Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# MISSOURI CLAIMED FEDERAL MEDICAID REIMBURSEMENT FOR TENS OF MILLIONS IN CONSUMER-DIRECTED PERSONAL CARE ASSISTANCE SERVICES THAT DID NOT COMPLY WITH FEDERAL AND STATE REQUIREMENTS

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**Report in Brief**
Date: February 2023
Report No. A-07-20-03243

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

# Missouri Claimed Federal Medicaid Reimbursement for Tens of Millions in Consumer-Directed Personal Care Assistance Services That Did Not Comply With Federal and State Requirements

## Why OIG Did This Audit

Consumer-directed personal care assistance (PCA) services assist Medicaid recipients by allowing the consumer (i.e., the recipient) to direct his or her care by hiring, training, supervising, and directing the service worker. In Missouri, the service worker provides assistance with activities of daily living, instrumental activities of daily living, or both, as an alternative to nursing facility placement to persons with a physical disability.

Our objectives were to determine whether Missouri: (1) ensured that consumer-directed PCA services for which it claimed Federal Medicaid reimbursement during fiscal years (FYs) 2018 and 2019 complied with Federal and State requirements, and (2) established and implemented pandemic emergency preparedness standards and protocols within the consumer-directed PCA program.

## How OIG Did This Audit

Our audit covered $918 million ($597 million Federal share) in Medicaid payments for consumer-directed PCA services provided and paid for in Missouri during FYs 2018 and 2019.

We reviewed documentation for a stratified random sample of 150 consumer-directed PCA net claim lines of $25 or more (sampled items) to determine whether the services provided were allowable and adequately supported.

## What OIG Found

Missouri did not always ensure that the consumer-directed PCA services for which it claimed Federal Medicaid reimbursement during FYs 2018 and 2019 complied with Federal and State requirements. Specifically, 17 of the 150 sampled items were at least partially unallowable because of errors related to: timesheets that could not be provided or that lacked detail; units of service charged that exceeded the number authorized; lack of documentation that attendants were registered, screened, and employable; and recipients with plans of care that were not signed. Based on our sample results, we estimated that Missouri claimed at least $52.5 million ($34.2 million Federal share) for unallowable consumer-directed PCA services during FYs 2018 and 2019. In addition, timesheets for 46 of the 150 sampled items did not identify the specific services that were performed in accordance with the plans of care. We are setting aside, for Centers for Medicare & Medicaid Services (CMS) resolution, an estimated $133.8 million ($87.0 million Federal share) associated with these 46 items.

For our second objective, Missouri did not have established and implemented pandemic emergency preparedness standards and protocols within the consumer-directed PCA program. Most providers for the sampled items did not have any emergency preparedness documentation for a pandemic response.

## What OIG Recommends and Auditee Comments

We recommend that Missouri refund the $34.2 million (Federal share) in overpayments to the Federal Government and work with CMS to determine the allowability of the $87.0 million (Federal share) and refund any amount that is determined to be unallowable. We also make procedural recommendations regarding the monitoring of PCA providers and the State's establishment of and adherence to policies and procedures.

Missouri disagreed with most of our findings and recommendations and gave us additional documentation. After reviewing Missouri's comments and the documentation, we revised the number of sampled items in error, from 18 to 17, and revised our statistical estimate and the amount conveyed in our first recommendation. We also removed one procedural recommendation. We maintain that our findings and recommendations, as revised, are valid.

The full report can be found at https://oig.hhs.gov/oas/reports/region7/72003243.asp.

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# INTRODUCTION

## WHY WE DID THIS AUDIT

Consumer-directed personal care assistance (PCA) services assist Medicaid recipients by allowing the consumer (i.e., the recipient) to direct his or her care by hiring, training, supervising, and directing the service worker. In some States, including Missouri, the service worker provides assistance with activities of daily living, instrumental activities of daily living, or both, as an alternative to nursing facility placement to persons with a physical disability. Our audit covered $918.4 million ($596.9 million Federal share) that the Missouri Department of Social Services (State agency) claimed during Federal fiscal years (FYs) 2018 and 2019. Previous Office of Inspector General (OIG) audits (Appendix B) found that some States did not always claim Federal Medicaid reimbursement for personal care services in accordance with Federal and State requirements.

## OBJECTIVES

Our objectives were to determine whether the State agency: (1) ensured that consumer-directed PCA services for which it claimed Federal Medicaid reimbursement during FYs 2018 and 2019 complied with Federal and State requirements, and (2) established and implemented pandemic emergency preparedness standards and protocols within the consumer-directed PCA program.

## BACKGROUND

### Medicaid Program

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.

### Medicaid Coverage of Personal Care Services

The Social Security Act (the Act) authorizes personal care services, which it defines as "services furnished to an individual . . . that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location" (the Act § 1905(a)(24)).

Federal regulations require that personal care services must be: (1) authorized for an individual by a physician in accordance with a plan of treatment or, at the State's option, otherwise authorized in accordance with a plan of care approved by the 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. In addition, personal care services may be provided only to individuals who are not inpatients at a hospital or residents of a nursing facility, an Intermediate Care Facility for Individuals with Intellectual Disabilities, or an Institution for Mental Disease (42 CFR § 440.167). Examples of personal care services include, but are not limited to, meal preparation, shopping, grooming, and bathing.

In accordance with 42 CFR § 430.30(c) and the CMS *State Medicaid Manual*, section 2500.2, the amounts that State Medicaid agencies report to CMS on the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64), and its attachments must represent actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available at the time the claim is filed. Furthermore, claims developed on the basis of estimates are not allowable.

**Missouri Medicaid Program and Consumer-Directed Personal Care Assistance**

In Missouri, the State agency administers the Medicaid program. The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims. The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation (FFP) or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on a State's relative per capita income. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase or decrease FMAPs at any time. During our audit period, Missouri's regular FMAP ranged from 64.61 percent to 65.40 percent.

In Missouri, responsibility for the administration of personal care services at the State level is shared between the State agency and the Department of Health and Senior Services (DHSS), a co-equal department of the State government. In general, the State agency makes Medicaid eligibility determinations, processes claims for payment, and reports expenditures for Federal reimbursement. By formal agreement with the State agency, DHSS develops plans of care for beneficiaries, authorizes services, and performs case management. More specifically, DHSS performs reviews that include assessments and reassessments of the necessity for, appropriateness of, and adequacy of the in-home and consumer-directed personal care services that beneficiaries receive.

Missouri identifies two types of personal care services: personal care services, also known as the agency model, and personal care assistance, also known as the consumer-directed model. Our audit covered only the consumer-directed PCA services; for this type of services, the consumer (i.e., the Medicaid recipient) directs his or her care by hiring, training, supervising, and directing the service worker.

Consumer-directed PCA services are provided to persons with a physical disability and do not include any task performed by a licensed professional. A Medicaid recipient who is receiving consumer-directed PCA services must be able to direct the care planning process and hire an attendant. In general, consumer-directed PCA services consist of personal care services including bathing, cleaning, and meal preparation.

State regulations define a consumer-directed service as "[t]he hiring, training, supervising, and directing of the personal care attendant (attendant) by the physically disabled person (consumer)" (19 Code of State Regulations (CSR) § 15-8.100(1)(D)).[1]

For a Medicaid recipient to qualify for personal care services, DHSS must assess the recipient for eligibility for personal care services and the required level of care, approve the services, and provide case management. If the recipient meets the eligibility and assessment criteria, DHSS develops an initial plan of care to authorize these services.

**HOW WE CONDUCTED THIS AUDIT**

Our audit period covered consumer-directed PCA services that the State agency provided and paid for during FYs 2018 and 2019. We developed a sampling frame of 11,612,322 consumer-directed PCA net claim lines of $25 or more with a total reimbursement of $918,449,560 ($596,940,725 Federal share), from which we selected a stratified random sample of 150 net claim lines.[2] We obtained and reviewed documentation for each sampled item to determine whether the services provided were allowable and adequately supported.

We reviewed the documentation that the State agency gave us for services rendered, recipient eligibility, and provider qualifications to determine whether the consumer-directed PCA provided and paid for complied with Federal and State requirements. We also reviewed documentation provided by the State agency to determine whether consumer-directed PCA providers had established and implemented emergency preparedness standards and protocols for a pandemic response within the consumer-directed PCA program.

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 objectives.

Appendix A contains details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, Appendix D contains our sample results and estimates,

[1] In the context of this audit report, we may think of "consumer" as being synonymous with "Medicaid recipient."

[2] We grouped the consumer-directed PCA services by recipient identification number (field name "DCN"), first date of service (field name "FDOS"), and provider number; we refer to the result as "net claim lines." This grouping is the basis of our sample unit, which we will refer to in the report as "sampled item(s)."

Appendix E contains details on the Federal and State requirements related to consumer-directed PCA, and Appendix F summarizes the errors for each sampled item.

## FINDINGS

The State agency did not always ensure that the consumer-directed PCA services for which it claimed Federal Medicaid reimbursement during FYs 2018 and 2019 complied with Federal and State requirements. Specifically, 17 of the 150 sampled items were at least partially unallowable because they had at least 1 of the following errors (some sampled items had more than 1 error), as shown in Table 1:

**Table 1: Summary of Deficiencies in Sampled Items**

| Type of Deficiency | Sampled Items Containing Deficiency |
|---|---|
| Timesheets could not be provided, or the timesheets included no detail of tasks performed | 8 |
| Units of service charged on the timesheets exceeded the number of units authorized by the recipients' plan of care | 6 |
| Neither providers nor the State agency could provide documentation showing that the attendants were registered, screened, and employable pursuant to the Family Care Safety Registry | 6 |
| Plans of care were not signed | 2 |

Based on our sample results, we estimated that the State agency claimed at least $52,547,876 ($34,171,397 Federal share) in unallowable Medicaid reimbursement for consumer-directed PCA services during FYs 2018 and 2019.

