Medicaid Waiver Utilization, Medicaid Service Documentation, and Medicaid Records Retention Practices by DSPD and DSPD Providers

Report Number 2019-01, 2019-05

September 28, 2022

Utah Office of
Inspector General

Gene Cottrell
Inspector General

September 28, 2022

To: Utah Department of Health and Human Services

Please see the attached report, **Medicaid Waiver Utilization, Medicaid Service Documentation, and Medicaid Records Retention Practices by The Division of Services for People with Disabilities (DSPD) and DSPD Providers**, (Report 2019-01, 2019-05). An Executive Summary is included at the inception of this report. Page 1 of this report contains information about the audit objectives and scope.

Sincerely,

Gene D. Cottrell
Gene Cottrell
Inspector General
Utah Office of Inspector General

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Rep. Raymond Ward, Social Services Appropriations Subcommittee Chair
Jon Pierpont, Chief of Staff, Office of Governor Spencer Cox
J. Stuart Adams, President of the Utah Senate
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PREFIX

Near the conclusion of the Utah Office of Inspector General (UOIG) Audits 2019-01 and 2019-05, House Bill 365 (2021) passed. The Bill directed the Utah Department of Health (DOH) and Utah Department of Human Services (DHS) to merge into a single state agency called The Department of Health and Human Services (DHHS). Changes to DOH, the Office of Quality and Design (OQD) within DHS, and the Division of Services for People with Disabilities (DSPD) processes continue to occur as a result from the merger. DOH and DHS each worked to facilitate an effective merge into DHHS. The Utah Legislature scheduled the realignment of agencies to commence on July 1, 2022, after the conclusion of this Audit. Consequently, throughout this report the UOIG references DOH, DHS, and DHHS, as appropriate. Similarly, the UOIG references OQD, and Continuous Quality and Improvement (CQI), which recently absorbed the former OQD.

The UOIG appreciates the cost and resource allocation necessary to address recommendations within this report to correct DSPD's programming and processes, so that DSPD service codes align with Medicaid HCPCS coding. DHHS's newly appointed Director publicly spoke about the need to reconcile approximately 50 separate databases and systems, as a part of the merger between DOH and DHS. However, because of the necessary reconciliation of multiple programs, databases, and systems, as well as the subsequent changes to Division and Department policies and processes resulting from the merger, this is an opportune time to correct the Findings identified in UOIG Audits 2019-01, and 2019-05. Incorporating these changes into the reconciliation efforts resulting from the DHHS merger would result in a more efficient and less costly correction than waiting to implement changes at a later point.

EXECUTIVE SUMMARY

The Utah Office of Inspector General (UOIG) identified inseparable links between Medicaid billing and Medicaid service record documentation practices by Utah's Division of Services for People with Disabilities (DSPD) and DSPD-contracted providers while conducting Audits 2019-01 and 2019-05. This report contains UOIG findings and observations for each of those audits, whose interwoven nature necessitated a combined report in order to illustrate the full scope of programmatic risk caused by the discrepancies in DSPD Medicaid claims submissions, the accompanying lack of supporting documentation, and the lack of sufficient program integrity controls in place to prevent such occurrences.

2019-01 Audit Objectives:

1. Determine Waiver utilization, including provision of service, applicable rate, unit of service, and payment information for services provided by DSPD providers to participants on the Acquired Brain Injury (ABI), Community Supports (CS), and Physical Disabilities (PD) Waivers.
2. Determine if Waiver utilization information processed by DSPD matches the Waiver utilization information of DSPD-contracted Providers. This information includes both authorized and processed service(s), rate(s), unit(s), and payment records for individuals on the ABI, CS, and PD Waivers.
3. Determine if Waiver utilization information processed by the Department of Health (DOH) matches the Waiver utilization information of DSPD, and of DSPD-contracted Providers. This information includes both authorized and processed service(s), rate(s), unit(s), and payment records for individuals on the ABI, CS, and PD Waivers.

2019-05 Audit Objectives:

1. Determine whether DSPD Provider training and direction for contracted Providers complies with DSPD contracts and Medicaid regulations governing Medicaid service record documentation and records retention requirements.
2. Determine whether DSPD Provider practices comply with DSPD contracts and/or Medicaid regulations governing service record documentation and records retention requirements.

Audit Scope:

The scope of UOIG Audit 2019-01 sought to determine Medicaid Waiver utilization practices by DSPD and the Medicaid providers that DSPD contracts with, for the provision of services to individuals participating in DSPD programs. UOIG Audit 2019-05 sought to determine whether DSPD Provider training and direction for contracted Providers complied with DSPD contracts and/or Medicaid regulations governing Medicaid service record documentation and service records retention requirements during 2017-2021. The audit also sought to determine

whether DSPD Provider practices during this time complied with DSPD contracts and/or Medicaid regulations governing service record documentation and records retention requirements.

Scope limitations for audits 2019-01 and 2019-05 existed due to multiple factors. Fundamental limitations included a general lack of consistent information provided by DHS staff governing all topics included in this audit, as well as a lack of sufficient documentation by providers to support DSPD's Medicaid billing submissions. Additional scope limitations existed due to a lack of provider training documentation by DOH or DSPD, and a lack of written processes for billing or provider onboarding by DSPD.

Utah's Department of Human Services (DHS) established the Office of Quality and Design (OQD) near the initiation of the audits. OQD sourced staff from existing DHS departments, including DSPD. Upon formation, OQD became responsible for DHS provider contracting processes and for DHS provider compliance requirements, including provider audits. OQD reported that staff derived from DSPD would continue in very similar roles and capacities, albeit within OQD. Non-fundamental scope limitations arose from the organizational and procedural changes, as well as from the subsequent uncertainty and inconsistencies in information provided by staff regarding these processes.

The UOIG placed audits 2019-01 and 2019-05 on hold from 2020 - 2021, in response to the COVID-19 pandemic. Upon a return to the audits in 2021, the UOIG compared current DSPD and OQD provider contracts, audit tools, and processes with those identified prior to the hold, to ensure that audit outcomes identified prior to the hold still remained relevant. The comparison between 2021 processes and documentation, and previously implemented versions led to minor modifications in UOIG findings and recommendations. The hold itself, the comparison of changes implemented during the hold, and the subsequent impact to the outcomes of these audits are additional, non-fundamental audit limitations.

Audit Findings:

Utah Medicaid and DSPD have placed strong emphasis upon ensuring DSPD and provider compliance with the Medicaid HCBS Settings Rule, and that services follow a person-centered plan of care, in accordance with HCBS Waiver program requirements. However, DSPD and DSPD-contracted provider adherence to other aspects of Medicaid regulation, including Medicaid service documentation and the retention of Medicaid service records is lax. Five separate DSPD providers reported that DSPD instructed them to destroy Medicaid service documentation records that they once held. Additionally, 20 DSPD providers reported that they no longer had access to the records. In each instance, the providers reported that they were therefore unable to respond to UOIG's request for records.

Regulatory guidance and the contracts between DHS and DSPD providers identify expectations for service record documentation and retention. Despite these requirements, Utah Medicaid and DSPD allow DSPD-contracted providers to document service provision in ways contrary to regulatory and contractual obligations. DSPD providers often bill based upon assumed service provision. For example, this practice has resulted in a complete lack of records to support billing for some residential and accompanying residential services. For other services, such as transportation, Utah Medicaid and DSPD allow providers to document service provision exclusively through a checkmark or an "X", often without the inclusion of

any other pertinent information, such as who received the service, when the service was provided, the duration or quantity of the service, etc. These examples, combined with several additional areas of concern, have led to an inability to verify the provision of services, or the appropriateness of billing through records documentation. As a result, there is a high level of risk to members of this vulnerable population, as well as to the ability of the program to ensure fiscal accountability.

Another area of concern is that Utah Medicaid and DSPD created a unique billing model for DSPD-contacted providers. DSPD Medicaid billing processes fall outside of normal Utah Medicaid billing processes, utilizing a series of data crosswalks and non-standard service codes. Because of DSPD's unique billing model, Medicaid claim submissions do not match the service provision reported by DSPD providers. Specifically, the service type and quantity of Medicaid services examined in the audit did not match either the information provided by DSPD providers, or the limited records contained in DSPD's database, USTEPS. Some of the inaccuracies in Medicaid billing by DSPD appeared to be an unintentional byproduct of the DSPD billing process. However, in other circumstances, inaccurate Medicaid claim submission was purposeful; for Self-Administered Services (SAS), Utah Medicaid and DSPD encouraged billing practices containing deliberately inaccurate dates of service in order to avoid denied Medicaid claims. DHHS reported that this process was necessary due to system limitations of Medicaid's 40-plus year old claims system.

As a result of the inconsistencies between DSPD Medicaid claim submissions and the service provision provided by DSPD providers, neither the UOIG nor the DOH are able to employ DSPD Medicaid claims to review or monitor Medicaid Waiver utilization in Utah. The inability to review electronic Medicaid claims, combined with a lack of sufficient service record documentation may result in an environment of a heightened risk of fraud, waste, and abuse of taxpayer resources, as well as a potential increased risk to the vulnerable population dependent upon receiving Medicaid services. It is therefore necessary to implement effective oversight and Program Integrity controls in Utah Medicaid HCBS Waiver programs.

Finding 1, DOH knowingly accepted inaccurate DSPD Medicaid claims

Finding 2, DSPD directs contracted providers to submit inaccurate Medicaid claims

Finding 3, Many DSPD-contracted providers are unaware they are Medicaid providers, and of the regulations that apply to Medicaid providers

Finding 4, Policies and contracts governing Home and Community Based Service record documentation and retention need improvement, and/or are unenforced

Finding 5, Policies and contracts governing DSPD provider services do not ensure compliance with state and federal Medicaid policies or Waiver program requirements

Finding 6, An operating agreement between DOH and DSPD governing the management of Medicaid Waivers did not exist from 2015-2019.

Finding 7, DOH allowed DSPD to violate policies requiring Medicaid enrollment by all Home and Community Based Service providers.

Finding 8, DSPD submits inaccurate Medicaid Claims.

Finding 9, Due to inaccurate billing practices, any analysis of DSPD Medicaid claims or Waiver utilization requires a manual review of service records.

Finding 10, Due to insufficient service record documentation practices, a manual review of DSPD service records is not possible.

Observation 1, Service provision reported by DSPD providers often does not match service authorized in care plans, and retroactive approval is normal.

Observation 2, DHS does not educate staff or providers about, or report instances of suspected Fraud, Waste, or Abuse or Medicaid funds to the Utah Office of Inspector General.

Conclusion:

The UOIG concludes that Medicaid claim submissions by DSPD are often inaccurate when compared to service attestation by traditional service providers. DSPD Providers' records of service provision are often nonexistent and/or insufficient to support payment for those services by Medicaid. Due to the lack of sufficient Medicaid service documentation by DSPD providers, and the inaccuracies in electronic billing that result from the DSPD crosswalk of Medicaid claims over to the DOH, the audit objectives for OIG audits 2019-01 and 2019-05 were not possible to meet. As a result, the UOIG has chosen to make recommendations for areas with the highest level of risk. These recommendations include:

- Clearly defined policies and contracts;
- The creation and maintenance of complete and detailed service records;
- Accurate and analyzable billing and claims submissions; and
- Changes in DOH and DSPD processes that result in standardized Medicaid enrollment and billing practices, which mirror those of other Medicaid providers and of other State Medicaid Agencies.

The UOIG anticipates future audits of DSPD Medicaid Waiver Utilization, including a review of any implemented changes in policy and practice resulting from these audits. At that time, the UOIG shall revisit the question of inaccurate or unsupported Medicaid billing claims and determine if financial reimbursement is appropriate.

INTRODUCTION

In 2015, the Utah Office of Inspector General (UOIG) received notification of the appearance of fraudulent Medicaid billing practices by Medicaid providers contracted through the Utah Division of Services for People with Disabilities (DSPD), a division within the Utah Department of Human Services (DHS). The allegation claimed that the number of service units DSPD billed Medicaid on behalf of their providers exceeded the possible number of units available during the identified service period. The UOIG contacted DSPD, who advised the UOIG of an inter-agency workgroup comprised of DSPD, DSPD-contracted providers, Utah Medicaid, and the Utah Medicaid Fraud Control Unit (MFCU). The goal of the workgroup was to identify solutions for DSPD billing and budgeting practices, thus eliminating the appearance of false Medicaid claims. After discussions with the involved entities, the UOIG chose to allow DSPD to pursue in-house solutions, and declined to pursue an audit at that time.

In 2018, a UOIG investigation and Medicaid provider audit identified a series of Medicaid claim submissions that appeared to mirror previously identified 2015 DSPD billing practices. The UOIG undertook Audit 2019-01 to determine the current utilization practices of three Medicaid Waivers operated by DSPD: the Community Supports (CS) Waiver; the Acquired Brain Injury (ABI) Waiver; and the Physical Disabilities (PD) Waiver.

During the course of Audit 2019-01, the UOIG encountered complications obtaining requested service record documentation to support Medicaid billing by DSPD providers. DSPD provider practices did not appear to match contractual or regulatory Medicaid records documentation and retention requirements. The UOIG determined that Audit 2019-05 was necessary to evaluate the full scope of the difficulty, and if applicable, to identify causation.

BACKGROUND

UTAH MEDICAID

Medicaid is a joint state and federal government health insurance program established by Title XIX of the 1965 Social Security Act. Medicaid offers health care services and coverage to eligible populations, including low-income adults, elderly adults, pregnant women, children, and individuals with disabilities. During the audit, state law designated the Utah Department of Health (DOH) as the single state agency responsible for administration of the Utah Medicaid program. At present, Utah Code 26-18-3[1] designates "the department" as the single state agency. At the federal level, the Centers for Medicare and Medicaid Services (CMS) is responsible for regulation and oversight of Medicaid. Together, Utah and the federal

[1] A discrepancy in the definition and identification of the single state agency exists in Utah Code under the Medical Assistance Act. Utah's Medical Assistance Act was amended in 2022 to define the "Division" as "the Division of Medicaid and Health Financing within the department, established under Section 26-18-2.1". Utah Code 26-18-2.1 specifies, "There is created, within the department, the Division of Medicaid and Health Financing which shall be responsible for implementing, organizing, and maintaining the Medicaid program and the Children's Health Insurance Program established in Section 26-40-103, in accordance with the provisions of this chapter and applicable federal law." However, Utah Code 26-18-3 specifies, "The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act."

government provide funding for Utah Medicaid at percentage rates determined by the federal medical assistance percentage (FMAP). Throughout this report, "Medicaid funds" refers to federal and/or state taxpayer dollars used to fund Utah Medicaid.

