMS selected four provider agencies to be interviewed: A Primary Choice, Metacorp Affiliates doing business as Trinity Home Care, Mocksville Senior Living, and Mint Hill Senior Living. **Trinity Home Care, Mocksville Senior Living, and Mint Hill Senior Living only conduct federal database checks on PCAs annually, not monthly as required by the Provider Administrative Participation Agreement. In addition, some PCS agencies reviewed did not utilize the SAM database as part of the required federal database checks. Further, the state's policies and procedures only address the required frequency of the LEIE database checks, not SAM.** In addition,

Mocksville and Mint Hill do not have a policy addressing 10A NCAC 13F regarding qualifications of the administrator in charge. In addition, Mocksville and Mint Hill do not have a policy on training materials mirroring section 6.1.2 of PCS Clinical Coverage Policy 3L. They have adopted the state's policy as their own.

In accordance with the Clinical Coverage Policy 3L provider manual, the PCS provider shall provide a qualified and experienced professional responsible for supervising and ensuring all services provided by the PCAs under their supervision are conducted in accordance with Clinical Coverage Policy 3L, other applicable federal and state statutes, rules, regulation, policies and guidelines, and the provider agency's policies and procedures. Other duties include the supervision of the provider organizations Continuous Quality Improvement program, completion and approval of all service plans for assigned beneficiaries, implementation of the service plan, and maintenance of complaint logs and service records in accordance with state requirements. Supervisory visits are required in the beneficiary's home every 90 days, with two visits per year to be completed while the aide is scheduled to be in the home.

Before hiring a new PCA, the PCS agency is required to perform a criminal background check, including a review of the North Carolina Health Care. All aides shall meet the qualifications contained in the applicable North Carolina Home Care, Adult Care Home, Family Care Home, and Mental Health Supervised Living Licensure Rules (10A NCAC 13J, 13F and 13G, and 10A NCAC 27G). According to North Carolina licensure rules, if a PCA is not listed with the nurse aide registry, the PCS agency must show that the PCA is competent to assist with the required tasks.

The PCS Clinical Coverage Policy 3L requires providers to offer an orientation based upon licensure rules for all new PCAs. This orientation should include an overview of the PCS policies and the North Carolina Home Care Licensure Rules. The PCS agency is further required to offer ongoing training pertaining to the job responsibilities of each employee as well as the requirement of the Clinical Coverage Policy 3L.

Other than the finding noted above, each of the PCS agencies reported compliance with these requirements.

> **Recommendation #2:** CMS recommends DHHS implement oversight procedures to ensure the PCS agencies are compliant with the requirements of the Provider Administrative Participation Agreement to conduct federal database checks on a monthly basis. CMS further recommends DHHS amend the Provider Administrative Participation Agreement to include the requirement for provider agencies to include checking SAM on a monthly basis.
>
> **Observation #6:** CMS encourages North Carolina to ensure that all PCS agencies have a policy addressing 10A NCAC 13F regarding qualifications of the administrator in charge as well as training materials mirroring section 6.1.2 of PCS Clinical Coverage Policy 3L.

IV. Conclusion

CMS supports North Carolina's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified three recommendations and five observations that require the state's attention.

We require the state to provide a corrective action plan for each of the recommendations within 30 calendar days from the date of issuance of the final report. The corrective action plan should explain how the state will ensure that the recommendations have been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action along with the specific steps the state expects will take place and identify which area of the SMA is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

CMS looks forward to working with North Carolina to build an effective and strengthened program integrity function.

V. Appendices

Appendix A: Status of Prior Review

North Carolina's last CMS program integrity review was in September 2015, and the report for that review was issued in May 2016. The report contained eight recommendations and zero observations. During the virtual review in September 2022, the CMS review team conducted a thorough review of the corrective actions taken by North Carolina to address all recommendations reported in calendar year 2016. The findings from the 2016 North Carolina focused PI review report have all been satisfied by the state.

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C: PCS Program Details

Table C-1 provides detailed information on the PCS programs available in North Carolina.