In addition, the State agency claimed Federal Medicaid reimbursement for some consumer-directed PCA services for which the timesheets used to document the services rendered did not identify the specific services that were actually performed in accordance with the recipients' plans of care. Specifically, 46 of the 150 sampled items included timesheets that did not detail the consumer-directed PCA services that were rendered. Based on our sample results, we are setting aside an estimated $133,858,094 ($87,018,594 Federal share) for CMS resolution and potential recovery related to the 46 sampled items for which we could not identify the actual services that were rendered.

With respect to our second objective, the State agency did not have established and implemented pandemic emergency preparedness standards and protocols within the consumer-directed PCA program that: (1) required providers to plan for pandemic preparedness and (2) directed steps for providers to take in preparing and training for a pandemic emergency. Specifically, we determined that most providers for the sampled items

did not have any emergency preparedness documentation for a pandemic response within the consumer-directed PCA program or training material and associated information related to a pandemic.

Regarding the first objective, the errors occurred because the State agency did not require consumer-directed PCA providers to comply with some of the State agency's established policies and procedures. In addition, the State agency did not monitor the consumer-directed PCA program to ensure that services for which it claimed Federal reimbursement complied with certain Federal and State requirements. Regarding the second objective (pandemic preparedness), the State did not have policies and procedures to: (1) specify what consumer-directed PCA providers must include in their emergency backup plans for recipients and (2) require development of pandemic preparedness plans and implement training to educate consumer-directed PCA providers on these plans.

## THE STATE AGENCY CLAIMED FEDERAL REIMBURSEMENT FOR UNALLOWABLE CONSUMER-DIRECTED PERSONAL CARE ASSISTANCE SERVICES

The State agency claimed Federal Medicaid reimbursement for some consumer-directed PCA claims that did not comply with Federal and State requirements. Of the 150 randomly sampled items, 17 were at least partially unallowable for Medicaid reimbursement (some sampled items had more than 1 error).

### Providers Did Not Maintain Adequate Documentation for Consumer-Directed Personal Care Assistance

According to section 1902(a)(27)(A) of the Act, a State plan for medical assistance must provide for an agreement with every provider under which such provider agrees "to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan."

The CMS *State Medicaid Manual* states that Federal Medicaid reimbursement is "available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers. Expenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met" (*State Medicaid Manual* § 2497.1).

State regulations require that adequate documentation shall include an accurate, complete, and legible description of each service provided (13 CSR § 70-3.030(2)(A)(2)). Additionally, State regulations require that documentation for personal care services delivered by the provider must include a description of the service (13 CSR § 70-91.010(4)(A)(2)(D)).

For eight sampled items, the State agency claimed unallowable Federal Medicaid reimbursement for consumer-directed PCA services rendered but for which the documentation

did not support the services. Specifically, either the State agency was unable to give us timesheets and descriptions of services to support that services were provided (5 sampled items) or the timesheets given to us did not contain any descriptive information of the tasks performed (3 sampled items). Therefore, we could not identify the specific services rendered or even determine whether the services were rendered. For example, a timesheet contained the names of the recipient and the attendant as well as the check-in and check-out times. However, the timesheet had no description of the PCA services the attendant had rendered to the recipient.

**Units Charged on Timesheets Exceeded Allowable Units**

Federal regulations state that "[p]ersonal care services means services . . . (1) [a]uthorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State" (42 CFR § 440.167(a)).

The Missouri State plan states that consumer-directed PCA services "include assistance with activities of daily living and/or instrumental activities of daily living, provided by a qualified and trained aide in accordance with a plan of care approved by the state" (Missouri State Plan, Attachment 3.1-A, page 18g).[3] The plan of care shall include the maximum number of units of consumer-directed PCA to be provided (19 CSR § 15-8.200(4)(B)(1)). State regulations also state that the personal care plan will include the maximum number of units of service for which the individual is eligible per month (13 CSR § 70-91.010(1)(B)(2)).

For six sampled items, the units of personal care services delivered to the recipient (and charged on the associated timesheets) exceeded the number of units authorized by the plan of care. The plan of care lists specific tasks to be performed and how many days per week each task is to be performed. We compared the timesheets to the tasks and time allowed in the recipients' plans of care and found that in these cases, the units of service exceeded the authorized units. For example, one sampled item charged 237 units of service; however, the time allowed to perform those services, according to the recipient's plan of care, amounted to 154 units; thus, 83 units of service were not allowable for Federal reimbursement.

**Background Screening for Attendants Not Documented**

Personal care services must be provided by an individual who is qualified to provide such services (42 CFR § 440.167(a)(2)). State regulations require that "vendors shall be responsible, directly or by contract, for the following: . . . (1) Ensuring that each attendant is registered,

[3] The State plan requires compliance with 19 CSR 15-8.

screened, and employable pursuant to the Family Care Safety Registry (FCSR) . . . maintained by DHSS, and applicable state law and regulations" (19 CSR § 15-8.400(4)).[4, 5]

For six sampled items, the State agency could not give us documentation supporting that the attendant was registered, screened, and employable pursuant to the FCSR as required by State regulations. Specifically, the State agency was unable to obtain from consumer-directed PCA providers the supporting documentation that the FCSR screening was performed.

**Plans of Care Not Signed**

Federal regulations require that personal care services are authorized by a physician in accordance with a plan of care or otherwise authorized in accordance with a service plan approved by the state (42 CFR § 440.167; State plan, Attachment 3.1-A, page 18ee). Furthermore, State regulations require that "[t]he personal care plan will be developed in collaboration with and signed by the recipient" (13 CSR § 70-91.010(1)(B)(2)).

The participant choice statement in the plan of care provides documentation of the recipient's involvement in the selection of services and providers and the development of the care plan. For two sampled items, a participant choice statement showing the recipient's signature approving the care plan could not be provided.

**The State Agency Did Not Require Providers To Comply With Policies and Procedures**

The State agency had policies and procedures in place to prevent the types of errors we identified in our findings; however, the State agency did not require consumer-directed PCA providers to comply with those established policies and procedures, which would have otherwise identified instances of noncompliance with Federal and State requirements among consumer-directed PCA providers. In addition, the State agency did not monitor the consumer-directed PCA program to ensure that services for which it claimed Federal reimbursement complied with certain Federal and State requirements.

**Effect of Unallowable Consumer-Directed Personal Care Assistance Claims**

Because the State agency did not require consumer-directed PCA providers to comply with the State agency's established policies and procedures, providers billed the State agency (and received payment) for some unallowable consumer-directed PCA services. The State agency

[4] For purposes of this report, "vendors" may be regarded as synonymous with "consumer-directed PCA providers."

[5] The FCSR was established to promote family and community safety. DHSS maintains this registry, which helps to protect children, seniors, and people with disabilities by providing background information on providers. Families and employers can call the registry's toll-free phone line to request background information on registered childcare, elder care, and personal care workers. This service is intended to provide information to help families and employers make informed decisions when hiring employees to work with children, the elderly, and people with disabilities.

then claimed Federal Medicaid reimbursement for some consumer-directed PCA services that did not comply with Federal and State requirements. Based on our sample results, we estimated that the State agency improperly claimed at least $52,547,876 ($34,171,397 Federal share) in unallowable Medicaid reimbursement for consumer-directed PCA services during FYs 2018 and 2019.

## THE STATE AGENCY DID NOT ENSURE THAT TIMESHEETS DOCUMENTED THE SPECIFIC CONSUMER-DIRECTED PERSONAL CARE ASSISTANCE SERVICES PERFORMED AS APPROVED IN THE PLAN OF CARE

The Act specifies that a State plan for medical assistance must provide for an agreement with every provider under which the provider agrees "to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan" (the Act § 1902(a)(27)(A)). In addition, section 2497.1 of the CMS *State Medicaid Manual* states that expenditures require adequate supporting documentation to be allowable for Federal reimbursement.

State regulations mandate that adequate documentation include an accurate, complete, and legible description of each service provided (13 CSR § 70-3.030(2)(A)(2)). Additionally, State regulations require that documentation for personal care services delivered by the provider must include a description of the service (13 CSR § 70-91.010(4)(A)(2)(D)).

During FYs 2018 and 2019, the State agency claimed Federal Medicaid reimbursement for some consumer-directed PCA services for which the timesheets used to document the services rendered did not identify the specific services that were actually performed in accordance with the recipients' plans of care. Specifically, 46 of the 150 sampled items included timesheets that contained only vague and generic descriptions. For example, the timesheets in question used only nonspecific descriptions—such as "personal care," "health," and "housekeeping"—for the services rendered.[6] The plan of care lists specific services that are to be performed (i.e., meal preparation, shopping, grooming, and bathing), the frequency at which they are to be performed, and the time allowed for each service. Because the timesheets did not provide any detail on the specific tasks performed, we could not identify the actual services that were rendered or determine whether those services were allowable under the terms of the plans of care.

The State agency did not require consumer-directed PCA providers to complete accurate and detailed timesheets in accordance with Federal and State requirements. The State agency lacked policies and procedures to ensure that timesheets included fully accurate and complete details on the specific tasks performed.

[6] The sampled items discussed in this finding should not be confused with the eight sampled items in our earlier finding, which did not have any descriptive information at all.

Although these 46 sampled items used timesheets that did not identify any specific services performed, the State agency claimed Federal Medicaid reimbursement for those consumer-directed PCA services. Based on our sample results, we are setting aside an estimated $133,858,094 ($87,018,594 Federal share) for CMS resolution and potential recovery.