In accordance with the Utah's Medicaid State Plan, with State Implementation Plans (SIPs) for the Utah Medicaid programs examined in UOIG Audits 2019-01 and 2019-05, and with Utah Code 26-18-3, the Utah Department of Health State Medicaid Program is the Single State Agency in Utah. With the sole exception of the determination of Medicaid eligibility by Utah's Department of Workforce Services (DWS), the DOH may not delegate their responsibilities as the Single State Agency; Utah's State Plan specifies, "The entire plan under Title XIX is administered or supervised by the [Single State Agency]". This means that DOH was, and now DHHS is, responsible for the management of Utah's Medicaid program, and must review and approve every Medicaid-related policy and process, including all policies and processes utilized by Utah's Division of Services for People with Disabilities (DSPD) in their administration of these Medicaid programs. DOH is responsible "for the effective and impartial administration (Utah Code 26-18-2.3(1), 2021)" of the program, and to "safeguard against unnecessary or inappropriate use of Medicaid services [and] excessive payments. (Utah Code 26-18-2.3(1), 2021)".

UTAH MEDICAID HOME AND COMMUNITY BASED SERVICE (HCBS) WAIVERS

Medicaid Waivers are programs whose statutory authority stems from certain sections of the Social Security Act (SSA). Each Waiver has its own unique list of available services, will operate in designated geographic areas, and/or will target specific demographic populations in the state. One of the most common types of Waivers are 1915(c) Waivers. Section 1915(c) of the SSA provides authorization for Home and Community Based Services (HCBS). UOIG Audits 2019-01 and 2019-05 focus exclusively upon several of Utah's HCBS Waivers. Consequently, unless otherwise specified, the term "Waiver" in this report refers to an HCBS Waiver.

States apply to operate Waiver programs through the Center for Medicare and Medicaid Services (CMS). The application process includes a Waiver-specific State Implementation Plan (SIP), which the state must submit to CMS for approval. CMS reviews each application and determines their approval or rejection of the SIP, and subsequent Waiver.

MEDICAID WAIVERS PROVIDE STATES WITH THE OPPORTUNITY TO TARGET KEY DEMOGRAPHICS FOR SPECIFIC SERVICE PROVISION

The section of the SSA from which a Waiver derives its name outlines the regulations that govern that respective Waiver type. It also governs the areas of Medicaid that states can "waive" in the operation of the Waiver program, because it allows an exception from usual Medicaid rules.

However, the only rules or regulations that a state may waive in the operation of a Waiver are those linked to the Waiver's authority; a state may not ignore other rules and regulations governing Medicaid simply because the program is a Waiver program.

The section of the SSA from which a Waiver derives its name outlines the regulations that govern that respective Waiver type. It also governs the areas of Medicaid that states can "waive" in the operation of that particular program, because it allows an exemption from those usual Medicaid rules. However, the only rules or regulations a state may waive in the operation of a Waiver are those linked to the Waivers authority; a state may not ignore all other rules and regulations governing Medicaid simply because the program is a Waiver program. For example, HCBS Waivers give states the option to waive comparability requirements contained in § 1902(a)(10)(B) of the SSA. Waiving comparability allows states to offer services to limited or targeted groups of individuals. States may also apply to waive a few other provisions of the SSA, such as a waiver of §1902(a)(10)(C)(i)(III). Waiving this section would allow the state to exclude a spouse's income when determining program eligibility for members of the targeted population. Despite a waiver of specified provisions, however, the HCBS Waiver program must still adhere to other Medicaid regulations. The ability to waive comparability or family income requirements in an HCBS Waiver does not negate the program's need to adhere to requirements such as service records documentation or retention requirements, which is a common misconception.

HCBS Waivers serve to provide long-term care services to individuals in home and/or community based settings, rather than in institutionalized settings. In designing a Waiver program, a state must ensure that the program demonstrates cost neutrality; a Waiver cannot cost taxpayers more than it would to provide those same services in an institution. States must further ensure that the program follows individualized plans of care, centered upon each participant's respective needs. The Waiver must protect the health and welfare of its participants, and the State must design a program that "provides adequate and reasonable provider standards (CMS, 2021)" while meeting the specific needs of the Waivers targeted population. The outcome of a Waiver program must also be trackable, and the State must report upon those outcomes to CMS on a recurring basis.

A state may apply to operate as many HCBS Waivers as it chooses; CMS does not limit the number of HCBS Waivers a State may have. As a result, many states operate multiple HCBS Waivers. At the time of this report publication, Utah requested approval from CMS to operate nine active HCBS Waivers, along with several other additional types of Waivers.

After CMS approves a Waiver, the identified services in the Waiver receive the bulk of their funding through the Federal Medical Assistance Percentage, or FMAP. In Utah, HCBS Waivers typically draw down approximately seventy (70) percent of their funding through the FMAP, while the States contribute the remaining thirty (30) percent, although certain services and administrative tasks associated with a Waiver may receive a higher match. In Utah, agencies sometimes refer to the state match as the "seed" money. The exact FMAP match rate varies incrementally each year, as determined by the federal government using a formula that compares the state's per capita income to the national average.

Utah's Community Supports (CS) HCBS Waiver is the most-utilized HCBS Waiver that DSPD administers. Services available under the CS Waiver SIP include the following, some with multiple levels of intensity:

- Center-Based Prevocational Services;
- Day Supports;
- Homemaker;
- Personal Assistance;
- Residential Habilitation;
- Respite Care;
- Supported Employment;
- Waiver Support Coordination;
- Financial Management Services;
- Behavior Consultation;
- Chore Services;
- Community Transition Services;
- Companion Services;
- Massage Therapy;
- Environmental Adaptations (Home and Vehicular);
- Extended Living Supports;
- Family and Individual Training and Preparation Service;
- Personal Budget Assistance;
- Personal Emergency Response System;
- Professional Medication Monitoring;
- Specialized Medical Equipment/Supplies/Assistive Technology;
- Supported Living; and
- Non-Medical Transportation Services

The CS Waiver SIP includes definitions for, and limitations surrounding each of the above-named services.

Utah's Acquired Brain Injury (ABI) HCBS Waiver SIP includes the following service options. Again, some are available at multiple levels of intensity:

- Waiver Support Coordination;
- Day Supports;
- Homemaker;
- Residential Habilitation;
- Respite; Supported Employment;
- Consumer Preparation Services;
- Financial Management Services;
- Behavior Consultation; Chore Services;
- Community Transition Services;
- Companion Services; Environmental Adaptation (Home and Vehicular);
- Extended Living Supports;
- Massage Therapy;
- Personal Budget Assistance;
- Personal Emergency Response System;
- Professional Medication Monitoring;
- Specialized Medical Equipment/Supplies/Assistive Technology;
- Supportive Living; and
- Non-Medical Transportation Services

The ABI Waiver SIP includes definitions for, and limitations surrounding each of the above-named services.

Utah's Physical Disabilities (PD) HCBS Waiver SIP includes fewer service options than the two previously mentioned Waivers. The PD SIP does not include multiple levels of intensity for any listed service option, although it does include definitions for, and limitations surrounding each available service. The following are services available under the PD Waiver:

- Financial Management Services;
- Personal Emergency Response Systems; and
- Personal Attendant Services;
- Specialized Medical Equipment and Supplies

INCREASED LEVELS OF RISK IN MEDICAID WAIVERS

Home and community based services include those which assist an individual with activities of daily living, or ADLs. Home Health Services (HHS) and Personal Care Services (PCS) are two categories of services designed to help individuals with their ADLs. CMS and the US Department of Health and Human Services Office of Inspector General (HHS OIG) have identified HCBS services, and Home Health and Personal Care Services in particular, as an area of increasingly high risk for Fraud, Waste, and Abuse of Medicaid resources.

CMS, HHS OIG, state Medicaid Fraud Control Units (MFCU), state Inspectors General, the US Department of Justice (DOJ), as well as program integrity experts from multiple state Medicaid Agencies have worked together to identify many vulnerabilities within Medicaid home health and personal care service program areas. These stakeholders developed and issued guidance for recommended strategies to mitigate the high levels of risk as well as to reduce the number of improper payments to home health and personal care service providers. Among those strategies were recommendations to "ensure services are fully and accurately documented", to "require claims to include complete specifications regarding services", and to "improve data analytics to reveal billing anomalies" (HHS OIG, 1998)[2]. The Federal Office of Inspector General's Compliance Program Guidance for Home Health Agencies includes nearly 17 pages of specific recommendations for providers of Home Health and Personal Care services to assist them in their efforts to "develop effective internal controls that promote adherence to applicable Federal and State law, and the program requirements of Federal, State, and private health plans. (HHS OIG, 1998)"

Along with increased levels of risk to the Medicaid program comes an increased risk to Medicaid beneficiaries. This is because there is a correlation between the high level of risk to taxpayer resources and a high level of risk to the vulnerable population of individuals who, through assessment, have demonstrated a need for one or more Home and Community Based Service. A risk exists that a provider may not provide a given service, or may not provide the correct service or correct amount of service. Each time there is risk involved in service provision, the risk also exists for the individual who needed that service, but may not receive it.

There is a significantly increased risk associated with each Waiver due to the already-elevated level of risk involved in HCBS service provision, and because Medicaid Waivers allow states to waive certain regulatory requirements associated with each respective Waiver program. States must include more stringent and meaningful controls in the design of each of their Waiver programs, or the programmatic flexibilities offered by a Waiver can result in a program without sufficient controls to ensure program integrity, fiscal responsibility, or service provision to a vulnerable population.

UTAH MEDICAID POLICIES GOVERNING HCBS WAIVER PROGRAMS

Policies for the Utah Medicaid program exist in several locations. DOH maintains Provider Manuals for each Medicaid program type, including those of the Waiver programs. Each Waiver has its own provider manual that, among other things, governs Waiver policies, documentation, enrollment, service provision, and acceptable billing practices. DOH also

[2] https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/vulnerabilities-mitigation-strategies.pdf

maintains program policy in Utah Administrative Rules, under Title R414, and R414-61 governs HCBS Waiver Services, although it merely incorporates by reference each respective Waiver.

Utah's CS Provider Manual identifies a waiver of comparability requirements under section 1902(a)(10)(B) of the SSA, as well as a waiver of institutional deeming requirements found under section 1902(a)(10)(C)(I)(III) of the SSA. This means that the state may provide the services identified in the CS Waiver to a limited number of individuals in the targeted demographic, and that Medicaid bases their eligibility income calculation upon a more relaxed income and resources standard.

The 2019 version of the CS Provider Manual references the CS Waiver SIP as Utah's authority to provide the services identified in the Waiver, which specifies, "The SIP and all attachments constitute the terms and conditions of the program. (DOH Utah Medicaid, 2019)". In July of 2020, DOH amended the CS Provider Manual, which now states, "The State Medicaid Agency (SMA) has ultimate administrative oversight and responsibility for the Waiver program. The day-to-day operations have been delegated to [DHS, DSPD] through an interagency agreement with the SMA. This agreement and the State Implementation Plan describe the responsibilities that have been delegated to DSPD as the Operating Agency for the Waiver Program (DOH, Utah Medicaid , 2020)." Similarly, the other Waiver provider manuals reference the corresponding Waiver SIP as the authority for each respective Medicaid HCBS Waiver program.

UTAH MEDICAID PROVIDER BILLING

Medicaid providers in Utah typically bill Utah Medicaid directly, although some of the larger providers choose to hire a billing service to assume that responsibility. When a provider hires a billing service, the billing service also typically bills Utah Medicaid directly, following standard billing processes discussed below. The data in each claim submitted through usual billing processes matches the adjudicated Medicaid claim data; no discrepancies in claim content occur. The reported service, the type of unit of service, the number of units of service, the date(s) of service, and all other data points remain consistent between what is billed and what is paid.

Providers typically submit their claims using Current Procedural Terminology, or CPT, and Healthcare Common Procedure Coding System, or HCPCS codes. CPT codes are a universal coding system used to identify medical procedures. Similarly, CMS developed HCPCS codes, as a universal coding system used to identify supplies, products, and healthcare services. Due to the nature of the claims, HCBS Medicaid Waiver claims typically utilize HCPCS coding. HCPCS codes fall into one of several categories: permanent; temporary; miscellaneous; and dental. HCPCS also allow for modifier codes that, when combined with the original HCPCS code, serve to supplement the claim through additional information about the service or product billed.

During their enrollment with Utah Medicaid, providers in Utah may also enroll or register with UHIN. UHIN is a third-party claims management company in Utah who processes Utah Medicaid claims data. When a provider bills Medicaid in Utah, most providers submit the claim into UHIN's system using CPT and/or HCPCS codes to identify the service provided, as is appropriate for each claim. Once UHIN processes the claim, the claim enters into Utah's Medicaid Management Information System, or MMIS. DOH is currently in the process of replacing MMIS with the Provider Reimbursement Information System for Medicaid, or PRISM project, although for now MMIS still processes Medicaid claims. Claims submitted to Utah

Medicaid through UHIN and MMIS must pass a series of programmed edits and validations. Examples of validation include elements such as verification of provider information, verification of beneficiary eligibility, and verification of prior authorization approval if applicable. Assuming that the claim passes each applicable edit, the system approves and pays the claim.

HCPCS CODING CHANGE REQUESTS

As noted in the Utah Medicaid Provider Billing section of this report, CMS maintains the Level II HCPCS code set. They have created an application for states to request a change to HCPCS coding, in the event that current coding options do not meet the needs of a state. States may request the creation of a one or more new HCPCS codes, the modification of an existing HCPCS code, or the discontinuation of an existing code for future use. CMS has additionally created a second similar form for use by providers and members of the public. Entities who utilize the form to apply for a change to HCPCS coding must demonstrate a national programmatic need in the application. Requests from states must include five letters from State Medicaid Directors or Medical Directors supporting the requested change(s). CMS's purpose for this process is to ensure that uniform coding occur throughout each state's respective Medicaid program.