Table C-1. North Carolina Medicaid PCS Programs

Program Name/Federal Authority	Administered By	Description of the Program
Section 1905(a) Personal Care Services Program	North Carolina DHHS	Pursuant to the North Carolina State Plan, PCS are available to assist Medicaid eligible members to perform ADL and IADL in the member's home, place of employment, or community. In addition to the specified assistance with ADLs and IADLs, qualified PCS direct-care workers may also provide Nurse Aide I and Nurse Aide II tasks as described in 21 NCAC 36.0403, and as specified in the beneficiary's approved plan of care. PCS is provided by a direct-care worker employed by a licensed home care agency, or by a residential facility licensed as an adult care home, family care home, supervised living facility, or combination home.
Section 1915(c) HCBS Waiver Authorities		
Community Alternatives Program for Children (CAP/C)	North Carolina DHHS	This waiver program provides an alternative to institutionalization for individuals between the ages of 0-20. These services allow the targeted individuals to remain in or return to a home or community-based setting. This waiver serves a limited number of medically complex children who are medically fragile and are at imminent risk due to caregiver network unraveling because of the severity and intensity of the care needs. The array of services of this waiver will lead to a reduction in unplanned institutionalization thus promoting continuous community living.
Community Alternatives Program for Disabled Adults (CAP/DA)	North Carolina DHHS	This HCBS waiver provides a safe and supportive network of services, promotes community integration, and autonomy of choice. This HCBS waiver serves Medicaid beneficiaries 18 years and older with a physical disability or 65 years and older with functional deficiencies due to age. This supportive network of services supplements Medicaid State Plan services to address deficiencies in the performance of ADLs, IADLs and gaps in the support systems.
Community Alternatives Program for Consumer-Directed (CAP/CD)	North Carolina DHHS	Consumer-direction is a service delivery model that allows a CAP/C or CAP/DA Medicaid beneficiary or designated representative to act in the role of employer of record to direct their PCS by: freely choosing who will provide care to

Program Name/Federal Authority	Administered By	Description of the Program
		meet medical and functional needs; independently recruiting, hiring, supervising, and firing when necessary a personal assistant; independently setting a pay rate for a personal assistant; and assigning work tasks for the personal assistant based on medical and functional needs.

Table C-2. North Carolina PCS Enrollment by Authority

Authority	FY 2019	FY 2020	FY 2021
1905(a) State Plan Authority	43,026	41,585	40,892
1915(c) HCBS Waiver Authority	13,549	13,366	13,132

Table C-3. Summary of North Carolina PCS Expenditures by Authority

Authority	FY 2019	FY 2020	FY 2021
1905(a) State Plan Authority	$472,438,859.67	$530,758,202.50	$608,142,535.27
1915(c) HCBS Waiver Authority	$288,063,222.09	$332,067,697.75	$373,751,654.79

Table C-4. Waiver Authority Expenditures by Type

1915(c) HCBS Waiver Authority	FY 2019	FY 2020	FY 2021
Community Alternatives Program for Children (CAP/C)	$42,355,741.07	$49,578,979.69	$57,785,235.40
Community Alternatives Program for Disabled Adults (CAP/DA)	$186,630,878.16	$201,510,705.63	$216,012,515.82
Community Alternatives Program for Consumer-Directed (CAP/CD)	$59,076,602.86	$80,978,012.43	$99,953,903.57

Table C-5. Program Integrity Post Payment Actions Taken – PCS Providers

Agency-Directed and Self-Directed Combined	FY 2019	FY 2020	FY 2021
Identified Overpayments	$473,385.60	$237,185.67	$80,740.67
Recovered Overpayments	$150,845.54	$90,587.62	$31,546.30
Terminated Providers*	0	0	0
Suspected Fraud Referrals	40	68	34
Number of Fraud Referrals Made to MFCU	1	3	1

Information regarding provider terminations was requested during the review. However, as of the 1/20/2023 deadline, this information had not been provided, despite several reminders by CMS to the state.

Appendix D: State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
Recommendation #1	CMS recommends the state develop and implement a process including written policies and procedures to conduct beneficiary verifications for self-directed care in accordance with § 455.20.		
Recommendation #2	CMS recommends DHHS implement oversight procedures to ensure the PCS agencies are compliant with the requirements of the Provider Administrative Participation Agreement to conduct federal database checks on a monthly basis. CMS further recommends DHHS amend the Provider Administrative Participation Agreement to include the requirement for provider agencies to include checking SAM on a monthly basis.		

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)