## LIMITATIONS IN EMERGENCY PREPAREDNESS STANDARDS AND PROTOCOLS RELATED TO A PANDEMIC

We requested, from the providers of all sampled items (associated with 109 different consumer-directed PCA providers), emergency preparedness documentation related to a pandemic. We found that for most providers, the State agency could not provide any emergency preparedness documentation related to a pandemic.[7] In addition, for some sampled items, the documentation that providers gave us included either no backup plans (whose purpose is to help ensure that recipients are safe if attendants cannot reach them during an emergency) or limited backup plan detail of actions to be followed in the event of a pandemic or emergency.

### Pandemic Preparedness Training and Documentation

We requested, from both the State agency and DHSS, emergency preparedness policies as well as details of the State's strategy for preparing for, responding to, and recovering from a pandemic. Currently, DHSS maintains a COVID-19 webpage and disseminates other information and memoranda to vendors and providers, on subjects such as electronic COVID-19 case reporting, COVID-19 data tracking, and vaccine information. For our audit period (which preceded the onset of the COVID-19 pandemic), we sought to identify whether the State agency had pandemic preparedness plans or policies in place.

For most of the sampled items, the State agency did not have emergency preparedness documentation related to a pandemic. Such documentation, if available, could have supported that the State agency had developed training material or associated information related to a pandemic, including: agency responses to the transmission of a virus, the proper use of personal protective equipment, and agency policy regarding infection control practices.

### Recipient Backup Plans

State regulations require that "vendors shall be responsible, directly or by contract, for the following: . . . (G) Ensuring the [recipient] has an emergency and/or backup plan; . . . (I) Ensuring that the [recipient]'s case file contains, at a minimum, the following: . . . (5) Documentation of the [recipient]'s emergency and/or backup plans" (19 CSR § 15-8.400(4)).

[7] The audit period preceded the declaration of the COVID-19 pandemic public health emergency. During the COVID-19 pandemic, the State agency noted that it encouraged compliance with Centers for Disease Control and Prevention guidance and kept its webpage updated with the most recent COVID-19 guidance. For this audit, we focused on emergency preparedness standards and protocols that the State agency had in place before the COVID-19 pandemic.

Backup plans are essential to ensure that recipients are safe in the event that their attendants are unable to reach them in emergency situations. During our review, we looked for documentation related to emergency preparedness information, including any updates to recipient emergency backup plans. Specifically, we found that some sampled items had only a contact name and phone number in the backup plan—and no other information or instructions—and that a few of the sampled items had no backup plans at all.

**Establishment and Implementation of Emergency Preparedness Standards**

During our audit period, the State agency did not issue any formal training or guidance for pandemic preparedness. Moreover, the State agency had not developed or disseminated general standards that: (1) required providers to plan for pandemic preparedness and (2) directed steps for providers to take in preparing and training for a pandemic emergency. Furthermore, although the State agency has policies in place requiring providers of consumer-directed PCA services to have emergency backup plans on behalf of their recipients, those policies do not specify what should be included in the plans.

State agency development and implementation of emergency preparedness standards that require development of a pandemic preparedness plan and delivery of associated training would educate consumer-directed PCA providers on those plans. These measures would be enhanced by clarification, in the State agency's policies and procedures, of guidance on the information that should be included in recipient backup plans. If consumer-directed PCA providers and recipients do not implement emergency preparedness standards and protocols and do not keep emergency backup plans updated with necessary information, there is an increased risk that recipients will not be protected in the event of an emergency. Furthermore, the ongoing COVID-19 public health emergency (which was declared after our audit period) amplifies the need to train provider staffs to the maximum extent possible as they continue working to protect the vulnerable recipients in their care.

## RECOMMENDATIONS

We recommend that the Missouri Department of Social Services:

- refund $34,171,397 (Federal share) in overpayments to the Federal Government;

- work with CMS to determine the allowability of $87,018,594 (Federal share) that we have set aside, and refund to the Federal Government any amount that is determined to be unallowable;

- monitor consumer-directed PCA providers to ensure compliance with the State agency's established policies and procedures such that:

    - timesheets are completed and the tasks performed are described accurately and in sufficient detail;

- units of service charged on timesheets do not exceed the units allowable on the recipients' plans of care;

- consumer-directed PCA providers maintain documentation showing that attendants are registered, screened, and employable pursuant to the FCSR; and

- plans of care are signed;

- establish policies and procedures to ensure that timesheets include fully accurate and complete details on the specific tasks performed; and

- establish and implement policies and procedures to:

  - specify what consumer-directed PCA providers must include in their emergency backup plans for recipients and

  - require development of pandemic preparedness plans and implement training to educate consumer-directed PCA providers on these plans.

## STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency (responding on behalf of both itself and DHSS) disagreed with most of our findings and did not concur with our first, second, and fourth recommendations. The State agency did not directly agree or disagree with our third and final recommendations but described its monitoring activities with respect to consumer-directed PCA providers. The State agency asked us to clarify the first half of our final recommendation and added that it had updated policy and guidance regarding emergency backup plans.[8]

Specifically, the State agency disagreed with our methodology for statistical sampling and estimation.[9] The State agency also disagreed with our findings for most of the 18 sampled items identified in our draft report and with the recommended refund in our first recommendation. The State agency said that we "erred in rejecting many of the 18 sampled items," 1 of which our draft report had found to be in error because an assessment had not been performed within the timeframe specified in State statute and regulations. For this sampled item, the State agency furnished additional documentation along with its written

[8] The State agency's comments refer to six recommendations rather than five. As discussed below, for this final report we removed one claim from our findings and removed what had been the fifth recommendation in our draft report.

[9] In this regard, the State agency used the term "extrapolation" in its comments. Except where directly quoting from or referring to the State agency's comments, we use the term "estimation" for consistency with language earlier in the report. For purposes of this report, the two terms can be regarded as synonymous.

comments. In addition, the State agency stated that a Federal refund was generally not an appropriate remedy for the deficiencies that we cited in our findings.

For our second recommendation, the State agency stated that it and DHSS do not believe that any of the funds we set aside for adjudication with CMS should be disallowed. The State agency and DHSS "disagree that the timesheets did not include sufficient detail of the services provided."

The State agency did not directly agree or disagree with our third recommendation but stated that it and DHSS "work diligently to monitor CDS [consumer-directed services] to maximize compliance with state and federal laws and policies. Prior to, during, and after the OIG's review period, the State agency has employed significant resources to monitor CDS providers' compliance with Federal and State regulations." The State agency cited a number of audits, investigations, training initiatives, and other activities completed by the Missouri Medicaid Audit & Compliance Unit and added that DHSS established a Quality Assurance Unit in late 2020. The State agency did not concur with our fourth recommendation because "the State already has such policies and procedures in place," referring to the monitoring activities summarized just above.

The State agency did not directly agree or disagree with our final recommendation and stated that DHSS requested further clarification regarding our recommendation to specify what consumer-directed PCA providers must include in their emergency backup plans for recipients. The State agency also said that DHSS had recently updated policy on emergency backup plans and had developed a quick-reference guide for consumer-directed PCA providers. In addition, the State agency described ongoing revisions to State regulations that will direct providers to develop preparedness plans and to implement ongoing annual training on them.

A summary of the State agency's comments and our responses follows. The State agency's comments appear in their entirety as Appendix G.

After reviewing the State agency's comments and the additional documentation that the State agency provided, we revised, for this final report, the number of sampled items in error that we identified, from 18 to 17. (Specifically, for this final report we reviewed and accepted the documentation, showing completion of a timely assessment for one sampled item, that the State agency furnished along with its written comments.) Accordingly, we revised our statistical estimate and the dollar amount conveyed in our first recommendation. We also removed our draft report's fifth recommendation, which had referred to annual reassessments (footnote 8). We maintain that our findings and recommendations, as revised, are valid.

**RECOMMENDED REFUND OF OVERPAYMENTS ASSOCIATED WITH SAMPLED ITEMS IN ERROR**

The State agency said that both it and DHSS did not concur with our first recommendation. The State agency disagreed as well with most of our findings and stated that we "erred in rejecting many of the 18 sampled items," and added that a Federal refund was generally not an

appropriate remedy for the deficiencies that we cited in our findings. The State agency also disagreed with our methodology for statistical sampling and estimation. We summarize the State agency's and DHSS's specific points of disagreement, and offer our responses to those points, below.

**Recommended Refund Based on Errors in Required Documentation**

*State Agency Comments*

The State agency listed 10 types of documentation that it said we requested for each of the 150 sampled items and stated "the inability of a CDS provider or DHSS to produce even one of the above items resulted in a recoupment recommendation. The OIG expects recoupment for every finding, with no regard to other administrative actions. Unlike the OIG, the State agency is required to consider at least six factors [citing to State regulations] in determining the sanction to be imposed."

*Office of Inspector General Response*

We did not in fact base our first recommendation on the 10 types of documentation that the State agency said that we requested. Rather, we recommended a refund of overpayments for the following reasons, as detailed in our report findings: timesheets not provided or timesheets that included no detail of the tasks performed; units of service charged on timesheets that exceeded number of units authorized (for which we recommended only a partial refund, for the unauthorized units); documentation that was not provided to show that attendants were registered, screened, and employable pursuant to the FCSR; and plans of care that were not signed. Other types of documentation that we requested, such as backup plans and pandemic emergency plans, led to procedural recommendations rather than recommended refunds. Furthermore, the State agency's comments refer to other types of documentation, such as Good Cause Waivers for CDS attendants and signed copies of attendant acknowledgements of recipient rights and responsibilities, for which we make no recommendations.

We understand that the State agency must consider additional factors in determining sanctions to be imposed for deficiencies or errors in documentation. However, we maintain that for these 17 errors, the claims are unallowable for the reasons we have detailed, and therefore a recommended refund is appropriate.