MEDICAID PROVIDER REASSIGNMENT OF CLAIMS

Reassignment of Claims typically occurs through limited circumstances under 42 CFR §447.10, Prohibition against Reassignment of Provider Claims. The basis and purpose of this section prohibits state Medicaid programs from submitting "payments for Medicaid services to anyone other than a provider or beneficiary, except in specified circumstances (Code of Federal Regulations, 2021)." The regulation additionally specifies who may receive payment of Medicaid funds from a state Medicaid program, specifically: the provider; the beneficiary (in further limited circumstances); or reassignments of payment through business agents or individual practitioners.

A business agent is an organization such as a billing service or accounting firm, hired by the provider to handle their billing, claims, and payments. Business agents may only receive a reassigned Medicaid claim when their compensation for the arrangement is "(1) Related to the cost of processing the billing; (2) Not related on a percentage or other basis to the amount that is billed or collected; and (3) Not dependent upon the collection of the payment (US Code of Federal Regulations, 2021)." Meanwhile, payment to individual practitioners may only be made to "(1) The employer of the practitioner, if the practitioner if required as a condition of employment to turn over his fees to the employer; (2) The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim; or (3) A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim (US Code of Federal Regulations, 2021)."[3]

DOH, DHS INTERGOVERNMENTAL TRANSFER OF FUNDS

An Intergovernmental Transfer (IGT) of funds is a transfer from one government entity to another. The funds are eligible for FFP when used for the state match of Medicaid

[3] CMS final rule 2444-F dated 5/12/22 provides clarification regarding reassignment of claims. This occurred after the scope date of UOIG Audits 2019-01 and 2019-05.

expenditures. Because DSPS administers several Medicaid Waivers, an IGT process between DOH and DSPD occurs each quarter, as follows:

1. Utah's Department of Health (DOH) estimates the state seed amount for the quarter.
2. The DOH sends the IGT request to Utah's Department of Human Services (DHS) for the estimated amount.
3. DHS processes the IGT request.
4. DHS approves the request.
5. DOH receives the funds before the start of the quarter.
6. At the end of the quarter, DOH determines the actual seed amount based on the paid claims.
7. The DOH sends the IGT request to DHS for the actual paid amount.
8. DHS approves the IGT request and DOH receives the funds.
9. DOH refunds the estimated amount to DHS via an IGT.

UTAH'S DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

The Division of Services for People with Disabilities (DSPD) is a Division under DHS. DSPD exists to provide services to individuals with disabilities. Their mission is to "promote opportunities and provide supports for persons with disabilities to lead self-determined lives". The Utah State Legislature charges DSPD with the duties listed below under Utah Code 62A-5:

I. The provision of services for people with disabilities
II. The Utah State Developmental Center
III. Admission to an Intermediate Care Facility for people with an intellectual disability
IV. The provision of home-based services for caregivers

At the initiation of UOIG Audits 2019-01 and 2019-05, DSPD was responsible for the operation of three Medicaid HCBS Waivers, called the Community Supports (CS) Waiver, the Acquired Brain Injury (ABI) Waiver, and the Physical Disabilities (PD) Waiver to meet the needs of the majority of the individuals served through DSPD. DSPD also operates the Utah State Developmental Center (USDC), who provides services to between 100-300 individuals annually, but USDC operation was not a part of the audit scope and is therefore not a part of this report. A nominal number of individuals also received services from DSPD through the Autism Waiver, but Utah Medicaid chose to move those services over to other Medicaid programs; during the initiation of this audit, the Autism Waiver was not accepting new participants, and the program has since ended. Therefore, the Autism Waiver was not included in the scope of Audits 2019-01 or 2019-05. Near the conclusion of UOIG Audits 2019-01 and 2019-05, the DOH began to solicit public feedback for the proposal of a new HCBS waiver, called the Limited Supports (LS) Waiver. Because the LS Waiver did not exist at the commencement of these audits, the UOIG similarly excluded it from the scope of each audit.

Each year, the Utah State Legislature allocates a specified budgetary amount to DSPD. The amount allocated varies annually, based upon a number of factors, but is usually linked to an availability of funds. DSPD divides the funding they receive from the Utah Legislature into several fiscal "blocks", primarily Administrative (KFA), Traditional/Service Delivery (KFB), Funding for the Utah State Developmental Center (KFC), and funding for mandated additional needs of Individuals who receive Waiver services. Additional blocks include one for

occasionally available funds for individuals on the DSPD Wait List, and a block for those in either Utah's Division of Juvenile Justice and Youth Services (JJS) or Division of Child and Family Services (DCFS) custody. The last budgetary category is necessary because DSPD provides Medicaid Waiver services to eligible children in either DCFS or JJS custody through a Memorandum of Agreement (MOA) between the respective Divisions. DSPD reports that DCFS and/or JJS, as is applicable, pays the state match dollars for any children in their custody that received DSPD-administered Waiver services. The arrangement is strictly one of convenience; it allows DCFS and JJS to obtain Waiver services for children in their care without the need to administer duplicative processes. DSPD could not cite an instance, but said that in the event a child aged out of DCFS or JJS custody while enrolled on a DSPD administered Waiver, DSPD would seek additional allocations to bring him or her into DSPD care.

DSPD proportions the amount allocated for services across all of the available types and units of service, in order to set a specified rate for each unit of service for the coming year. A senior financial DSPD staff member provided an example to the UOIG. She said that if the Legislature allocated two million dollars to DSPD, DSPD would divide it up amongst all the possible service types to set a rate that ensured that they used the entire two million dollars.

DOH must approve DSPD rate setting. To accomplish this, DSPD submits the newly allocated rates to DOH for review in a spreadsheet called the Rate Master. DOH and DSPD jointly developed the Rate Master, although some staff referred to it as the Crosswalk. DOH and DSPD staff naming of the spreadsheet and transmittal process was inconsistent. The Rate Master includes DSPD codes for each service, along with the corresponding Healthcare Common Procedure Coding System, or HCPCS code used by Medicaid. Upon receipt of the Rate Master, DOH staff at various levels of leadership must review and approve the payment rate for each service.

Once reimbursement rates per service have been set, DSPD determines the number of individuals who may receive service that year. DSPD must take into account the necessary budgets for each currently enrolled Waiver participant when determining the number of new individuals that may receive service each year. This is because once an individual enters Waiver services he or she generally remains enrolled for life. Limited exceptions occur when an individual loses Waiver eligibility; usually through an out-of-state move, or transfer to services in an institutionalized setting. If a loss of Waiver eligibility occurs, the individual has the right to appeal the decision through an Administrative Hearing process. There is also the possibility that an individual could move off one Waiver in order to move directly onto a different Waiver. This usually occurs when the new Wavier offers a better or more appropriate list of possible services to meet the specific needs of a particular individual than the previously utilized Waiver.

THE ANNUAL EXPENDITURES OF DSPD WAIVER PROGRAMS

The state funds allocated by the Utah Legislature become the seed, or the State's contribution to Medicaid Waiver funding. As noted earlier, the federal contribution level varies, but is usually approximately 70%. The costs of the program vary each year as well, but have risen in recent years at an increasingly high rate.

DSPD's annual HCBS claims rose nearly $100,000,000 from 2017 to 2020 (*figure 1*). Medicaid Home and Community Based Services paid under the CS, ABI, and PD Waivers in calendar year 2017 totaled $257,021,578. In 2018, that number increased to $290,012,815. In 2019, it rose

again to $323,664,619, and in 2020, totaled $352,717,593. These numbers reflect the total amount paid out in adjudicated Medicaid claims using the U4, U5, and U6, modifiers, which represent the PD, ABI, and CS Waivers, respectively. Because DSPD administers the PD, ABI, and CS Waivers, these claims are solely attributable to individuals receiving DSPD services.

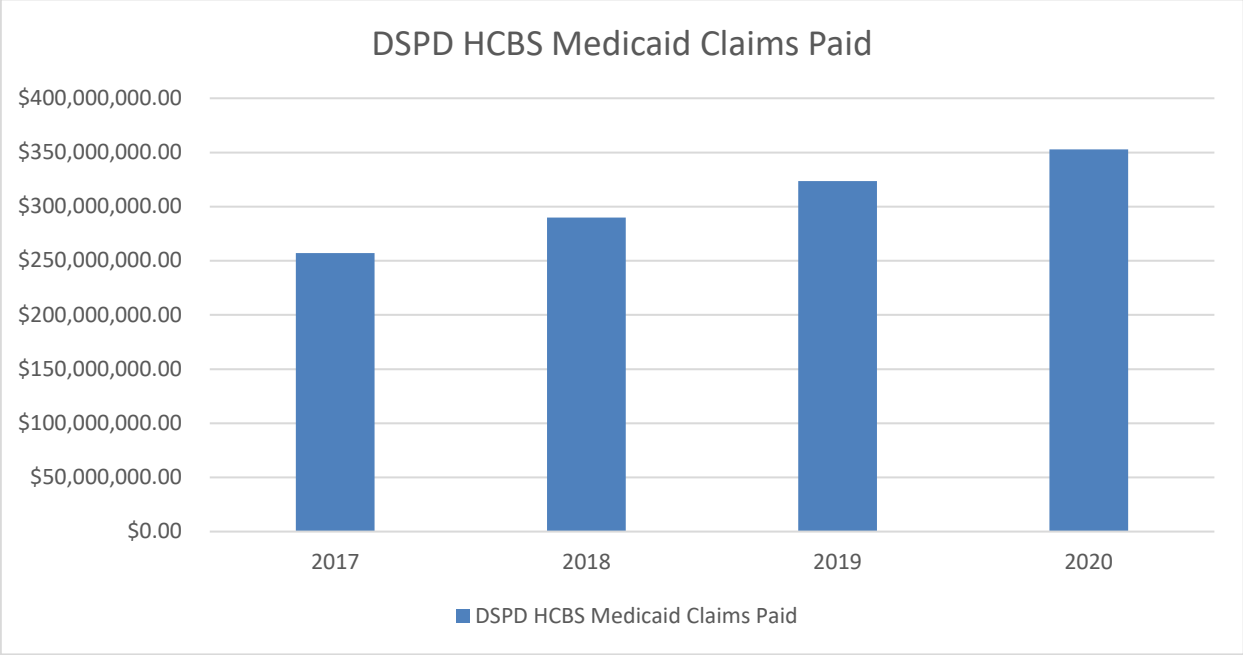

Figure 1

Although the cost of the ABI, CS, and PD Waivers continues to rise, so does demand. Because there are more people interested in obtaining Medicaid Waiver services through DSPD than their budget allows for, DSPD maintains a Wait List for those individuals. DSPD reports that occasionally they have small amounts of funding available to carry over into the next fiscal year. When that occurs, DSPD provides respite services to the families of individuals on the Wait List. DSPD selects the families who receive respite services through a lottery system, and winners are not eligible to enter the lottery the following year.

The data and metrics DSPD reports, detailing the exact number of individuals in care, the exact number of individuals on the Wait List to obtain service, and the annual expenditures by DSPD, changed several times from 2017 - present. The information came from DSPD annual reports for 2016 - 2020 as well as from metrics published on the DSPD Dashboard, but totals for each of the above named categories randomly changed several times throughout the audit. DSPD published this information on their public-facing website from 2016 - present. The UOIG spoke with DSPD staff about the differences in their reported Waiver utilization metrics, however, the information provided by staff to explain the variation would have, if applied, increased the discrepancies, rather than resolve them. The UOIG sought to verify total Waiver utilization expenditures through annual Medicaid Claims as a comparison, although those claims naturally only reflect the total number of billed services in a given period (*figure1*). No other independent sources of data are available to verify or compare the number of individuals on the DSPD Wait List or in care.

Although the reported Waiver utilization metrics changed several times during the course of the audits, at the time of publication, DSPD reports serving between 5,335 and 6,100 individuals annually between 2017- 2020 *(figure 2).* DSPD further reports that the number of people on the DSPD Wait List has grown over the last several years from approximately 2,752

in 2017 to 3,911 in 2020, and projected 4,307 individuals on the Wait List in 2021 *(figure3).* These numbers reflect only the number of participants on the CS, PD, and ABI Medicaid Waivers. Because it is outside of the audit scope, these totals do not include individuals who receive service at the Utah State Developmental Center, or those whose service funding is non-Medicaid in nature.

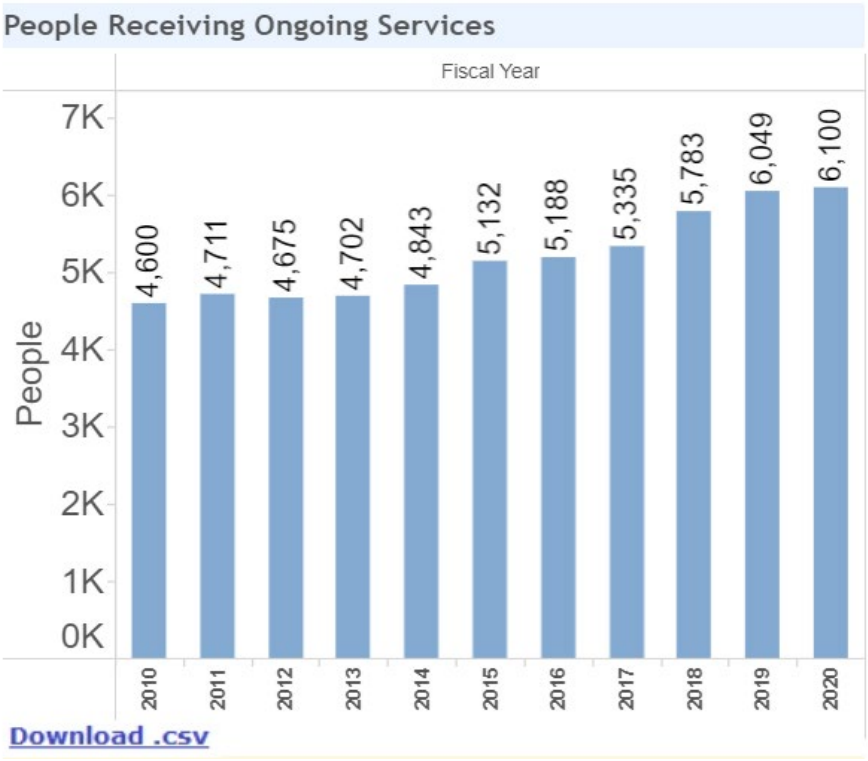

Figure 2

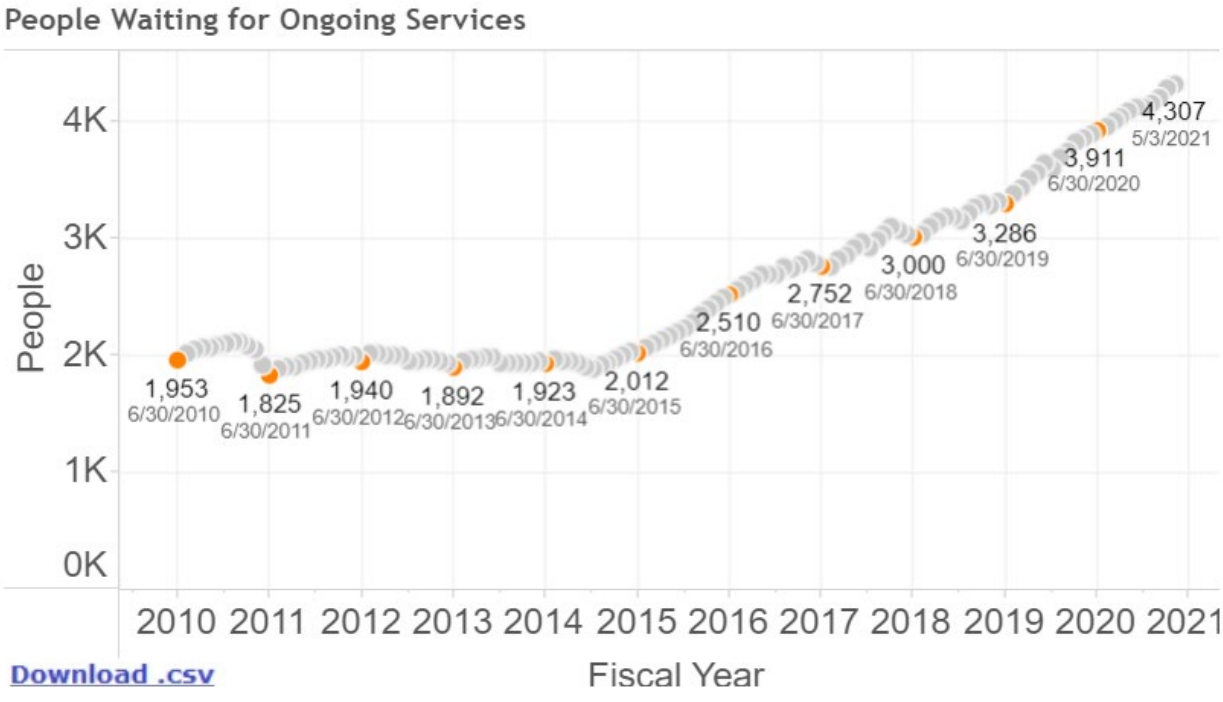

Figure 3

Upon determination of Medicaid Waiver eligibility and with the availability of funding, DSPD brings individuals into service and utilizes a nationally recognized needs assessment tool to determine their individual needs based upon a scale that rates the intensity of necessary supports for each participant. Results from the assessment tool drive the identification of authorized services for each individual. DSPD then works with the individual to develop a Person-Centered Support Plan (PCSP) to meet that individual's unique needs within a personalized annual budget that DSPD has allotted for those services.

DSPD ORGANIZATION AND SEPARATION OF DUTIES

DSPD internal processes in administering Waivers focus on a separation of duties between the Provider setup, the Medicaid beneficiary setup through DSPD, and the approval of payment submitted by providers. Provider setup occurs initially through the actual contracting process, and later through a New Provider Orientation designed to assist providers in successfully acclimating to DSPD expectations for their respective roles. A DSPD staff person is singularly responsible for the internal electronic setup of new providers, while DSPD Medicaid beneficiary setup begins with a DSPD Waiver service application. Applicants must supply documentation in support of their circumstances, including copies of school or psychological evaluations, medical health summaries, and copies of personally identifying information. Once approved, each Individual receives a "needs score", indicating the severity of needed service. DSPD bases the score upon a variety of factors, such as urgency, caregiver or parent ability, length of time on the DSPD waiting list, and the severity of an applicant's disability. The score also determines an Individual's rank or placement on DSPD's waiting list. When an Individual moves from the Wait List onto Waiver services, a small number of DSPD-employed staff with responsibilities similar to that of an SCE provider assist in the transition. They work with the Individual and his or her team to locate a permanent SCE provider and develop a PCSP that meets the Individual's needs and assigned budget. DSPD staff called Payment Techs are responsible for provider payments. They work within the Finance department of DSPD, and process Medicaid Waiver service claims submitted by providers.

DSPD'S USTEPS DATABASE

DSPD designed their USTEPS database with assistance from contactors and what is now Utah's Division of Technology Services (DTS) , and built it and its capabilities to DSPD specifications. DSPD staff and contracted providers utilize the program for a wide variety of tasks, including the review and creation of a PCSP, the creation and monitoring of log notes denoting service provision, progress or lack of progress made toward identified goals, and billing. The USTEPS database has separate programs or sections within the database, designed for specific components, such as provider log note entry and billing and claims processing. Access within USTEPS is role-based, and dependent upon DSPD approval. During Audits 2019-01 and 2019-05, DSPD staff referred to the separate components or programs by USTEPS, CAPS, and/or UPI, but explained that USTEPS encompasses the entire program or system. Throughout this report the term USTEPS shall refer to any programming component within DSPD's USTEPS program, for purposes of continuity.

DSPD'S PERSON-CENTERED PLANNING

The PCSP, or Plan, is DSPD's solution to Medicaid person-centered planning requirements governing HCBS Waiver services[4]. Each Plan is unique, tailored to the individual, and details the individual's demographic information, any available supports, the items that are important to that individual, and the items that are important for that individual. DSPD staff explained the difference through the following example. An individual may wish to set a goal that helps ensure he or she spends as much time as possible on a particular activity that he or she enjoys, which would be important to that person. By contrast, assistance with regular grooming and hygiene practices may be a necessary goal that is important for that person.

Together with the individual receiving services, DSPD forms a Person-Centered Support Team (PCST), whose purpose is to form a support system for each individual in care, and to work together to plan and develop a PCSP for the individual. Each year, the PCST comes together to review and update the PCSP to meet the evolving needs of that person, although DSPD reports that the PCST may meet more often, as needed. Members of the PCST can include friends or family of the individual, neighbors, DSPD staff members, contracted traditional Providers, and the Support Coordinator-External (SCE) provider, who acts in a capacity similar to that of a contracted caseworker for the individual.

In addition to demographic information about the individual, the PCSP also includes a list of the specific services authorized for the individual, the authorized quantity and intensity of services, the name of the provider who will provide the services, and the reimbursement rate for each service. DSPD sets a monthly maximum that caps the frequency of service per month for each individual in his or her Plan. This serves as a passive budget control to ensure that the services identified in the Plan remain available each month for the duration of the plan; DSPD reports that programming edits within their USTEPS database prohibit payment for services that exceed the monthly max, or for services that are not included as an authorized service on an Individual's PCSP. The purpose is to prevent the use of all budgeted services within the first several months of the PCSP, which would necessitate a Request For Service (RFS) authorization to expand the budget and add additional services to the individual's PCSP to finish out the plan cycle.

The RFS Committee is a group composed of DSPD staff who review requests made for additional services and funding outside of those identified in the PCSP. The RFS Committee staff members do not change; DSPD reports that this ensures continuity in approval and rejection practices made to DSPD across each RFS request. Any change that affects the individual's budget, such as a change in number of authorized units of service, a change in rate, or a change in service type must go through the RFS process. The RFS Committee meets to discuss any requested change(s) as needed. The RFS must be justified, or the RFS Committee may deny the request.

SCE providers submit requests for additional service and funding, along with justification for each request. The Committee meets to review the submission, and approve or reject the request based upon the information provided. Reports regarding the success rate for requests for additional service vary; DSPD staff initially reported a "high percentage" of rejection by the

[4] CMS Final Rule, HCBS Waiver Services, https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

RFS Committee, but DSPD staff later reported that the vast majority of requests for additional funding do receive approval. Similarly, Providers universally reported RFS approval, often retroactively. Provider C also reported that DSPD staff often approve smaller increases of $1000-$5000 outside of the RFS process. Many providers said that any initial RFS rejection was resolvable through a second request containing additional information. One documented instance indicated that Provider AL faced technical difficulty in submitting a retroactive RFS approval. The documentation about this occurrence was contained in log notes submitted to the UOIG as part of Audit 2019-01. It is unclear if the RSF request was successful; any approval or rejection of provider AL's request fell outside of the audit sample.

DSPD PROVIDERS GO THROUGH A UNIQUE MEDICAID ENROLLMENT PROCESS

In Utah, service providers typically enroll to become Medicaid providers directly through Medicaid.

DSPD-contracted providers, however, do not complete the Medicaid enrollment process through Medicaid. Instead, DSPD staff disclosed that they enroll new providers through a unique process outside typical Medicaid enrollment procedures, as part of the DHS provider contracting process.

Consequently, the majority of DSPD providers included in UOIG Audits 2019-01 and 2019-05 are unaware that they are Medicaid providers, and are similarly unaware of Medicaid regulations.

DSPD AND OQD PROVIDER CONTRACTING AND MEDICAID ENROLLMENT PROCESSES

In order to obtain services identified in the PCSP for the individuals brought onto a Medicaid Waiver, DSPD enters into contractual relationships with private companies called providers, who are responsible to provide care to those Individuals, in accordance with each individual's respective PCSP. Because Medicaid funds DSPD Waiver service delivery, the providers that DSPD contracts with must also be enrolled Medicaid providers.

In Utah, service providers typically enroll to become Medicaid providers directly through Medicaid. A series of web-based trainings are available to guide the new provider through the application process on the DOH's website. There is also an option for providers to enroll in Medicaid through DHHS using paper forms. When a provider enrolls in Utah Medicaid, it is possible for others within the provider's organization to assist providers with the Medicaid enrollment process. For example, an administrator within a group practice may enroll the physicians for the group practice. Because the administrator is a part of the group practice, the organization as a whole would therefore be aware of their Medicaid enrollment status.

By contrast, DSPD-contracted providers do not complete the Medicaid enrollment process through Medicaid. Instead, DSPD staff disclosed that they enroll new providers through a unique process outside typical Medicaid enrollment procedures, and as part of the DHS provider contracting and onboarding process.

The contracting process with DSPD providers changed several times before and during the course of Audits 2019-01 and

2019-05. Divisions within DHS were each historically responsible for contracting with providers through their own procurement processes. However, near the initiation of UOIG Audits 2019-01 and 2019-05, DHS underwent organizational changes, wherein DHS established the Office of Quality and Design (OQD). OQD sourced its staff from existing DHS Divisions, including DSPD. Upon formation, OQD became responsible for DHS provider contracting and for DHS provider compliance requirements, including annual provider audits. OQD reported that staff derived from DSPD would continue in very similar roles and capacities, albeit within OQD. Because both DSPD and OQD processes are relevant to the outcome of the Audit, this report details each, and references each accordingly.

DSPD originally contracted directly with their service providers through standard State of Utah Request for Proposal (RFP) processes with the Bureau of Contracts Management (BCM), in accordance with Utah's Division of Purchasing and General Services requirements. Other DHS Divisions, such as the Division of Child and Family Services (DCFS), and Juvenile Justice Services (JJS) contracted with their own providers in independent processes that appear to have mirrored DSPD's. It was common for these providers to contract with multiple DHS Divisions at the same time, resulting in a provider holding multiple contracts for each respective Division. However, this also resulted in multiple provider audits of the same provider by each respective DHS division each year. For example, if DSPD and DCFS had contracted with the same provider, that provider would undergo two provider audits: one for the services provided to DSPD clients, and a second for any services rendered to DCFS clients.

When the contracting process moved from DSPD to OQD, providers had the opportunity to contract with all DHS Divisions simultaneously under a single contract. DHS employees cited efficiency and a desire to eliminate duplication in duties as motivation for the formation of OQD and the subsequent change in the number of audits a provider could anticipate each year. In this report, the UOIG will refer to both DSPD contracting processes and DHS contracting processes, as is applicable in each particular situation.

DSPD reports that prior to the creation of OQD by DHS, all elements of contracting and onboarding were the responsibility of DSPD staff. Once a provider responded to an RFP with an offer to fulfill the request, DSPD and the Bureau of Contract Management (BCM) worked with the provider and assisted them through each step of completion of the contract. This included a review of credentials, staff qualifications for services, and licensure. After the provider submitted all mandatory information, an evaluation committee reviewed the documentation and either requested missing components, or approved the provider through an award letter. After provider approval, DSPD staff then worked with the provider and offered onboarding and training.

It is at this point in the process that DSPD enrolls some of their newly contracted providers with Medicaid. DSPD reported that not all DSPD contracts require Medicaid enrollment; therefore, only those providers whose DSPD or DHS contract mandates Medicaid enrollment become enrolled as a Medicaid provider. DSPD staff do this on behalf of their providers as a courtesy, to make the process easier on providers. Once BCM approves a provider, DSPD may contact the provider to begin sending and receiving paperwork. There are seven forms specific to Medicaid that the provider must sign and return to DSPD. They include the Medicaid Provider Agreement, and a PRISM access form authorizing a DSPD staff person as the Medicaid system user for the provider's company. There is also a form for voluntary reassignment of claims, wherein DSPD may bill for, and receive payment for any Medicaid service provided by

the provider. DSPD reports that no provider has ever declined to allow DSPD to bill or receive payment on his or her behalf. Provider reports on this matter are conflicting; it is therefore unclear if providers are aware that they have a choice in this process. Reassignment of claims falls outside of the audit scope for UOIG Audits 2019-01 and 2019-05, although the UOIG may pursue this compliance element at a future date. All other providers in Utah enroll directly through Medicaid, DSPD's provider Medicaid enrollment process falls outside usual procedures.