**Use of Estimation in Calculating Unallowable Claims and in Recommending a Disallowance**

*State Agency Comments*

The State agency said that our use of estimation to develop our recommended refund "based on such a small sample size is entirely inappropriate." The State agency said that the 150 claim lines we reviewed represented "0.0012% of the claim lines for which the OIG expects the State agency to ensure 100% compliance with federal and state regulations. The OIG then

. . . extrapolated [estimated] those findings . . . onto a population of 11,612,322 claim lines during the audit period." The State agency also stated that our sampling and estimation methodology was "entirely inconsistent" with CMS's use of sampling and estimation to evaluate compliance under its Payment Error Rate Measurement (PERM) program. According to the State agency, "CMS only recoups funds for the actual claims that are sampled and found to be noncompliant, except to the extent the State's eligibility improper payment error rate exceeds three (3) percent."

Furthermore, the State agency described what it called a "technical error" in our sampling: "Prior to selecting the random sample to be used for this audit, the OIG did not attempt to identify and exclude thousands of CDS claims lines within the specified review period that had already been audited, identified as being fully or partially unallowable, and recouped. That is, the OIG failed to confirm the reliability of the frame before selecting the sample." Therefore, according to the State agency, we should limit the actual overpayment amount "to the claim lines in the review sample that the State does not dispute."

*Office of Inspector General Response*

We maintain that our sampling and estimation (i.e., extrapolation) methodology was entirely appropriate. Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.[10] The legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology.[11] We properly executed our statistical sampling methodology in that we defined our sampling frame and sample unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

With respect to the State agency's comment about differences between our and CMS's use of sampling and extrapolation under its PERM program, we would note that the purpose of the PERM program is to measure and report a national improper payment rate, which includes both overpayments and underpayments. Thus, CMS's use of sampling and extrapolation under the PERM program is not analogous to our use in this review.

[10] See *Yorktown Med. Lab., Inc. v. Perales*, 948 F.2d 84 (2d Cir. 1991); *Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982); *Momentum EMS, Inc. v. Sebelius*, 2013 U.S. Dist. LEXIS 183591 at *26-28 (S.D. Tex. 2013), *adopted by* 2014 U.S. Dist. LEXIS 4474 (S.D. Tex. 2014); *Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

[11] See *John Balko & Assoc. v. Sebelius*, 2012 U.S. Dist. LEXIS 183052 at *34-35 (W.D. Pa. 2012), *aff'd* 555 F. App'x 188 (3d Cir. 2014); *Maxmed Healthcare, Inc. v. Burwell*, 152 F. Supp. 3d 619, 634–37 (W.D. Tex. 2016), *aff'd*, 860 F.3d 335 (5th Cir. 2017); *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012); *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

Further, regarding the State agency's objections to our choice of sample size, small sample sizes, e.g., smaller than 100, have routinely been upheld by the Departmental Appeals Board (DAB) and Federal courts.[12] The legal standard for a sample size is that it must be sufficient to be statistically valid, not that it be the most precise methodology.[13] Because absolute precision is not required, any imprecision in the sample may be remedied by recommending recovery at the lower limit, which was done in this audit.[14] This approach results in an estimate that is lower than the actual overpayment amount 95 percent of the time, and thus it generally favors the provider.[15]

With respect to what the State agency described as a "technical error" in our sampling, we disagree with the State agency's assertion that we failed to confirm the reliability of the frame before selecting the sample. It is not possible to review more than 11 million claim lines individually to ensure that all the claims that have been selected for any prior audit are removed before we select our sample. For our 150 sampled items, if the State agency told us during our audit that any of our sampled items had been selected for a prior audit—whether those items were found to be allowable, in error, or partially in error—we treated those sampled items as fully allowable for purposes of this audit.

We accordingly maintain that our statistical approach resulted in a legally valid and reasonably conservative estimate of the unallowable consumer-directed PCA payments for which the State agency claimed reimbursement.

**Two Sampled Items Involving Plans of Care That Were Not Signed**

*State Agency Comments*

For two sampled items that we found to be in error, the State agency cited State and case law and said we erred in recommending a disallowance based on the absence of signatures on the associated plans of care. "Federal law does not require that a care plan be signed, and a lack of signature on a care plan does not [make] claims delivered pursuant to the care plan unallowable. OIG asserts that the lack of signature violates state regulations . . . but there is no basis in law for a federal disallowance based on noncompliance with a state regulation." The State agency cited to *Pennhurst State School & Hosp. v. Halderman*, 465 U.S. 89, 105-06 (1984),

[12] See *Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012) (upholding a sample size of 95 claims); *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 (S.D. Tex. 2012) (upholding a sample size of 30 claims).

[13] See *John Balko & Assoc. v. Sebelius*, 2012 U.S. Dist. LEXIS 183052 at *34-35 (W.D. Pa. 2012), *aff'd* 555 F. App'x 188 (3d Cir. 2014); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012).

[14] See *Pruchniewski v. Leavitt*, 2006 U.S. Dist. LEXIS 101218 at *51-52 (M.D. Fla. 2006).

[15] See *Puerto Rico Dep't of Health*, DAB No. 2385, at 10-11 (2011); *Oklahoma Dep't of Human Servs.*, DAB No. 1436, at 8 (1993) (stating that the calculation of the disallowance using the lower limit of the confidence interval gave the State the "benefit of any doubt" raised by use of a smaller sample size).

in support of its position that the "federal government lacks a general inherent power to enforce (as well as any valid interest in enforcing) compliance with state law."

*Office of Inspector General Response*

Although Federal requirements do not provide specifications regarding the administration and provision of personal care services, such specific requirements appear in State regulations—as the State agency acknowledged in its comments.

Longstanding Federal cost principles have established that costs must be in compliance with State and local laws and regulations in order to be allowable under Federal awards.[16] In addition, the DAB has upheld CMS disallowances under the Medicaid program based on providers' noncompliance with applicable State regulations based on these Federal cost principles.[17] Finally, the State agency's reliance on *Pennhurst* is misplaced, as that decision specifically pertained to Federal court jurisdiction (i.e., whether the Eleventh Amendment, which established that a State cannot be sued in Federal courts by its citizens, barred Federal jurisdiction over a suit against State officials for violating a State law).

**Eight Sampled Units for Which Providers Did Not Maintain Adequate Documentation for Consumer-Directed Personal Care Assistance**

*State Agency Comments*

The State agency said that we "erred in concluding that the timesheets associated with several claims lacked sufficient detail. The timesheets identified the services provided, and OIG does not point to any federal law that requires these timesheets to include information beyond the information that was included in them." Referring to our report's citations to section 1902(a)(27)(A) of the Act and section 2497.1 of the CMS *State Medicaid Manual*, the State agency said that "neither of those authorities includes specific requirements for personal care timesheets."

*Office of Inspector General Response*

We disagree with the State agency's comments on this finding. As explained in our finding, for five of these sampled items, the State agency could provide no timesheet at all, and for the other three sampled items, the timesheets included no details of the tasks performed. Section 1902(a)(27)(A) of the Act requires providers "to keep such records as are necessary fully to

[16] 2 CFR part 225, App. A, § C.1.c; 45 CFR §§ 75.403, 75.404. Office of Management and Budget Circular A-87, Cost Principles for State, Local, and Tribal Government, was relocated to 2 CFR part 225 and made applicable to HHS awards by 45 CFR § 92.22(b). Federal cost principles were consolidated under uniform requirements for Federal awards, which are now located at 2 CFR part 200 and implemented for HHS awards at 45 CFR part 75.

[17] See *New York State Department of Health*, DAB No. 2637 (2015), citing *New York Department of Social Services*, DAB No. 1112 (1989), and *New York State Department of Social Services*, DAB No. 1235 (1991).

disclose the extent of the services provided to individuals receiving assistance under the State plan" and section 2497.1 of the *State Medicaid Manual* states, "Expenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met." Though not specific to personal care timesheets, these Federal requirements clearly require documentation to support the extent of services provided, and such adequate documentation was not provided for these eight sampled items.

**Six Sampled Items for Which the Units Charged on Timesheets Exceeded Allowable Units**

*State Agency Comments*

With respect to the six sampled items in this finding, the State agency said that it was not clear why we concluded that four of the sampled items (sampled item numbers 129, 132, 133, and 142) were not authorized, "as OIG did not review all the claim lines . . . for each [recipient] in the applicable month to determine if the entire set of services provided was or was not consistent with the plan of care."[18] The State agency added that services do not need to follow strict adherence to the frequency outlined in the care plan and that consumer-directed attendants are directed to provide the necessary care that a recipient requests and needs.

*Office of Inspector General Response*

We understand that recipients' needs may not always conform to the frequency and schedule of their plans of care, and for this reason we granted considerable leeway in evaluating the scheduled tasks and comparing the units of service to what was allowable under the plans of care. We note that only one of the sampled items to which the State agency referred (sampled item number 132) was related to our finding on units charged on the timesheets that exceeded the allowable number of units. This sampled item covered 4 days of consumer-directed PCA services, but the provider in question could furnish timesheets for only 3 days. We determined that there were 33 total unallowable units for this sampled item; during our audit, State agency staff told us that the State agency would recoup at least some of the units of service associated with the day of service that lacked a timesheet.

With respect to the other three sampled items to which the State agency referred in its comments on this finding, we offer the following details:

- Sampled item number 129: We fully disallowed this sampled item because the plan of care was not signed (recipient ineligible) and because an FCSR background screening for the attendant could not be furnished (attendant ineligible).

[18] Of these four sampled items, we identified only one of them (number 132) as having a finding for this issue of excessive units of care; see Appendix F.

- Sampled item number 133: We fully disallowed this sampled item because the associated timesheet lacked any detail of the tasks performed.