After the creation of OQD, the Office moved to change not only whom each provider contracted with, but also how contract recruitment and solicitation worked. Instead of an RFP, OQD shifted to an open-ended Request for Statement of Qualifications (RFSQ), which results in an approved vendors list. Under Utah Code 63G-6a-507, an approved vendor list allows OQD to continually solicit providers who wish to contract with and provide services for DHS. Once a potential vendor submits all necessary documents in the RFSQ, the vendors receive approval to provide services. Every 18 months, the provider's credentials undergo review, to ensure that the vendor continues to meet any necessary eligibility requirements for that type of vendor.

DSPD AND OQD NEW PROVIDER ORIENTATION

Due to settings changes to HCBS regulations, requirements under the Medicaid Settings Rule (CMS HCBS Final Rule 2249-F/2296-F, 2021) are a priority for DSPD. Consequently, DSPD staff report that newly contracted traditional providers receive an HCBS Settings Transition Provider Assessment Tool. The tool is an eleven-page matrix that identifies settings criteria outlined in 42 CFR §441.530, and in the Final Rule. Providers may use the tool to analyze their business model and assess their compliance with the listed expectations. If the provider indicates compliance, they must document evidence of their compliance in the tool. Alternatively, if the provider's analysis identifies a settings requirement that they believe to be inapplicable, the provider must document their evidence and reasoning.

After a provider has attested to and documented their compliance with the Settings Rule, DSPD offered, and now OQD offers, a New Provider Orientation (NPO) for providers. Since OQD assumed responsibility for the NPO, both DSPD and OQD report that processes have not substantively changed. The NPO serves as initial provider training, and assists in the onboarding process. OQD manages a book of forms and topics and reviews these with the provider. The contents of the NPO book change marginally each year, but the core content remains the same. Topics such as Human Rights, Behavior Intervention, Background screening requirements, DSPD's payment process, annual training requirements, Incident reporting, medication handling, medication distribution errors, site licensing, and a Continuity of Operations (Emergency) Plan are discussed at length with the provider.

The UOIG had the opportunity to sit in during a new employee orientation, which lasted approximately two hours. The orientation focused primarily on several important regulatory requirements in Utah involving licensing and background checks. OQD staff went over several forms and verified that the provider understood their responsibilities in this matter. The newly contracted provider was able to ask pertinent questions about his facilities, business practices, and adherence to DHS expectations for treatment of the individuals in their care. Staff also spoke with the provider about his background or any previous experience working with individuals with disabilities. The provider reported that he had very limited experience, but was looking forward to providing direct care. He stated that he had little interest in

policies or rules, and did not want to be bothered with compliance concerns. For that reason, he had hired a consultant to worry about those issues for him; he wanted to spend his time with the people they served. From there, the NPO segued into the PCSP, specifically how DSPD and Individuals determined goals and authorized PCSP service levels.

The NPO also addressed the OQD audit tool. The audit tool is a document that OQD uses to guide the direction of annual provider audits, and to ensure consistency in each audit. OQD staff spent a substantial portion of the allotted two hours identifying each area that they would review during the annual provider audit, and the provider achieved a firm understanding of what he could expect, and how to be successful in an audit.

The NPO next covered the topic of Rep Payee responsibilities, which assist individuals with financial management of personal funds. There was also some discussion of the provider-formed organization called the Utah Association of Community Services, or UACS. OQD told the provider the participation was voluntary, but that most providers joined and that the group offered a lot of DSPD information and support to its members.

After nearly two hours, and toward the end of the NPO, OQD staff very briefly mentioned the Medicaid Settings Rule. OQD told the new provider that the Settings Rule was "a requirement about people being included in the community (Training, 2019)" tied to DSPD's Employment First initiative, and that as a new provider, he was expected to comply. DSPD's Employment First plan believes that "every person who receives services from DSPD achieves their career possibilities. (State of Utah DHS, DSPD, 2021)" Although laudable, the plan is not, in fact, the full purpose or scope of the Medicaid Settings Rule. Before the UOIG could interject, a DSPD staff member joined the training and said that he only had a few moments to discuss billing.

The NPO continued with a brief overview of DSPD's 520 provider billing form, which DSPD utilizes to identify provider billing in their USTEPS database. The 520 form identifies the Individual who received a service, the provider who provided the service, the service type, the reimbursement rate, and number of units authorized for payment each month to the listed provider. The DSPD staff person then provided some information about billing while an individual was in the hospital that contradicted Medicaid billing polices. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services may not be furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

At that point during the NPO, the UOIG offered correction to DHS staff and the new provider regarding the misinformation about the Settings Rule and the misinformation about Medicaid billing guidelines. The UOIG then referred each party to training and resources for Medicaid. OQD reported that they would update the NPO accordingly. Although the issue of potential double billing while a Medicaid beneficiary is institutionalized does fall within the audit scope of UOIG audit 2019-01, the audit sample did not contain any instances of it occurring. This may or may not be a result of the inaccuracies in DSPD billing and the lack of service record documentation to support billing; double billing could occur, or it may not have. The UOIG

discusses those implications further in this report, and in the Audit Findings. No further mention of Medicaid rules, policies, or regulations occurred during the NPO training. [5]

DSPD PROVIDER TYPES, THEIR ROLES, AND THE SERVICES THEY PROVIDE

DSPD administers the CS, PD, and ABI Waiver programs by contracting with multiple types of service providers, who each provide one or more types of service identified in the Waiver SIPs. To do this, DSPD managed multiple contract types for their providers, based upon the specific services each offered, and their subsequent roles and responsibilities. When OQD assumed authority over DHS contracting, this process became theirs. In this report, the UOIG references several different DSPD/DHS provider types. In order to help differentiate between the several types of service providers, the UOIG refers to them by category, using DSPD provider category language: Traditional Providers; SCE Providers; Financial Management (FM) Providers; Self-Administered Service (SAS) Providers; and Environmental Adaptation (EA) Providers.

DSPD providers that provide a traditional service to an individual are traditional providers. They offer a wide array of services identified in the CS, PD, and ABI Waiver SIPs. The majority of traditional providers utilize the largest type of DSPD/DHS contract, the ABI.ID.RC. The ABI.ID.RC stands for Acquired Brain Injury, Intellectual Disability, and Related Conditions. Providers who provide the services identified in the ABI.ID.RC contract provide the following DSPD services, using the following DSPD-created service code(s) listed in parenthesis:

- Behavioral Consultation (BCI, BC2, BC3);
- Chore (CHA),
- Companion (COM);
- Day Supports Group (DSG);
- Day Supports for an Individual (DSI);
- Day Supports Partial (DSP);
- Day Supports, Full Day over 6 Hours (DSG);
- Extended Living Supports (ELS);
- Host Home Supports (HHS);
- Homemaker (HSQ);
- Motor Transportation Payment (MTP);
- Personal Assistance Services (PAC);
- Personal Budget Assistance (PBA);
- Professional Medication Monitoring by a Licensed Practical Nurse (PMI, PM2);
- Professional Parent Supports (PPS);
- Residential Habilitation Supports (RHS);
- Exceptional Care Respite Without Room and Board (RP3);
- Routine Respite With Room and Board Included (RP4);
- Exceptional Care Respite With Room and Board Included (RP5);
- Respite Session (RPS);
- Supported Employment With a Co-Worker (SEC);
- Supported Employment Group (SED);
- Supported Employment Enterprise (SEE);
- Supported Employment for Individual (SEI);
- Supported Living Quarterly Hourly (SLH);
- Supported Living Natural (SLN);
- Family Training and Preparation (TFA);
- Family and Individual Training and Preparation (TFB)

[5] After the conclusion of the Audit, DHHS reported that DSPD providers attend a separate 30-minute core training, which discusses the Medicaid Settings Rule and "other Medicaid policies". The training was not disclosed during the course of the Audit fieldwork, and DHHS did not provide any supporting documentation.

The ABI.ID.RC contract identifies the requirements and limitations for each type of service, including the expected duration of service. The contract further stipulates any other services that a provider may not deliver concurrently with another given service. For example, DSG services must exceed 6 hours per day. If the total service exceeds 10 hours, the provider may bill for a 10-hour rate.

In addition to the ABI.ID.RC contract, DSPD/OQD utilizes several other contracts with traditional provider vendors. One such example is their PER Contract for traditional providers who offer personal emergency response equipment. Personal emergency response equipment provides the Individual with device that has constant access to a response center, and allows the Individual to summon assistance in the event of an emergency. Service options include the following, with corresponding DSPD service codes in parenthesis:

- Personal Emergency Response Device, or PERS (PEI);
- Combination PERS and Medication Dispenser (PE3);
- PERS with Equipment Purchase (PEP);
- Additional Replacement Devices (PEQ);
- Medication Dispenser (PEI)

The contract held by the Utah Transit Authority (UTA), to provide an array of transportation services to Individuals in care is another example of traditional service that is available to Individuals enrolled with DSPD Waivers. Transportation options listed in UTA's contract, along with the corresponding DSPD service code include:

- Paratransit Daily Fare (UTP);
- Adult Monthly Pass (UTA);
- Paratransit Trip Fare (UTA);
- Route Deviation (UTD); and
- Trip with Route Deviation (UTF)

Two other types of traditional providers with unique contract types are Massage Therapists and Environmental Adaptation (EA) providers. Massage Therapists provide service through Specialized Supports Massage Therapy, under DSPD service code SSM. Massage Therapy providers must be licensed, and, as with any other service, the Individual's PCSP must reflect massage therapy as an authorized service. EA Providers are licensed contractors who provide modifications to homes and/or vehicles, as necessitated by each Individual's respective need, and the service authorized on the PCSP.

When an Individual selects a traditional provider, the traditional provider works with the Individual and other team members, such as the SCE, DSPD staff, and any family, friends, or guardians of the Individual to identify goals and the PCSP, and then proceeds to provide the traditional service or services identified in the PCSP. Traditional providers enter notes into the USTEPS database to detail any progress made toward PCSP goals, and/or to document any lack of progress toward goals. The providers then submit billing in USTEPS, for approval by the SCE Provider.

As previously mentioned, SCE providers act as an independently employed caseworker for DSPD, and the Individuals whom DSPD serves. DSPD employees originally met the role that SCE providers now fill, but a legislative change led to their privatization in or around 2009. Today, an SCE provider contracts with DHS to provide case management services. Because the

Waivers provide participants with freedom of choice, Individuals select and hire their chosen SCE provider. Similarly, Individuals may also choose to dismiss their SCE and hire another.

SCE providers have a unique contract specific to their duties. Their contract details the eleven key functional activities for which they are responsible, including the monitoring of the health, safety, and welfare of the Individual the SCE is contracted to provide service. They assist in the development of an Individual's PCSP, and coordinate with both DSPD/DHS, and traditional providers, to ensure the delivery of "quality Waiver services (DOH Utah Medicaid, 2019)" to Individuals in care. SCE providers also have responsibilities related to the approval of other provider billing. Further information is located in the DSPD Billing section of this report.

Self-Administered Services (SAS) refers to service delivery provided by helpers, such as family members, neighbors, or friends, who provide PCSP-authorized service to an Individual. This service delivery model varies from more traditional provider services, in that the SAS providers are not typically professional caregivers or home health workers. SAS providers record their hours on weekly timesheets, which they then submit to a Fiscal Agent (FA) provider. The FA processes the timesheet, submits the billing, and disburses payment to the SAS provider through an approved method. Like traditional service delivery models, SAS services must be included on the Individual's PCSP.

SAS services include the following DSPD services and corresponding DSPD service code in parenthesis for Individuals enrolled on the CS Waiver:

- Financial Management Services (FMS);
- Chore Services (CHI);
- Homemaker Services (HSI);
- Companion Services (COI);
- Personal Assistance Service (PAI);
- Family Training and Preparation (TFI);
- Supported Living (SLI);
- Respite (RPI, RP6);
- Respite Group (RP7, RP8); and
- Transportation Services (DTP)

SAS services for Individuals enrolled on the ABI Waiver include the following DSPD services and corresponding DSPD service code:

- Chore Services (CHI);
- Homemaker Services (HSI);
- Respite (RPI);
- Supported Living Services (SLI); and
- Transportation Services (DTP)

SAS services for Individuals enrolled on the PD Waiver include the following DSPD services and corresponding DSPD service code in parenthesis:

- Financial Management Services (FMS); and
- Personal Assistance Services (PAI)

Fiscal Agent (FA) providers are licensed Certified Public Accountants (CPA) who act as a financial intermediary, and have a unique contract that is specific to their duties. The PCSP must identify Fiscal Agent services in order for an Individual to select and receive FA services. FA providers assist the Individual with payroll duties for SAS. FA providers ensure proper completion of I-9 forms and SAS timesheets, and submit billing to DSPD through the DSPD USTEPS database, based upon information contained in the timesheets sent to FA provider.

Upon payment by DSPD, the FA provider distributes the funds or payroll accordingly through either paychecks or Electronic Benefit Transfers (EFT) to pay cards. The FA contract prohibits payment through cash or currency. FA providers may additionally provide tax and withholding services, assistance with processing insurance premiums, or managing other financial withholding for benefits. The FA provider must generate and submit a spending summary report each pay period, in order to assist the Individual in managing their available resources.

PREVIOUSLY IDENTIFIED DSPD BILLING ANOMALIES, THE UOIG'S HISTORIC INVOLVEMENT, AND CURRENT DSPD BILLING PRACTICES

In 2015, the Utah Office of Inspector General (UOIG) received notification of the appearance of fraudulent Medicaid billing practices by Medicaid providers contracted through DSPD, wherein the number of service units billed exceeded the possible number of units available during the identified service period. The UOIG undertook a joint audit/investigation of DSPD Medicaid claims, and began the groundwork of an audit of the DSPD billing processes. Shortly afterward, however, DSPD revealed the existence of a work group populated by DSPD staff, DSPD providers, and staff from the Medicaid Fraud Control Unit (MFCU) who were working in concert to identify solutions for consistent DSPD billing and budgeting practices, thus eliminating an appearance of false Medicaid claims. After discussions with each of the involved entities, the UOIG chose to allow DSPD to pursue in-house solutions, and declined to pursue the matter at that time.

In 2018, a UOIG investigation and a UOIG Medicaid provider audit identified a series of Medicaid claim submissions that appeared to mirror previously identified 2015 DSPD billing practices of potentially fraudulent Medicaid claims submissions. Once again, several providers appeared to have billed Medicaid for more units of service than were possible in the period identified on the claims. The UOIG Data Scientists examined patterns in DSPD provider billing for several of the most frequently billed DSPD service types, and noticed other anomalies in the data. The UOIG then met and spoke with several DSPD-contracted providers, who denied providing the services that Medicaid had paid them. The providers reported that the Medicaid claims also reflected units of service that did not match the units of service they billed; Provider A reported that they "absolutely did not (A, 2018)" bill any service as a 15-minute unit. Provider A reported that the majority of services they provided billed as a per diem, with a few hourly codes as well. Provider A repeated again that they did not bill or provide 15-minute units of service.

The UOIG expanded its review of DSPD claims, and identified instances of unusual services that are not authorized services under the Waiver SIPs. For example, DSPD billed Medicaid for Overnight Camping services provided by multiple providers on multiple occasions. However, neither the CS, ABI, nor PD Waivers include an overnight camping service option in the list of services authorized in each respective Waiver SIP. The DSPD-contracted providers contacted by the UOIG reported that they did not provide overnight camping services. After the conclusion of the Audit, DSPD staff reported, "Respite Care – Session is care rendered on a session basis which is provided to relieve, or during the absence of, the normal care giver which is furnished to a covered participant on a short-term basis in a facility or other approved community based entity. This code provides services as a part of camps, summer programs, extended respite programs, overnight camps and programs, and other comparable programs." DSPD did not offer an explanation or any documentation to address the discrepancy between

DSPD staff reports and DSPD provider reports regarding the possible provision of overnight camping.

During discussions with the UOIG about their billing processes and claim submissions, Provider A reported that the provision of some services to one individual would affect the billing and service provision of other individuals. The provider used the following example: Residential Habilitation Supports (RHS) is a daily rate service, so the provider bills per diem. However, if one of the roommates in a facility changes, that change should spread across the DSPD billing worksheet for all of the roommates in the facility associated with the change. This is because the roommate change results in a staffing change for the organization, which means that what the provider can and should bill for each individual also changes. They therefore change what they bill for each roommate in the facility each time another roommate's circumstances change. In response to Provider A's example, the UOIG discussed the concept of a finite service; either the provider provides a service to an individual, or they do not. What occurs with another person's service or with the provider's staff should not affect the service provided to the other individuals in that facility. Provider A reported that the example they gave is how DSPD directed them to bill, so that is what they had to do.

After meeting with providers and DHS staff during the 2018 investigation, the UOIG concluded that the situation necessitated further review and a deeper examination of DSPD policy and processes. As such, the UOIG undertook Audit 2019-01 to determine the current utilization practices of three Medicaid Waivers utilized by DSPD: the Community Supports (CS) Waiver; the Acquired Brain Injury (ABI) Waiver; and the Physical Disabilities (PD) Waiver, all solely operated by DSPD.

DSPD'S UNIQUE MEDICAID BILLING PROCESS

Upon discovery of potential discrepancies between the services reported by DSPD providers and the adjudicated Medicaid claims, the UOIG requested copies of service provision records from DSPD-contracted providers, from DSPD, and from UHIN for comparison, based upon the discovery of reported anomalies in billing between provider-described services and adjudicated Medicaid claims paid to those providers. Provider records submitted to the UOIG were largely insufficient to support billing. Further information about service record documentation is located later in this report, as well as in Audit Findings. DSPD records provided a framework of authorized services per individual, and UHIN was unable to locate the records in question. After extensive review by UOIG and by UHIN, it was determined that DSPD Medicaid claims do not follow more commonly used Utah Medicaid claim submission processes through UHIN. Instead, DSPD bills on behalf of their providers and sends their Medicaid claims directly to DOH in batch files on a scheduled basis using non-standard DSPD-specific service coding.

DSPD-contracted providers enter their service and billing information into DSPD's USTEPS database. Each Wednesday, DHS's Department of Technology Services (DTS) runs data from USTEPS. The system picks up any payments that are eligible for reimbursement, based upon eligibility codes. Senior DSPD financial staff provide DHS's DTS with the eligibility codes, which they program into the system, along with payment information, including DSPD service codes, units, and other fields of data from the Rate Master spreadsheet.

Once DHS DTS identified the eligible claims, DOH received DSPD's Medicaid claims through one of two batch files each week. DHS sent the batch files directly to DOH via email. DHS had

responsibility to submit the batched claims to DOH; DOH reported that they do not typically assist DSPD with the claims submission process. The twice-weekly batch files may arrive any day of the week, because there is not a schedule or set day for claim submittal. A variety of different personnel at DSPD send an email to the DOH each week to tell them that the batch files are ready for submission, and again to notify DOH of transmittal.

DHS DTS reported that once the system processes the batch and sends the transmittal notice, no one could change or correct a claim. The UOIG inquired about system controls or validation, and DHS DTS reported that they validate the number of units in a claim against the number of units available in an Individual's PCSP, and that they validate the customer directory to ensure that the client is eligible for service. If either of those two elements fail, they flag the claim, which goes into a table for DSPD to review and resubmit. They also have the ability to pick out a payment for validation, if desired.

DHS DTS reported that as long as the rate on a claim is less than or equal to the allowable rate, it will pass validation. DSPD provided DHS DTS with a spreadsheet that identifies the allowable rate. Access to change the allowable rate programming is role-based, so once DSPD provides the information, the maximum allowable rate typically remains unchanged unless or until DSPD submits a new allowable rate per service. The process generally presumes USTEPS claim validity, in terms of service provision; as long as the PCSP lists the service, and as long as the amount does not exceed Individual's remaining budget, claim approval normally occurs, and the batch may proceed to DOH for processing.

The programmers for DOH and DSPD automated the process, so that there is no human involvement in the system-to-system transmission. As a result, neither DHS nor DOH staff questioned could articulate the contents of a batch file, because they reported that they do not see the raw data. They additionally reported that they did not know of a way to provide a copy of the raw data to the UOIG. DOH did report, however, that they are able to see DSPD claims in MMIS after the system processes the batch. The UOIG also has the ability to examine claims in MMIS.

After the DSPD batch file reached DOH, it entered into the Medicaid Management Information System (MMIS), at which point MMIS ran the incoming files. The runs by MMIS occurred twice daily and MMIS automatically also ran a scheduled report to determine whether it rejected the claims from DSPD's batch file or not, based upon two DOH validations that each claim must pass. If rejected, the report will detail causation for rejection, and DOH then notified DSPD of either the acceptance or denial of the claims in question. According to DOH staff, there is a very low rejection rate for Medicaid claims submitted by DSPD, although they again could not articulate a number or percentage of denied claims, except to say that it was very low.

During the DSPD and DOH system-to-system processing for DSPD claims, the two DOH system validations involved a National Provider Identifier (NPI) and a provider verification. In the case of the NPI, the system verifies that the NPI is valid, in the event that an NPI was included on the claim. The second validation that occurs checks to verify the provider listed on the claim. When the provider is valid, claim acceptance occurs. DOH reported no other system validation beyond those two elements; as long as the NPI matches, and as long as the provider information is valid in the claim, the system automatically pays the claim from DSPD.

THE UOIG COULD NOT IDENTIFY ANY CORRECTED MEDICAID CLAIMS SUBMITTED BY DSPD DURING THE AUDIT PERIOD

DOH reported that DSPD works with UHIN to correct improper Medicaid claims. However, neither UHIN nor the UOIG could identify any corrected Medicaid claims submitted by DSPD during the Audit period.

It is possible that either DSPD does not work with UHIN to correct improper Medicaid claims, or that DSPD determined that no claims required correction during the identified Audit period.

DSPD did not provide a written policy governing their Medicaid claims corrections process, and discrepancies existed in processes reported by DOH and DSPD staff.

The lack of consistent information about if and how improperly paid DSPD Medicaid claims are corrected and monies returned is therefore an area of high risk for fraud, waste, and abuse.

In the infrequent event of a DSPD claim rejection by DOH, DSPD is responsible to correct the claim. DOH reported that DSPD works with UHIN to correct incorrect claims on a claim-by-claim basis, but UHIN was unable to locate any records in their database to support this. DSPD provided a series of conflicting responses about their claim correction processes. They initially reported that they worked with DOH to back out and correct claims, but later the same senior DSPD financial staff member reported that they were personally responsible to calculate any FMAP match and pay back funds for any incorrectly entered Medicaid claim. Additionally, when the UOIG met with DOH, and the Directors of OQD and DSPD, DSPD and OQD requested the flexibility to pursue any UOIG identified take-backs for improper Medicaid payments using their own processes for correcting incorrect claims. However, staff at each organization reported divergent practices for improper DSPD Medicaid claim correction, and each was unable to provide the UOIG with any documentation to support their respective interpretations of how the process works.

It is possible that either DSPD does not work with UHIN to correct the claims, or that there was not a single claim in need of correction via UHIN's assistance. Due to UHIN's inability to provide the records and the inconsistent information provided by staff, along with the inability of DSPD providers to produce sufficient records to support claims, the UOIG was unable to determine what may have occurred. It is also possible the DSPD worked with DOH, and/or determined the FMAP and paid back monies tied to any improperly paid Medicaid claims, or that there was not a single claim in need of correction through this process. Again, because neither DOH nor DSPD staff could provide documentation to support those processes, the UOIG was unable to determine what may have occurred DHHS provided documentation that resulted in additional areas of discrepancy. DHHS submitted copies of 11 letters addressed to DSPD providers that identified various overpayment amounts. Of the letters provided, 7 fell within the Audit Scope. DHHS further reported that they sent 85 payback or recovery letters to DSPD providers during this time. DHHS did not provide documentation to support the receipt of the money from DSPD providers, nor return of the Medicaid FMAP funds. Information verbally provided by DHS staff, OQD Auditors, DHS Internal Auditors, and senior DHS leadership during the Audit all indicated that although DHS may have identified overpayment amounts, DHS did not typically process financial takebacks from providers. Due to inconsistencies in staff reports, a lack of written processes and policies, and documentation supporting either

possibility, the UOIG was unable to determine what occurred. This was outside the Audit Scope, but the lack of consistent information about if and how improperly paid DSPD Medicaid claims are corrected and funds returned is an area of high risk for fraud, waste, and abuse.

If DSPD claims receive approval, DOH sends the payment to DHS in a lump sum for each respective batch of claims submitted by DSPD. The payment amount per batch varies, due to the claims included in that batch. The rate per claim also varies, due to the service and quantity identified in each claim. Investigation into DHS Medicaid claim payment processes determined that the only post-approval reconciliation of claims and payment that occurs is a verification of total dollar amount per batch. The UOIG met with several DHS financial staff within the Office of Fiscal Operations (OFO), who reported that as long as there is no discrepancy in the lump sum total sent by DOH, with the amount that DSPD anticipates receiving, no further reconciliation or action occurs. After OFO verifies that the amount received matches the expected amount, OFO releases the funds to DSPD. DSPD-contracted providers never see the Medicaid coding or claim, only the information that they have entered into USTEPS, and the payment from DSPD.

The DSPD Medicaid billing process is unique among Utah Medicaid claims. DOH reports that they are unaware of any other instances in which a claim might bypass UHIN, other than those of DSPD-contracted providers.

DSPD-CONTRACTED PROVIDERS' AUTHORIZATION TO PROVIDE SERVICE

In conversations with 69 separate DSPD Providers, the majority reported that they were unaware that they were Medicaid Providers, or that they provided Medicaid services. Only the larger provider companies who provided other Medicaid services to individuals outside of DSPD expressed any familiarity with Medicaid or the Waivers. Those that did express familiarity with the Waivers were unaware of Medicaid policies or regulations governing the provision of services, billing allowances, or service records and retention. Because of their lack of knowledge about their Medicaid provider status, and/or about the policies and regulations governing Medicaid, providers were not aware of the responsibilities they bore as Medicaid service providers.

Providers contacted during the audit reported to the UOIG that the PCSP acts as their initial authorization to provide services. However, when the need arises for a change in service level or quantity, providers report that they simply proceed with the new level, type, or quantity of service, and seek retroactive approval and reimbursement. Providers pointed out that once the individual is in their care; waiting for prior authorization is not feasible. Providers reported that because Medicaid Waivers mandate the provision of services to Waiver participants, DSPD must provide all eligible services to the enrolled individual. However, the resources available to achieve this are finite in nature. Consequently, DSPD and DSPD provider processes attempt to skirt the line between appropriate responsiveness to an individual's changing service needs, and inappropriately providing service outside of the authorization and funding to do so.

The UOIG spoke with DOH about DSPD service provision outside the authorization of a PCSP. A DOH Assistant Division Director (ADD) explained that "requiring service providers to amend care plans to account for each temporary fluctuation in services that are provided multiple times per week, and on an ongoing basis, would create a significant, undue administrative burden and would have the undesired consequence of forcing the waiver client into a more

regimented experience than would naturally occur[6]". She later added, "As long as the claims for each service do not exceed the total amount authorized for that service for the care plan period, the care plan is found to be in compliance[7]". However, DSPD Providers report that their standard procedure often involves a modification of the plan retroactively, to match the increased level of service or altered service type. Only once provided do they seek approval for the increased or changed service. Such a practice is not in keeping with the expectation that fluctuation may occur, so long as it does not exceed the authorization identified in the PCSP. Instead, providers interviewed during the course of the audit reported that they, along with the PCSP Team, regularly retroactively alter PCSPs to support changes in service that the provider has identified as necessary. Providers further reported that they always receive payment for these self-identified changes; DSPD does not deny claims for payment even when it exceeds the plan allowance.