- Sampled item number 142: We did not identify any errors with this sampled item and therefore treated it as fully allowable.

In light of these details, the State agency's comments offered no information on five of the six sampled items in this finding.

**Six Sampled Items for Which the Background Screening for Attendants Was Not Documented**

*State Agency Comments*

The State agency disagreed with this finding and said that we did not ask the State agency to give us supporting documentation that FCSR screenings were performed for these six sampled items. The State agency added that it would give us documentation of these screenings as a supplement to its written comments on our draft report.

*Office of Inspector General Response*

We disagree with the State agency's comments about documentation of FCSR screenings for these six sampled items. The original documentation request that we transmitted to the State agency for all 150 sampled items included a request for "documentation to support [that] attendant is qualified to provide services." For four of these six sampled items, the State agency gave us no documentation at all (sampled item numbers 31, 85, 103, and 119). For the two sampled items for which the State agency gave us some documentation (sampled item numbers 129 and 148), we followed up with the State agency and requested FCSR screening results for the attendants; the State agency responded that it was not able to furnish FCSR screening results for these two sampled items. The State agency has not provided documentation of FCSR screenings for the six sampled items.

**RECOMMENDATION THAT THE STATE AGENCY WORK WITH CMS REGARDING THE ALLOWABILITY OF FUNDS THAT WE HAVE SET ASIDE**

**State Agency Comments**

The State agency said that it and DHSS do not believe that any of the funds we set aside for adjudication with CMS (our second recommendation) should be disallowed. Specifically, the State agency said that it and DHSS "disagree that the timesheets did not include sufficient detail of the services provided."

**Office of Inspector General Response**

We maintain that our second recommendation remains valid. The timesheets used to document the services rendered did not identify the specific services that were actually performed in accordance with the recipients' plans of care. Because the timesheets did not provide any detail on the specific tasks performed, we could not identify the actual services that were rendered or determine whether those services were allowable under the terms of the plans of care. The generic descriptions used on these timesheets did not constitute complete, accurate, and detailed timesheets in accordance with Federal and State requirements.

**RECOMMENDATION REGARDING MONITORING OF CONSUMER-DIRECTED PERSONAL CARE ASSISTANCE PROVIDERS**

**State Agency Comments**

The State agency neither agreed nor disagreed with our third recommendation but stated that it and DHSS "work diligently to monitor CDS to maximize compliance with state and federal laws and policies. Prior to, during, and after the OIG's review period, the State agency has employed significant resources to monitor CDS providers' compliance with Federal and State regulations." The State agency cited a number of audits, investigations, training initiatives, and other activities completed by the Missouri Medicaid Audit & Compliance Unit during our audit period. The State agency said that "[o]f the 18 claim lines that were identified as being unallowable by OIG, the CDS providers for seven of those claim lines were deactivated by the State prior to or during the audit. Those seven deactivations were the result of separate audits, investigations, or CDS non-compliance actions conducted by the State."

The State agency added that in late 2020, DHSS established a Quality Assurance Unit, whose primary focus is "to develop staff and providers to improve the consistency and accuracy of the assessment and care planning process. One method used is a standardized case record review process. . . . to identify the areas where there is the greatest opportunity for development" of State staff.

**Office of Inspector General Response**

We acknowledge and commend the work that the State agency and DHSS have undertaken to monitor consumer-directed PCA providers to maximize compliance with Federal and State regulations, and we acknowledge the enormity and difficulty of the work to be completed in ensuring provider compliance. Based on our findings, we continue to recommend that the State agency continue to monitor consumer-directed PCA providers with a specific focus on areas we identified in the report.

**RECOMMENDATION FOR THE ESTABLISHMENT OF POLICIES AND PROCEDURES TO ENSURE ACCURACY AND COMPLETENESS IN PROVIDER TIMESHEETS**

**State Agency Comments**

The State agency did not concur with our fourth recommendation because "the State already has such policies and procedures in place," referring to the monitoring activities that the State agency mentioned in its comments on our third recommendation.

**Office of Inspector General Response**

Notwithstanding the State agency's and DHSS's activities to monitor consumer-directed PCA providers, the number of errors we identified that involve timesheets reinforce our view that our fourth recommendation—that the State agency establish policies and procedures to ensure that timesheets include fully accurate and complete details on the specific tasks performed—remains valid.

**RECOMMENDATION FOR THE ESTABLISHMENT OF POLICIES AND PROCEDURES REGARDING EMERGENCY BACKUP PLANS AND PANDEMIC PREPAREDNESS PLANS**

**State Agency Comments**

The State agency neither agreed nor disagreed with our final recommendation. The State agency said that DHSS requested that we clarify our language in the first half of that recommendation and noted that backup plans are updated at each annual reassessment or during care plan maintenance activities. The State agency added that "[t]his is not something the provider is required to maintain." The State agency also said that DHSS "recently updated policy to further expand on what must be included in the emergency backup plans and developed a quick guide to reiterate this information as a quick desk reference." For the second half of our final recommendation, the State agency said that "[r]ecent edits have been made to state regulation outlining the requirements of providers to develop preparedness plans and to implement ongoing annual training of these plans. These regulations will need to go through the state regulatory process and will likely go into effect later in 2023."

**Office of Inspector General Response**

Our recommendation is that the State agency should set clear requirements for what information each backup plan must contain. In most cases, the backup plan included only a name and phone number.

The quick guide that DHSS developed is helpful in clarifying what is needed for the backup plans' contact information. Some material we found in backup plans for some of our other sampled items might be helpful to include, such as information on an additional contact, neighbor, or family member in the event of an emergency. Backup plans could also include

other appropriate information that may be helpful in the event of an emergency, such as contact information of local law enforcement and the fire department, a list of medications, and emergency preparedness plans. In addition, we commend the State agency and DHSS for updating requirements for providers to develop preparedness plans and to implement ongoing annual training on these plans. Until then, we maintain that our final recommendation remains valid.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit period covered $918,449,560 ($596,940,725 Federal share) in Medicaid payments for consumer-directed PCA services that the State agency provided and paid for during FYs 2018 and 2019.

We identified a sampling frame of 11,612,322 consumer-directed PCA net claim lines of $25 or more with a total reimbursement of $918,449,560 ($596,940,725 Federal share), from which we selected a stratified random sample of 150 net claim lines (footnote 2).

We assessed internal controls necessary to satisfy the audit objective. In particular, we assessed the control activities related to the State agency's administration of the consumer-directed PCA program, which included services rendered by consumer-directed PCA providers.

We conducted our audit work from March 2021 to September 2022.

### METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal laws, Federal and State regulations, the CMS *State Medicaid Manual*, and the Missouri consumer-directed PCA State plan;

- held discussions with State agency and DHSS officials to gain an understanding of the consumer-directed PCA program's operation and of the two departments' lines of responsibility;

- obtained the MMIS claims payment data for consumer-directed PCA services provided and paid for in FYs 2018 and 2019;

- reconciled the MMIS claims payment data for consumer-directed PCA services to the Medicaid payments that the State agency claimed on the Forms CMS-64 for FYs 2018 and 2019;

- developed a sampling frame of 11,612,322 consumer-directed PCA net claim lines of $25 or more with a total reimbursement of $918,449,560 ($596,940,725 Federal share);

- selected a stratified random sample of 150 net claim lines and reviewed timesheets and other supporting documentation for each sampled item to determine whether:

    - the consumer-directed PCA service(s) rendered were allowable according to the consumer-directed PCA State plan and adequately supported and whether the

unit(s) of service recorded on the timesheets were within the number of units authorized by the recipients' plans of care;

- the attendants rendering consumer-directed PCA services to recipients were registered, screened, and employable pursuant to the FCSR;

- each recipient was eligible for consumer-directed PCA services;

- each plan of care was supported by an assessment or annual reassessment and was properly authorized; and

- reviewed documentation provided by the State agency for the providers of the consumer-directed PCA services in our sample to determine whether those providers had established and implemented emergency preparedness standards and protocols for a pandemic response within the consumer-directed PCA program;

- used the results of the sample to estimate (Appendix D) the unallowable Federal Medicaid reimbursement associated with the deficiencies we identified (for which we are recommending refund to the Federal Government);

- used the results of the sample to estimate (Appendix D) the set-aside Federal Medicaid reimbursement associated with the deficiencies we identified (for which we are recommending CMS resolution and potential recovery); and

- discussed the results of our audit with State agency and DHSS officials on March 10, 2022.

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 objectives.

## APPENDIX B: PREVIOUSLY ISSUED OFFICE OF INSPECTOR GENERAL REPORTS

| Report Title | Report Number | Date Issued |
|---|---|---|
| *New York Improved Its Monitoring of Its Personal Care Services Program But Still Made Improper Medicaid Payments of More Than $54 Million* | A-02-19-01016 | 12/9/2020 |
| *New York Claimed Federal Reimbursement for Consumer-Directed Personal Assistance Services That Did Not Meet Medicaid Requirements* | A-02-16-01026 | 6/4/2018 |
| *Missouri Claimed Federal Reimbursement for Unallowable Personal Care Services Claims Submitted by the Whole Person, Incorporated* | A-07-11-03170 | 3/6/2013 |
| *Missouri Claimed Federal Reimbursement for Unallowable Personal Care Services Claims* | A-07-11-03171 | 9/24/2012 |
| *Review of Medicaid Personal Care Claims Submitted by Providers in New Jersey* | A-02-09-01002 | 12/29/2011 |
| *Nebraska Medicaid Payments for Personal Care Services* | A-07-10-03152 | 6/28/2011 |
| *Review of Medicaid Personal Care Services Claimed by Washington State* | A-09-09-00030 | 6/3/2011 |
| *Review of Medicaid Personal Care Services Claims Submitted by Providers in North Carolina* | A-04-10-04003 | 6/1/2011 |
| *Review of Medicaid Person Care Services Claims Made by Providers in New York State* | A-02-08-01005 | 10/13/2010 |
| *Review of Medicaid Personal Care Services Claims Made by Providers in New York City* | A-02-07-01054 | 6/8/2009 |

## APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

### SAMPLING FRAME

The sampling frame consisted of 11,612,322 net claim lines[19] of $25 or more of consumer-directed PCA services (footnote 2) that were provided during FYs 2018 and 2019 and for which the State agency was paid during the same time period. The net claim lines in the sampling frame had a total reimbursement of $918,449,560 ($596,940,725 Federal share).

### SAMPLE UNIT

The sample unit was a net claim line.

### SAMPLE DESIGN AND SAMPLE SIZE

Our sample design was a stratified sample consisting of three strata, as shown in Table 2.

**Table 2: Division of Strata for Sample Design**

| Stratum | Dollar Range | Frame Size | Frame Dollar Value (Total) | Frame Dollar Value (Federal Share) | Sample Size |
|---|---|---|---|---|---|
| 1 | $25 to $59.10 | 7,127,839 | $334,930,674 | $217,708,836 | 50 |
| 2 | $59.11 to $141.84 | 3,812,348 | 277,510,063 | 180,307,280 | 50 |
| 3 | $141.85 and higher | 672,135 | 306,008,823 | 198,924,609 | 50 |
| **Total** | | **11,612,322** | **$918,449,560** | **$596,940,725** | **150** |

### SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, OAS, statistical software.

### METHOD FOR SELECTING SAMPLE UNITS

For each stratum, we consecutively numbered the items. After generating the random numbers for each of these strata, we selected the corresponding frame items for review.

[19] Each claim for consumer-directed PCA services can include multiple line items in which each claim line represents a service rendered by a personal care service provider to one recipient. We grouped the claim line items by recipient identification number (field name "DCN"), first date of service (field name "FDOS"), and provider number; we refer to the result as "net claim lines."

## ESTIMATION METHODOLOGY

We used the OIG, OAS, statistical software to estimate the total dollar value of the State agency's unallowable payments for consumer-directed PCA services in our sampling frame at the lower limit of the two-sided 90-percent confidence interval (Appendix D, tables 3 through 5). We also used the statistical software to estimate the total dollar value of the State agency's set-aside payments, for consumer-directed PCA services in our sampling frame, at the lower limit of the two-sided 90-percent confidence interval (Appendix D, tables 6 through 8). Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

## APPENDIX D: SAMPLE RESULTS AND ESTIMATES

### Table 3: Sample Results (Total)

| Stratum | Frame Size | Value of Frame | Sample Size | Value of Sample | Number of Sampled Items with Unallowable Services | Value of Unallowable Sampled Items |
|---|---|---|---|---|---|---|
| 1 | 7,127,839 | $334,930,674 | 50 | $2,343 | 3 | $141 |
| 2 | 3,812,348 | 277,510,063 | 50 | 3,515 | 1 | 62 |
| 3 | 672,135 | 306,008,823 | 50 | 23,597 | 13 | 5,580 |
| **Total** | **11,612,322** | **$918,449,560** | **150** | **$29,455** | **17** | **$5,783** |

### Table 4: Sample Results (Federal Share)

| Stratum | Frame Size | Value of Frame | Sample Size | Value of Sample | Number of Sampled Items with Unallowable Services | Value of Unallowable Sampled Items |
|---|---|---|---|---|---|---|
| 1 | 7,127,839 | $217,708,836 | 50 | $1,523 | 3 | $91 |
| 2 | 3,812,348 | 180,307,280 | 50 | 2,282 | 1 | 40 |
| 3 | 672,135 | 198,924,609 | 50 | 15,348 | 13 | 3,630 |
| **Total** | **11,612,322** | **$596,940,725** | **150** | **$19,154** | **17** | **$3,761** |

### Table 5: Estimated Value of Unallowable Services in the Sampling Frame (Limits Calculated at the 90-Percent Confidence Level)

| | Total | Federal Share |
|---|---|---|
| **Point estimate** | $99,854,610 | $64,888,386 |
| **Lower limit** | 52,547,876 | 34,171,397 |
| **Upper limit** | 147,161,345 | 95,605,374 |

**Table 6: Sample Results Set Aside (Total)**

| Stratum | Frame Size | Value of Frame | Sample Size | Value of Sample | Number of Sampled Items Set Aside | Value of Sampled Items Set Aside |
|---|---|---|---|---|---|---|
| 1 | 7,127,839 | $334,930,674 | 50 | $2,343 | 17 | $503 |
| 2 | 3,812,348 | 277,510,063 | 50 | 3,515 | 14 | 703 |
| 3 | 672,135 | 306,008,823 | 50 | 23,597 | 15 | 3,476 |
| **Total** | **11,612,322** | **$918,449,560** | **150** | **$29,455** | **46** | **$4,683** |

**Table 7: Sample Results Set Aside (Federal Share)**

| Stratum | Frame Size | Value of Frame | Sample Size | Value of Sample | Number of Sampled Items Set Aside | Value of Sampled Items Set Aside |
|---|---|---|---|---|---|---|
| 1 | 7,127,839 | $217,708,836 | 50 | $1,523 | 17 | $328 |
| 2 | 3,812,348 | 180,307,280 | 50 | 2,282 | 14 | 457 |
| 3 | 672,135 | 198,924,609 | 50 | 15,348 | 15 | 2,257 |
| **Total** | **11,612,322** | **$596,940,725** | **150** | **$19,154** | **46** | **$3,041** |

**Table 8: Estimated Value of Services Set Aside in the Sampling Frame (Limits Calculated at the 90-Percent Confidence Level)**

| | Total | Federal Share |
|---|---|---|
| **Point estimate** | $172,815,862 | $111,897,192 |
| **Lower limit** | 133,858,094 | 87,018,594 |
| **Upper limit** | 210,373,631 | 136,775,789 |

## APPENDIX E: FEDERAL AND STATE REQUIREMENTS FOR CONSUMER-DIRECTED PERSONAL CARE

### FEDERAL REQUIREMENTS

The Act authorizes personal care services, which it defines as "services furnished to an individual . . . that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location" (the Act § 1905(a)(24)).

In accordance with 42 CFR § 430.30(c) and the CMS *State Medicaid Manual*, section 2500.2, the amounts that State Medicaid agencies report to CMS on the Form CMS-64 and its attachments must represent actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available at the time the claim is filed. Furthermore, claims developed on the basis of estimates are not allowable.

Federal regulations require that personal care services must be: (1) authorized for an individual by a physician in accordance with a plan of treatment or, at the State's option, otherwise authorized in accordance with a plan of care approved by the 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. In addition, personal care services may be provided only to individuals who are not inpatients at a hospital or residents of a nursing facility, an Intermediate Care Facility for Individuals with Intellectual Disabilities, or an Institution for Mental Disease (42 CFR § 440.167). Examples of personal care services include, but are not limited to, meal preparation, shopping, grooming, and bathing.

Personal care services must be provided by an individual who is qualified to provide such services (42 CFR § 440.167(a)(2)).

In accordance with section 1902(a)(27)(A) of the Act, a State plan for medical assistance must provide for an agreement with every provider under which the provider agrees "to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan."

The CMS *State Medicaid Manual* states that expenditures require adequate supporting documentation to be allowable for Federal reimbursement (CMS *State Medicaid Manual* § 2497.1).

### STATE REQUIREMENTS

The Missouri State plan states that consumer-directed PCA services "include assistance with activities of daily living and/or instrumental activities of daily living, provided by a qualified and

trained aide in accordance with a plan of care approved by the state" (Missouri State Plan, Attachment 3.1-A, page 18g).

The Missouri State plan requires that consumer-directed PCA providers must comply with all provisions of Sections 208.900 to 208.927 of the Missouri Statutes and the regulations at 19 CSR 15-8 (Missouri State Plan, Attachment 3.1-A, page 18g).

State regulations define consumer-directed as "[t]he hiring, training, supervising, and directing of the personal care attendant (attendant) by the physically disabled person [consumer]" (19 CSR § 15-8.100(1)(D)).

State regulations at 13 CSR § 70-91.010 state:

> (1) Persons Eligible for Personal Care Services . . . .
>
> (B) Obtaining Personal Care Services . . . .
>
> 2. The personal care plan will be developed in collaboration with and signed by the recipient. The plan will include a list of tasks to be performed, weekly schedule of service delivery, and the maximum number of units of service for which the recipient is eligible per month.

State regulations state that adequate documentation shall include an accurate, complete, and legible description of each service provided (13 CSR § 70-3.030(2)(A)(2)).

Additionally, State regulations require that documentation for personal care services delivered by the provider must include a description of the service (13 CSR § 70-91.010(4)(A)(2)(D)).

State regulations specify that the plan of care shall include the maximum number of units of consumer-directed PCA to be provided (19 CSR § 15-8.200(4)(B)(1)).

State regulations specify that the personal care plan will include the maximum number of units of service for which the individual is eligible per month (13 CSR § 70-91.010(1)(B)(2)).

State regulations state: "vendors shall be responsible, directly or by contract, for the following: . . . (1) Ensuring that each attendant is registered, screened, and employable pursuant to the Family Care Safety Registry (FCSR) . . . maintained by DHSS, and applicable state law and regulations" (19 CSR § 15-8.400(4)).

According to State statute: "The needs of the consumer shall be reevaluated annually by [DHSS], and the amount of assistance authorized by [DHSS] shall be maintained, adjusted, or eliminated accordingly" (Missouri Revised Statute § 208.906.5). State statute also makes provisions for annual reevaluation of continued eligibility and necessity for PCA services and for

adjustments to or elimination of services in the plan of care accordingly (Missouri Revised Statute § 208.930.8.(1)).