SCE BILLING APPROVAL

DSPD staff and SCE providers reported that the SCE providers are responsible to review the monthly or quarterly log notes entered by other providers in USTEPS. This matches the responsibilities of an SCE provider outlined in their DSPD contracts. Each SCE provider is responsible to review all notes to ensure that each Individual receives quality services, and to note any progress or lack thereof made toward identified goals listed in the PCSP. DSPD reported that once the SCE provider reviews the log notes, the SCE provider is responsible to approve any subsequent billing submitted by the service provider. This also matches the Scope of Work within SCE provider contracts. SCE Providers, however, report that although they approve any billing submitted by service providers, it is the responsibility of DSPD and OQD staff to ensure billing accuracy for any submitted and approved claims.

SCE providers understanding of the billing approval process varied; some believed that DSPD and OQD staff checked billing accuracy during annual provider audits. Other SCE providers reported that DSPD verified billing prior to payment approval. Provider C, who employs several former DSPD staff members as SCE providers, verified that they, and all other SCE providers, are responsible to review log notes entered into the USTEPS database each month, or each quarter, and approve the log notes as part of their responsibility to approve billing submitted by traditional providers. Provider C said that the SCE providers are not, however, directly responsible to ensure that traditional provider's billing matches actual service provision, or that traditional provider billing accounts for any institutionalization or hospitalization of the Individual. Provider C reported that SCE providers look at the Plan, and make sure that the traditional provider has entered a log note into USTEPS. If so, the SCE provider approves the traditional provider's billing, at which point the claim goes to DSPD staff for the next part of the process. Provider C said that someone at DSPD should alter any submitted billing, to reflect dates of hospitalization, or if the billing approved by the SCE was otherwise incorrect. The provider further reported that only a service listed on a Plan would pay; any claim for a service not identified on the Individual's PCSP would automatically deny. The UOIG was unable to identify any information or documentation to support that any SCE providers compare actual service provision against submitted billing. It appeared that SCE providers counted on the passive USTEPS programming edits to catch any possible overbilling

[6] Emil from DOH Assistant Division Director, Utah Medicaid, to the UOIG, July 2011. Provided by UOIG Nurse Investigator, June 2019.
[7] Emil from DOH Assistant Division Director, Utah Medicaid, to the UOIG, July 2011. Provided by UOIG Nurse Investigator, June 2019.

or billing outside a plan, and either DSPD or OQD to catch any billing that did not match service provision.

DSPD PAYMENT TECHNICIANS

Provider billing and payment approval by DSPD at the initiation of Audits 2019-01 and 2019-05 was manual, and the responsibility of DSPD staff called Payment Techs. In 2019, DSPD payment approval within USTEPS and the internal billing system of USTEPS called CAPS moved from manual processing of forms to an electronic approval process. The UOIG met with several DSPD payment techs, USTEPS programmers, and DSPD financial staff to observe and learn about both the manual and the electronic payment approval processes.

When the DSPD payment approval process was manual, providers submitted their billing to DSPD through a form called a 520. DSPD's payment system automatically generated the 520 forms, which contained a grid of the provider's billing information that month, including all available or authorized services, the Individual's name, the start and end date of service, the eligibility code, the units of service, the rate of service, the subtotal, and the initials of the SCE who authorized the Provider's billing submission. Once DSPD generated the form, the service provider filled in the reimbursement rate and the number of units of service that they provided. The provider then sent the completed form to DSPD. DSPD payment techs then forwarded the 520 to each Individual's SCE. The SCE provider then approved or denied any billing listed on each provider's 520 form, as appropriate. If denied, the SCE worked with the provider to resolve any concerns, such as a lack of a monthly process note. If approved, the SCE provider initialed the 520 form to denote their approval of the billing. SCE providers then sent the approved 520 forms back to their assigned DSPD payment tech once per week, by a Tuesday evening deadline. Once DSPD payment techs received the 520 forms, they manually entered the billing and payment information into DSPD's system to create the payment. If the SCE providers did not submit the approved 520 to the payment techs before the deadline, it resulted in a delay in provider payment by DSPD. When the 520 forms moved to an electronic format, the overall payment approval process remained, with the exception of a new allowance of electronic signatures by service providers and electronic authorization by SCE providers.

DSPD payment techs, financial staff members, and USTEPS programmers all reported to the UOIG that automatic programming edits existed in USTEPS/CAPS to prevent unauthorized billing. If a provider attempts to bill for a service that is not included on an Individual's PCSP, DSPD's system will automatically deny the claim. Staff at all levels within DSPD referred to this passive control whenever asked about billing accuracy and verification.

While discussing the payment process, one DSPD payment tech demonstrated a "pay all" payment approval for the UOIG. She disclosed that although payments entered into DSPD's system could be broken out to allow for individual claim line approval, it was much easier to simply pay all submitted claims at once. The UOIG inquired about claims approval, and verification of accuracy and appropriateness of the submitted claims. If they used the "pay all" feature, did they first verify each claim for accuracy? Was payment appropriateness and accuracy verified in a separate process? Each DSPD payment tech that the UOIG spoke with reported that they were unfamiliar with the Individuals who received the service, the services provided, or the providers. As such, it was not their responsibility to verify billing accuracy, or claim appropriateness. If a claim arrived with SCE approval, the payment techs processed the payment.

By contrast, DSPD Financial Managers initially reported to the UOIG that DSPD payment techs verified billing accuracy prior to approval. However, after the 520 forms moved from a manual to an electronic process, the same DSPD financial staff members reported that the SCE providers were responsible to verify billing accuracy prior to claims approval, and that the payment techs were not responsible to ensure that the billing was accurate. The UOIG was unable to identify any information or documentation to support that any DSPD staff members verify actual service provision or review submitted billing and payment for appropriateness or accuracy. It appeared that DSPD automatically pays any service approved by an SCE within Plan allowances. The UOIG observed payment entry and processing, and met with staff and providers at each level of the process.

THE UOIG REQUESTED MEDICAID SERVICE RECORDS FROM DSPD PROVIDERS

The UOIG requested records from seventy-seven DSPD-contracted providers with unique Medicaid provider ID numbers. The UOIG requested that the providers submit records to support the provision of 1,757 combined services, and the subsequent payment for those services by Medicaid. The records requested by the UOIG represented a random statistical sample of claims paid by Medicaid during calendar year 2017 to providers contracted by DSPD for services provided to individuals assisted by DSPD. Additional details about the audit sample methodology is located in the Audit Methodology section of this report.

In response to the UOIG's request for records, DSPD providers reported to the UOIG that: Medicaid service records were inaccessible by the service provider and thus could not be submitted to the UOIG for review or audit; that DSPD had directed providers to destroy their copies of Medicaid service records; and that DSPD had directed providers to document service provision exclusively in DSPD's USTEPS database, to which providers lost access upon loss of client/transfer of service to a new provider. As a result, nearly one-third of the providers contacted did not provide any records to the UOIG, while others provided records for only some of the claims attributable to them in the Audit Sample.

Of the service record documentation submitted to UOIG for review by the fifty-seven remaining DSPD providers, nearly

A LACK OF DSPD PROVIDER SERVICE RECORDS

In response to the UOIG's request for records, DSPD providers reported to the UOIG that:

1. Medicaid service records were inaccessible;
2. DSPD had directed providers to destroy their copies of Medicaid service records; and/or
3. DSPD had directed providers to document exclusively in DSPD's USTEPS database, resulting in a lack of access to records.

Consequently, nearly one-third of the providers contacted during this audit did not provide any records to the UOIG, while others provided records for only some of the claims attributable to them in the Audit Sample.

Of the service record documentation submitted to UOIG for review by the fifty-seven remaining DSPD providers, nearly every record was insufficient to support billing for Medicaid services.

every record was insufficient to support billing for Medicaid services. Providers alternatively provided copies of service authorization forms from DSPD, copies of the PCSP, copies of worksheets detailing the planned rate and allowed hours per month, and copies of schedules of planned service delivery. Provider L submitted copies of their 'Grievance Procedure for Clients and their Advocates' policy as documentation of Medicaid service provision to clients identified in the audit sample.

The majority of providers who submitted more substantive records of service provision to the UOIG were SCE providers, who almost exclusively used log notes from DSPD's USTEPS database as documentation to support service delivery. Providers also occasionally referred to those log notes as progress notes, which is a more apt description of their content; the log notes submitted to the UOIG universally spoke of the individual's progress toward identified goals, or satisfaction with their service(s). The log notes almost never contained identifying information about the client, the provider, or the service, however. For example, they did not contain the client's full name or service provider's full name, and often referred to the client by a nickname only. The logs further lacked information that identified the service provided, or the amount or quantity of service provided. In some instances, the note specified that an SCE provider attested that a direct service provider attested to providing service, but did not offer additional detail, or verification of the type, quantity, or intensity of service attested to by either provider. In many other instances, notes contained single vague sentences such as "Progress maintained". Although some notes provided to the UOIG from the USTEPS database identified progress made toward satisfaction or personal goals, overall, the notes were generally insufficient to support billing Medicaid for reimbursement for all but casework management types of service. Even the logs that supported casework services did not always specify SCE casework occurred; a review of the logs resulted in a need for an auditor to presume casework service based upon the content.

After a review of the service record documentation submitted by providers identified in the Audit Sample, the UOIG was unable to ascertain the precise service provided; the quantity or amount of service provided; or the intensity of service provided, when applicable. The UOIG therefore determined that it was necessary to gather additional information about DSPD service record policies and processes. Because the Audit Scope of UOIG Audit 2019-01 excluded a review of DSPD service provision requirements, policies, and any subsequent provider guidance, the UOIG elected to initiate a second Audit targeted toward DSPD training, provider guidance, and policies surrounding Medicaid service records.

UOIG AUDIT 2019-05

While performing UOIG Audit 2019-01, which focuses on Medicaid Waiver Utilization by DSPD, the UOIG identified discrepancies between reported DSPD and DSPD provider practices. The UOIG also identified discrepancies between DSPD and DSPD provider practices and the contractual and regulatory Medicaid records documentation and retention requirements for these entities. DSPD Providers reported to UOIG that: historical (2017) Medicaid service records were inaccessible by the service provider and thus could not be submitted to UOIG for review or audit; that DSPD had directed providers to destroy their copies of Medicaid service records, and; that DSPD had directed providers to document service provision exclusively in DSPD's USTEPS database. Information provided to UOIG by DSPD staff directly contradicted information provided by DSPD providers; concerning record documentation and retention, DSPD staff reported that Providers must individually retain

service records and that those records remain available for annual audit and review by DSPD, DHS, and OQD staff.

In several instances, information provided by DSPD staff about internal processes was inconsistent with information provided by other DSPD staff about those same processes. In several other instances, information provided by DSPD staff was inconsistent with information later provided by those same DSPD staff members; responses to UOIG questions and requests for information changed repeatedly throughout the course of the Audit. Similarly, the responses by DSPD staff and OQD staff, DHS staff, and DOH staff were often inconsistent. For example, DSPD and OQD staff asserted that a thorough review of provider service records occurred each year during annual provider audits. However, when the UOIG requested copies of these records from providers, providers reported that they did not document to a level that would support the type, or quantity of service provided. Provider G reported, "It would be a nightmare" to document the quantity of service, or the start and end time of service provided each day. Provider G went on to say that they could not do that, and that DSPD "never asked for proof of six hours of service" for a per diem claim.

The UOIG undertook Audit 2019-05, to determine whether DSPD training and direction for contracted providers complied with DSPD contracts and/or Medicaid regulations governing service record documentation and retention. The UOIG also sought to determine whether DSPD provider practices complied with DSPD contracts and/or Medicaid regulations governing service record documentation and records retention requirements. The UOIG met again with staff throughout DSPD, OQD, and DOH to learn about DSPD service record documentation practices, DSPD and OQD annual provider audit processes, and to obtain copies of any written policies, training, or guidance maintained by DSPD and/or provided to DSPD providers related to service records and documentation.

In an effort to resolve the discrepancy between DSPD and OQD reported practices and the documentation submitted to the UOIG by DSPD providers, which did not reflect a level of detail sufficient to meet OQD and DSPD reported practices, the UOIG determined that it was necessary to learn about DSPD and OQD provider audit processes. The UOIG also elected to shadow OQD staff during traditional and SCE provider audits, to observe their processes first-hand.

DHS PROVIDER CONTRACTS

As previously detailed, several types of contracts for DSPD providers exist. The precise content of each type of contract varies slightly, dependent upon the scope of service and expected duties of each type of service provider. The location of requirements for service provision documentation also varies within each contract type, although the ABI.ID.RC and SCE provider contracts utilize consistent language to identify the necessary elements each provider must capture when documenting the delivery of service. Despite the differences between various contract types, each DSPD contract outlines DSPD and/or Medicaid requirements for the documentation and retention of service provision to DSPD clients somewhere within the body of the contract.

DSPD AND OQD ANNUAL PROVIDER AUDITS

Throughout UOIG Audits 2019-01 and 2019-05, DSPD and OQD staff repeatedly reported that they verify that service records match billing during annual provider audits. The UOIG met with staff on several occasions, to learn about current and historical processes, and to examine

the DSPD and OQD audit tools. The UOIG inquired about the differences in DSPD and OQD provider audit process, and any changes that occurred when OQD assumed responsibility for provider audits. OQD responses to the question varied; some OQD staff reported that nothing had changed, while other OQD staff on the same team reported that OQD had included additional qualitative questions regarding an Individual's level of satisfaction with the provider's service delivery. A review of DSPD and OQD provider audit tools supported the addition of qualitative elements after OQD assumed responsibility for the audits. Throughout this report, the UOIG shall reference either DSPD or OQD provider audit processes, as appropriate. The UOIG shall also reference DHS processes, as applicable.

Despite the inconsistencies in response regarding any changes that occurred after OQD became responsible for provider audits, both DSPD and OQD offered consistent responses about current OQD provider audit processes. OQD utilizes different types of provider audit tools for different types of provider audits. They have tailored these tools to the type of provider undergoing an annual audit. Each tool has specific audit directions that the OQD staff member must follow in order to rate each element of the provider's performance and compliance. OQD staff disclosed that although their audit tool does provide guidance, rating is sometimes subjective, based upon the auditor. OQD staff then detailed the steps and actions involved in each type of provider audit.