In addition to the statutory requirement for an annual reassessment, State regulations also require that the consumer-directed PCA provider always have, and provide services in accordance with, a current plan of care and that this plan of care be based on eligibility determined by an in-home assessment performed by DHSS (13 CSR § 70-91.010(1)(B)(1) and (3)).

State regulations state: "vendors shall be responsible, directly or by contract, for the following: . . . (G) Ensuring the [recipient] has an emergency and/or backup plan; . . . (I) Ensuring that the [recipient]'s case file contains, at a minimum, the following: . . . (5) Documentation of the [recipient]'s emergency and/or backup plans (19 CSR § 15-8.400(4)).

## APPENDIX F: SUMMARY OF ERRORS FOR EACH SAMPLED ITEM

### Table 9: Errors Identified for Each Sampled Item

| | Unallowable Sampled Item Errors | | | | Set-Aside Errors |
|---|---|---|---|---|---|
| Count | Lack of Timesheet Detail or No Detail Provided | Units Charged Exceed Units Allowable | Attendant Not Screened | Plan of Care Not Signed | Set-Aside Units |
| 1 | X | | | | |
| 2 | | | | | X |
| 3 | | | | | X |
| 4 | | | | | |
| 5 | | | | | X |
| 6 | | | | | X |
| 7 | | | | | |
| 8 | | | | | |
| 9 | | | | | |
| 10 | X | | | | |
| 11 | | | | | |
| 12 | | | | | |
| 13 | | | | | |
| 14 | | | | | X |
| 15 | | | | | X |
| 16 | | | | | |
| 17 | | | | | X |
| 18 | | | | | X |
| 19 | | | | | X |
| 20 | | | | | X |
| 21 | | | | | X |
| 22 | | | | | X |
| 23 | | | | | |
| 24 | | | | | |
| 25 | | | | | |
| 26 | | | | | |
| 27 | | | | | |
| 28 | | | | | |
| 29 | | | | | |
| 30 | | | | | X |

| | Unallowable Sampled Item Errors | | | | Set-Aside Errors |
|---|---|---|---|---|---|
| Count | Lack of Timesheet Detail or No Detail Provided | Units Charged Exceed Units Allowable | Attendant Not Screened | Plan of Care Not Signed | Set-Aside Units |
| 31 | X | | X | | |
| 32 | | | | | |
| 33 | | | | | |
| 34 | | | | | |
| 35 | | | | | |
| 36 | | | | | |
| 37 | | | | | |
| 38 | | | | | X |
| 39 | | | | | |
| 40 | | | | | X |
| 41 | | | | | |
| 42 | | | | | |
| 43 | | | | | X |
| 44 | | | | | |
| 45 | | | | | |
| 46 | | | | | |
| 47 | | | | | |
| 48 | | | | | |
| 49 | | | | | |
| 50 | | | | | X |
| 51 | | | | | X |
| 52 | | | | | X |
| 53 | | | | | |
| 54 | | | | | X |
| 55 | | | | | |
| 56 | | | | | |
| 57 | | | | | |
| 58 | | | | | |
| 59 | | | | | |
| 60 | | | | | |
| 61 | | | | | X |
| 62 | | | | | |
| 63 | | | | | |
| 64 | | | | | X |
| 65 | | | | | X |

| | Unallowable Sampled Item Errors | | | | Set-Aside Errors |
|---|---|---|---|---|---|
| Count | Lack of Timesheet Detail or No Detail Provided | Units Charged Exceed Units Allowable | Attendant Not Screened | Plan of Care Not Signed | Set-Aside Units |
| 66 | | | | | X |
| 67 | | | | | |
| 68 | | | | | |
| 69 | | | | | |
| 70 | | | | | |
| 71 | | | | | X |
| 72 | | | | | |
| 73 | | | | | |
| 74 | | | | | |
| 75 | | | | | |
| 76 | | | | | X |
| 77 | | | | | |
| 78 | | | | | X |
| 79 | | | | | X |
| 80 | | | | | |
| 81 | | | | | |
| 82 | | | | | X |
| 83 | | | | | |
| 84 | | | | | |
| 85 | X | | X | | |
| 86 | | | | | |
| 87 | | | | | |
| 88 | | | | | |
| 89 | | | | | |
| 90 | | | | | |
| 91 | | | | | |
| 92 | | | | | X |
| 93 | | | | | |
| 94 | | | | | |
| 95 | | | | | |
| 96 | | | | | X |
| 97 | | | | | |
| 98 | | | | | |
| 99 | | | | | |
| 100 | | | | | |

| | Unallowable Sampled Item Errors | | | | Set-Aside Errors |
|---|---|---|---|---|---|
| Count | Lack of Timesheet Detail or No Detail Provided | Units Charged Exceed Units Allowable | Attendant Not Screened | Plan of Care Not Signed | Set-Aside Units |
| 101 | | | | X | |
| 102 | | | | | X |
| 103 | X | | X | | |
| 104 | | X | | | |
| 105 | | | | | X |
| 106 | | | | | |
| 107 | | | | | X |
| 108 | | | | | |
| 109 | | | | | |
| 110 | | | | | |
| 111 | | | | | |
| 112 | | | | | X |
| 113 | | | | | |
| 114 | | | | | |
| 115 | | | | | X |
| 116 | | | | | |
| 117 | | | | | X |
| 118 | | | | | X |
| 119 | X | | X | | |
| 120 | X | | | | |
| 121 | | | | | |
| 122 | | | | | |
| 123 | | | | | X |
| 124 | | | | | |
| 125 | | | | | X |
| 126 | | X | | | |
| 127 | | | | | |
| 128 | | | | | |
| 129 | | | X | X | |
| 130 | | | | | |
| 131 | | X | | | |
| 132 | | X | | | |
| 133 | X | | | | |
| 134 | | | | | X |
| 135 | | | | | |

| | Unallowable Sampled Item Errors | | | | Set-Aside Errors |
|---|---|---|---|---|---|
| Count | Lack of Timesheet Detail or No Detail Provided | Units Charged Exceed Units Allowable | Attendant Not Screened | Plan of Care Not Signed | Set-Aside Units |
| 136 | | | | | X |
| 137 | | | | | X |
| 138 | | | | | X |
| 139 | | | | | |
| 140 | | | | | |
| 141 | | X | | | |
| 142 | | | | | |
| 143 | | | | | |
| 144 | | X | | | |
| 145 | | | | | |
| 146 | | | | | |
| 147 | | | | | X |
| 148 | | | X | | |
| 149 | | | | | X |
| 150 | | | | | |
| **Total** | **8** | **6** | **6** | **2** | **46** |

X – Sample units with an error.

Missouri Department of
SOCIAL SERVICES

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November 22, 2022

James Korn
U.S. Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

RE: A-07-20-03243 – Draft Audit Report - Missouri Consumer-Directed Personal Care Assistance Services

Dear Mr. Korn:

This letter is in response to your September 23, 2022 letter and draft audit report titled *Missouri Claimed Federal Medicaid Reimbursement for Tens of Millions in Consumer-Directed Personal Care Assistance Services That Did Not Comply With Federal and State Requirements.* Please find below the OIG's findings followed by responses from both the Missouri Department of Social Services (DSS) and the Missouri Department of Health and Senior Services (DHSS).

**OIG Recommendation #1**: OIG recommends the state agency refund $37,765,579 (federal share) in overpayments to the Federal Government, because OIG found that 18 of the 150 sampled items were at least partially unallowable and, based on those sample results, estimated that the State agency claimed at least $58,105,010 ($37,765,579 Federal share) in unallowable Medicaid reimbursement for consumer-directed PCA services during FYs 2018 and 2019.

**DSS/DHSS Response #1**: DSS and DHSS do not concur with this recommendation.

For each of the 150 claim lines the OIG reviewed, the OIG requested:

- Copies of the Consumer-Directed Service (CDS) provider's timesheets or EVV records for dates of service on the claim;
- A copy of the FCSR background screening conducted on the CDS attendant;
- A copy of the Good Cause Waiver (GCW) for the CDS attendant (if applicable);
- A signed copy of the CDS participant's acknowledgement of the attendant's rights and responsibilities;

- A signed copy of the CDS attendant's acknowledgement of the participant's rights and responsibilities;
- A copy of the CDS participant's emergency back-up plan;
- A copy of the participant's DHSS annual assessment;
- A copy of the participant's DHSS authorized care plan;
- A signed copy of the participant's DHSS choice statement; and
- A copy of the CDS provider's pandemic emergency preparedness plan.

The inability of a CDS provider or DHSS to produce even one of the above items resulted in a recoupment recommendation. The OIG expects recoupment for every finding, with no regard to other possible administrative actions. Unlike the OIG, the State is required to consider at least six factors[1] in determining the sanction to be imposed:

- Seriousness of the offense(s)
- Extent of violations
- History of prior violations
- Prior imposition of sanctions
- Prior provision of provider education
- Actions taken or recommended by peer review groups

The OIG's extrapolation of its recoupment recommendations based on such a small sample size is entirely inappropriate. The OIG reviewed 150 claim lines, or 0.0012% of the claim lines for which the OIG expects the State agency to ensure 100% compliance with federal and state regulations. The OIG then rejected all or part of the payment for any of these claim lines for which the OIG found any documentation or other error, and extrapolated those findings with respect to a miniscule number of claims onto a population of 11,612,322 claim lines during the audit period. The amount the OIG considers to be unallowable is $58,105,101, which is an average of $3,228,061 per claim line, after the OIG extrapolated the 18 claim lines that were fully or partially unallowable across the 11,612,322 claim lines in the review sample.

Indeed, the OIG's sampling and extrapolation is entirely inconsistent with the Centers for Medicare & Medicaid Services' (CMS) approach to using sampling and extrapolation to evaluate compliance. Specifically, in CMS's Payment Error Rate Measurement (PERM), CMS uses sampling and extrapolation to identify potentially improper Medicaid payments made by the State, but CMS only recoups funds for the actual claims that are sampled and found to be noncompliant, except to the extent the State's eligibility improper payment error rate exceeds three (3) percent. *See* 42 C.F.R. Part 431, Subpart Q. The extrapolated error rate is used to develop corrective action plans, not to recoup funds. CMS is the agency charged with administering the Medicaid program, and its approach recognizes the inherent limits and unfairness in issuing program-wide disallowances based on a finding that a handful of providers did not fully comply with all documentation requirements.

Further, the OIG made a technical error in its sampling, and therefore should limit the actual overpayment amount to the claim lines in the review sample that the State does not dispute.

[1] 13 CSR 70-3.030(5)(A)(1) through (6).

Prior to selecting the random sample to be used for this audit, the OIG did not attempt to identify and exclude thousands of CDS claims lines within the specified review period that had already been audited, identified as being fully or partially unallowable, and recouped. That is, the OIG failed to confirm the reliability of the frame before selecting the sample.[2]

In any event, OIG erred in rejecting many of the 18 sampled items.

First, the OIG erred in rejecting a claim on the ground that the agency did not complete the annual assessment. After further review, DHSS has located documentation that indicates an assessment was completed for the individual in this sampled item on October 18, 2016, September 31, 2017, and July 19, 2018. All of these timeframes fall within the annual assessment requirements. We have attached the assessment documentation to this response as Attachment 1.

Second, OIG erred in recommending a disallowance of two claims based on the plan of care lacking a signature. Federal law does not require that a care plan be signed, and a lack of signature on a care plan does not claims delivered pursuant to the care plan unallowable. OIG asserts that the lack of signature violates state regulations (13 CSR § 70-91.010(1)(B)(2)), but there is no basis in law for a federal disallowance based on noncompliance with a state regulation. The federal government lacks a general inherent power to enforce (as well as any valid interest in enforcing) compliance with state law. *Cf. Pennhurst State School & Hosp. v Halderman*, 465 U.S. 89, 105-06 (1984) (holding that Eleventh Amendment prohibited federal court from enjoining state officials to comply with state law, in part because "[a] federal court's grant of relief against state officials on the basis of state law . . . does not vindicate the supreme authority of federal law"). As the Supreme Court has observed, in a case involving a state recipient of federal dollars, "it is difficult to think of a greater intrusion on state sovereignty than when a federal court instructs state officials on how to conform their conduct to state law." *Id.* at 106 (emphasis added).

Third, the OIG erred in concluding that the timesheets associated with several claims lacked sufficient detail. The timesheets identified the services provided, and OIG does not point to any federal law or policy that requires these timesheets to include information beyond the information that was included in them. The OIG cites the general documentation requirements in Section 1902(a)(27)(A) of the Social Security Act and Section 2497.1 in the State Medicaid Manual, but neither of those authorities includes specific requirements for personal care timesheets.

Fourth, the OIG erred in rejecting claims on the ground that the paid units exceeded the units specified in the plan of care. It is not clear why the OIG concluded that the services in Sample Nos. 129, 132, 133, and 142 were not authorized, as OIG did not review all the claim lines provided pursuant to the service authorization for each participant in the applicable month to determine if the entire set of services provided was or was not consistent with the plan of care. In any event, services need not be provided in strict adherence to the frequency outlined by the care plan. Rather, consumer-directed attendants are employed by the participant and are

[2] U.S. Department of Health and Human Services, Office of Inspector General, Statistical Sampling: A Toolkit for MFCUs, September 2018, Appendix F: Steps That Can Have Unintended Consequences - Page 14.

directed to provide the necessary care the participant requests and needs within the constraints of the overall authorized care plan limitations. Performing person-centered care based on the participant's needs and requests ensures the participant has the right to choose and ensures any variant needs are met. For example, a participant may not be feeling well and may ask the attendant to complete a lighter variation of tasks in order to rest. Alternatively, a participant may have higher needs one day due to illness. The participant is entitled to the dignity and respect to have their additional needs met that day.

Fifth, the OIG erred in concluding that, for six sampled claims, "the State agency was unable to obtain from consumer-directed PCA providers the supporting documentation that the FCSR screening was performed." The OIG did not request that DSS provide it with "supporting documentation that the FCSR screening was performed." DSS will be gathering this documentation and it will supplement this response with that documentation.

**OIG Recommendation #2**: The OIG found 46 of the 150 sampled items included timesheets that OIG asserts did not detail the consumer-directed PCA services that were rendered. Based on OIG's sample results, OIG recommends the state agency work with CMS to determine the allowability of $87,018,594 (Federal share) that OIG has set aside, and refund to the Federal Government any amount that is determined to be unallowable.

**DSS/DHSS Response #2**: DSS and DHSS do not believe that any of these funds should be disallowed. DSS and DHSS disagree that the timesheets did not include sufficient detail of the services provided.

**OIG Recommendation #3**: OIG recommends the state agency monitor consumer-directed PCA providers to ensure compliance with the State agency's established policies and procedures such that:

- timesheets are completed and the tasks performed are described accurately and in sufficient detail;
- units of service charged on timesheets do not exceed the units allowable on the recipients' plans of care;
- consumer-directed PCA providers maintain documentation showing that attendants are registered, screened, and employable pursuant to the FCSR; and
- plans of care are signed.

**DSS/DHSS Response #3**: DSS and DHSS work diligently to monitor CDS to maximize compliance with state and federal laws and policies. Prior to, during, and after the OIG's review period, the State agency has employed significant resources to monitor CDS providers' compliance with Federal and State regulations. During the OIG's review period, the Missouri Medicaid Audit & Compliance Unit (MMAC):

- Conducted 167 desk or on-site audits of CDS providers;
- Conducted 13 Special Projects that requested records from 679 CDS providers.
- Monitored CDS provider's compliance with submission of quarterly financial and service reports, annual service reports, and an annual audit conducted by a licensed CPA;

- Initiated quarterly CDS Orientation Training for prospective CDS providers. Attendees are required to attend the one-day training and pass a written test before they can submit a proposal to the State to enroll as a CDS provider.
- Presented semiannual CDS provider update training to address evolving Federal and State regulations and program requirements.
- Conducted 140 investigations of CDS providers, which resulted in 81 fraud referrals to the Missouri Medicaid Fraud Control Unit (MFCU) or the OIG;
- Terminated the Medicaid participation of 63 CDS providers;
- Denied Medicaid enrollment to 206 prospective CDS providers; and
- Deactivated the Medicaid contracts of 117 CDS providers for enrollment related issues (i.e. failure to successfully revalidate their enrollment).

In addition, DHSS completed 1,597 employee disqualification list reports in federal fiscal years 2018 and 2019, of which 110 were closed as completed.

Of the 18 claim lines that were identified as being unallowable by OIG, the CDS providers for seven of those claim lines were deactivated by the State prior to or during the audit. Those seven deactivations were the result of separate audits, investigations, or CDS non-compliance actions conducted by the State.

Finally, DHSS established a Quality Assurance Unit in late 2020. The quality unit uses a variety of metrics and methods to identify opportunities for development amongst state staff and provider reassessors. The primary focus of the Quality Unit is to develop staff and providers to improve the consistency and accuracy of the assessment and care planning process. One method used is a standardized case record review process. These reviews are aggregated and presented to staff to identify the areas where there is the greatest opportunity for development. The Quality Unit reviews the plan of care and if an error is identified in this area, the individual is required to remediate.

**OIG Recommendation #4**: OIG recommends the state establish policies and procedures to ensure that timesheets include fully accurate and complete details on the specific tasks performed.

**DSS Response #4**: The State does not concur, because the State already has such policies and procedures in place, as explained in the State's responses to #3 above.

**OIG Recommendation #5**: OIG recommends the state follow its policies and procedures to ensure that DHSS completes assessments and annual reassessments within specified timeframes to evaluate the needs of Medicaid recipients.

**DHSS Response #5**: DSS and DHSS work to ensure compliance with all state and federal laws, policies, and procedures, including those relating to assessments and reassessments.

**OIG Recommendation #6**: OIG recommends the state establish and implement policies and procedures to: 1) specify what consumer-directed PCA providers must include in their

emergency backup plans for recipients and 2) require development of pandemic preparedness plans and implement training to educate consumer-directed PCA providers on these plans.

**DHSS Response #6**: DHSS requests further clarification regarding what is meant by "specify what consumer-directed PCA providers must include in their emergency backup plans for recipients."

Currently, at each annual reassessment and during care plan maintenance activities, back up plans are updated by the assessors or care plan change team. This is not something the provider is required to maintain. Providers are required to report any changes that are needed as they become aware.

In addition, DHSS recently updated policy to further expand on what must be included in the emergency backup plans and developed a quick guide to reiterate this information as a quick desk reference, see Attachment 2. Recent edits have been made to state regulation outlining the requirements of providers to develop preparedness plans and to implement ongoing annual training of these plans. These regulations will need to go through the state regulatory process and will likely go into effect later in 2023.

Thank you for allowing us time to respond to the findings presented in this draft audit report. Please contact Alicia Kolb, DSS Compliance Services Director, at (573) 751-2432 or at Alicia.M.Kolb@dss.mo.gov with any questions regarding this response.

Sincerely,

/s/

Patrick Luebbering
Chief Financial Officer

PL:bb

cc: Charlie Arnold, Acting Director Audit & Review Branch
Alicia Kolb, Compliance Services Director
Todd Richardson, DSS MHD Director
Marissa Crump