Traditional or ABI.ID.RC provider audit tools in Fiscal Year 2017 (FY17) directed staff to audit the following elements during annual provider audits:

- a review of medical and/or dental examination records;
- verification of medication dosage and administration;
- verification of the presence of an authorization for emergency medical treatment;
- verification of dissemination of the provider's grievance policy;
- an inventory of the client's belongings;
- verification of retention of Human Rights Committee authorization, documentation, and restriction information, and/or other applicable legal documents;
- verification that any checks for cash do not exceed $35.00 per month from the Individual's accounts;
- a review of the Individual's financial records and expenditures;
- verification that the Provider's staff did not accept money or loans from the Individual;
- an accounting of the Individual's petty cash funds;
- a review provider staff completion of mandatory training (e.g. completion of CPR training within 90 days of hire, key elements of the Americans With Disabilities Act within 6 months of hire, etc.); and
- a review of the Provider's internal policies for Emergency Procedures, Incident Reporting, etc.

The audit tool grouped each of the above named elements into separate sections for "contractor requirements", "staff requirements and training", and "Personal Budget Assistance (PBA)"

DSPD FY17 audit tools also included a section for the review of the Provider's Fiscal practices and client records, which included a requirement to ensure that the provider maintained "accurate records, such as attendance records and timesheets of all instances of service delivery" and that the provider "bills only for actual units of service delivered and maintains

records that adequately support delivery of such services" while maintaining "supporting documentation for payments which do not require time sheets and/or attendance logs". OQD staff who had been DSPD auditors prior to the creation of OQD, reported that in order to meet this requirement the auditor generally reviewed logs entered into USTEPS by the provider, and/or employee time sheets. FY17 audit tools allowed for a pass/fail feature on each compliance element named above; the auditor selected "yes" or "no" to each question. Staff reported that they used FY17 audit tools in FY18.

In FY19, the tools underwent minor changes to include a rating scale between 1 and 6 for qualitative questions relating to evidence that: "the Individual is struggling with unstable medical, behavioral, or mental health" needs; that the contractor made efforts to address those needs; that the contractor worked effectively in the PCSP team to make improvements to the Individual's life; and progress occurred. The same questions from FY17, regarding a review of "accurate records" remained, and OQD again reported that they looked at monthly summaries entered into USTEPS by providers to determine provider compliance with this requirement.

Much as DSPD did, prior to the shift in responsibilities, OQD staff conduct an annual provider audit on each contracted DSPD provider. They may conduct additional audits on a provider during the year if any concerns or complaints arise. OQD schedules the audit with the provider, and submits a copy of the Audit Tool to the provider 30 days prior to the audit, in order to help the provider prepare. DSPD staff use a formula to determine the number and precise selection of Individuals whose records OQD will examine during the audit. Five days before the audit occurs, OQD sends the provider a list of the selected Individuals. This allows the provider to gather all needed documentation, and to ensure everything is ready for the audit when the OQD auditors arrive.

OQD auditors reported that they review each section of the audit tool, grading provider compliance for each requirement listed on the tool. OQD staff review training completion, provider policies and practices, Human Rights restrictions, and provider records. Their focus is to ensure contract compliance with key requirements listed in the provider's contract with DSPD. The UOIG asked for additional information about a provider's service records; what precisely did the OQD look for, and what did they review to determine if those elements were present? OQD reported that most providers housed their records on-site. OQD staff check to ensure the records are stored in a secured area, either with passwords for electronic records, or with locks for physical records. The UOIG asked about the content of service records; should they contain any specific information, and did either DSPD or OQD provide training to providers about the expected content of a service record? OQD reported that most records consist of logs in USTEPS or of timesheets, but that outside of the NPO, providers do not receive any formal training on record keeping or expected record content. Instead, providers use the audit tools to prepare for an audit. OQD staff also provide feedback to providers during and after each audit, which OQD believed would result in the provider's full understanding of all DSPD and OQD expectations.

SCE provider audits vary from traditional service provider audits in that OQD conducts SCE audits in two parts. Initially, OQD staff perform a desk audit of the SCE provider, which occurs remotely. OQD staff read each log notes and entry entered into USTEPS, to determine the SCE provider's compliance with their contractual obligations. This portion of the audit typically takes one to two hours to complete. OQD then tabulates the provider's score and compliance using the audit tool, and visits the SCE provider onsite to complete the second portion of the

SCE provider audit. During the onsite, OQD auditors meet with the SCE provider to talk to him or her about the results of the desk audit.

Once OQD completes a provider audit, they send a letter to the provider detailing the written outcome of the audit. If any compliance element requires rectification, the provider must submit a plan of correction to OQD. OQD then approves or rejects the corrective action plan. If they reject the plan, the provider must resubmit a revised plan of correction until OQD is satisfied that the plan will result in provider compliance with their contractual obligations. When a plan of correction is necessary, OQD is also responsible to verify the provider's completion of each action item identified in the plan.

After OQD detailed each component of annual SCE and traditional service provider audits, the UOIG inquired about a financial audit component. While relaying their audit processes to the UOIG, OQD did not discuss a review of provider billing to a level that would ensure that any service provision matched the claims submitted to Medicaid. OQD staff again reported that they review service records, and reiterated each of the steps involved in a provider audit.

The UOIG identified a discrepancy in reported DSPD and OQD annual provider audit processes. Several DSPD and OQD auditors reported that they reviewed provider log notes as verification of service provision and service records. However, two other OQD auditors reported that only SCE providers, nurses, and DSPD staff had access to enter log notes into USTEPS; traditional service providers do not have that ability. DSPD staff verified that access within USTEPS is role-based; SCE providers have additional access and capabilities that other providers do not.

VERIFICATION OF SERVICE PROVISION AND BILLING ACCURACY

As detailed earlier in the body of this report, the UOIG asked staff members of DSPD, OQD, and DOH who was responsible to verify service provision and billing accuracy in relation to DSPD Medicaid claims submissions. DOH staff initially reported that DSPD verified service provision and billing accuracy, but later reported that OQD verified service provision and billing appropriateness through annual provider audits. DSPD staff provided inconsistent answers to the same question. In multiple instances, a DSPD staff member changed his or her answer several times over the course of the Audit. For example, a senior DSPD financial

DHS STAFF DO NOT CONDUCT FINANCIAL AUDITS OF DSPD PROVIDER MEDICAID CLAIMS

OQD staff initially reported to the UOIG that they verify service provision during their mandatory annual provider audits.

However, OQD staff later admitted that they did not look at variations in level or quantity of service, or at other indications of unusual service provision or billing patterns during their audits.

Instead, OQD staff appear to review qualitative aspects of service; annual provider audits focus strongly on the satisfaction of Individuals who received service, and any progress made toward each Individual's PCSP goals, but do not include a financial audit of claims and billing against documentation of specific dates, quantities, or intensity of service.

manager reported that other staff in DSPD's financial department reviewed claim submissions to ensure billing appropriateness and accuracy. However, months later, the same manager reported that no one in the financial department bore responsibility to verify service provision or billing accuracy. The DSPD financial staff that the senior financial staff member had initially identified as the party responsible for ensuring billing accuracy reported that DSPD payment techs verified billing accuracy prior to payment. DSPD's payment techs denied that they verified billing accuracy prior to payment, and instead reported that the SCE providers verified that all service provision matched submitted claims to ensure billing accuracy. The SCE providers reported that they only received monthly summaries from direct service providers, but that DSPD staff, and later OQD staff, verified billing accuracy and service provision through annual audits. Each group also pointed to internal edits in the USTEPS database that would automatically deny any claim that exceeded the budgeted amount available in any given PCSP.

Similarly, OQD staff reported that they verify service provision during their mandatory annual provider audits, but then later admitted that they did not look at variations in level or quantity of service, or other indications of unusual service provision or billing patterns during their audits. Instead, OQD staff appear to review qualitative aspects of service; annual provider audits focus strongly on the satisfaction of Individuals who received service, and any progress made toward each Individual's PCSP goals, but do not include a financial audit of claims and billing against documentation of specific quantities of service.

UOIG ONSITE AUDITS WITH DSPD-CONTRACTED PROVIDERS

The UOIG determined that onsite audits of several DSPD providers were necessary to evaluate the respective service documentation and retention practices of DSPD providers. The UOIG selected nine providers to audit in-person, based upon a variety of provider and service types, at geographical service locations throughout Utah. During the course of these audits, the UOIG identified prevalent trends in DSPD Provider service documentation and retention practices. Records supplied to the UOIG were, in turn, incomplete, insufficient to support Medicaid billing, and/or identified service provision inconsistent with Medicaid claims.

During the onsite audits, the UOIG questioned providers about the service records provided to the UOIG, which did not include sufficient information to detail a specific service, at a specific level/intensity of service, or in a specific quantity. The UOIG asked each provider for additional records that supported Medicaid claims identified in the Audit Sample. The traditional service providers unanimously reported that they did not provide the services identified in Medicaid claims listed in the Audit Sample. Providers also unanimously reported that the number of units of service billed to Medicaid did not reflect the number of units of service provided. One DSPD provider reported that DSPD directed them to submit inaccurate Medicaid claims. Another provider reported that DSPD did not give providers an option to back out Medicaid claims that contained errors, in order to rebill the claim correctly.

When the UOIG conducted an onsite visit with Provider F, the provider asked about a recent Payment Error Rate Measurement (PERM) audit. PERM audits serve to measure improper payments in the Medicaid program, and to ensure compliance with the Improper Payments Elimination and Recovery Improvement Act (IPERIA) (2012). CMS conducts PERM audits on a cycled schedule, reviewing a stratified random sample of claims in each state every three years. Provider F stated that they did not understand one of the components of a PERM audit that they had been involved with, and asked the UOIG Auditors to look at the PERM

documentation and to explain what the PERM auditor had documented. UOIG Auditors reviewed the PERM audit documentation, and identified services that corresponded with HCPCS coding. A discussion with Provider F about Medicaid and medical coding ensued. Provider F said that the services in the PERM audit were not DSPD services; the PERM description of services did not match the description of the services that they provide for DSPD. Provider F said that they only provided DSPD services, which matched DSPD coding and DSPD quantities of service. Provider F pointed to one of the services listed in the PERM Audit, as an example: two sessions of personal budget assistance (PBA) had changed into HCPCS coding for co-worker support or respite care services, and those descriptions did not relate to the service that Provider F actually provided. Provider F said that for another service the Medicaid coding for overnight services should have been a DSPD service called respite care, and that Medicaid coding for community wrap-around services should have been DSPD services for residential care. Provider F reiterated that none of the DSPD services they provided matched the Medicaid coding, either in service description or in quantity of service. The provider was extremely concerned that it appeared that they had billed Medicaid for the "wrong service" and in the "wrong amount".

The majority of the service records submitted by Provider G were either unavailable/missing, or were insufficient to support billing, in keeping with the service record documentation trends identified with other DSPD providers. However, additional areas of concern existed for the records Provider G did submit. In one instance, the records contained conflicting information. Provider G submitted records that claimed an individual received a single service at the same time from two different employees in two different service locations belonging to the provider. Other records submitted by Provider G included manifests with stated dates of service that either predated or postdated the date of the record creation by several weeks or months. Many records also included scratched out or altered dates of creation and/or service, leading to the appearance of possible tampering.

In addition to the documentation practices detailed above, Provider G also billed a per diem rate of service. Utah Medicaid per diem billing for these Waivers generally require 6 hours or more of service per day, although discrepancies do exist. For example, some of the more recent versions of the SIPs and DSPD contracts identify per diem service at six hours or more, but also define service as "as average of six hours" daily". The UOIG discusses this situation further in Finding 3.

DSPD PROVIDERS REGULARLY BILL FOR LARGER QUANTITIES OF SERVICE THAN WERE ACTUALLY PROVIDED

Utah Medicaid HCBS Waivers included in the Audit, and DHS provider contracts define per diem or daily rate billing as 6 hours or more of service per day.

DSPD providers, however, reported to the UOIG that "if [the individual] gets any service, we can bill for the whole day", and that "the standard is 4 hours", rather than Medicaid's and their contract definition of 6 hours or more.

DSPD Providers interviewed by the UOIG further reported that their billing practices fall within DSPD expectations and guidelines.

To meet fixed costs, DSPD reported that they allow providers to bill per diem for any portion of service provided when a per diem service is included in a Plan.

When the UOIG discussed Medicaid per diem billing requirements with the provider, Provider G's Executive Director disagreed, and reported to the UOIG that "if [the individual] gets any service, we can bill for the whole day", and that "the standard is 4 hours". The Director went on to say that, their billing practices fall within DSPD expectations and guidelines, and their processes have been in place since the advent of the Waivers.

Similarly, during the onsite audit with Provider E, the provider reported, "we just know to bill 18 hours per day" for day support services, "because it's an hourly code and the kids go to school for the rest of the time during the day". Provider E also reported that they knew to bill a specified number of hours for any given service, and that in terms of documentation, the provider presumes service delivery. For example, instead of documenting the actual service provided for day supports and residential services, Provider E maintains absentee logs that show when someone leaves, because they "cannot bill for them if they are gone for 24 hours". Provider E assumes that each individual was present and received every service identified on his or her respective PCSP, unless the absentee log shows an absence. Provider E then creates a monthly log or summary note that details progress toward the individual's goal, as well as a note to document that each individual's finances are up-to-date. The provider provides a brief statement to each individual's SCE that attests to service provision each month. Provider E pointed to their experience as a provider, their contract with DSPD, and verbal direction from DSPD and OQD during annual audits as authorization to document and bill in this manner.

The UOIG discussed with DSPD the question of providers billing per diem, when a shorter duration of service provision occurred. DSPD reported to the UOIG, "When people participate in a day program, those services are based on a daily rate with the expectation that they are receiving services for that time. For day support services, that is typically a 6 hour day of service. However, the daily service may be for shorter or longer periods based on the individual, and would be identified on the budget worksheet. Once that rate is set, if the person is there for less than or more than the typical hours the provider receives that daily rate. There are exceptions when a person may miss part of a day due to illness or an appointment. The [provider] would still receive the daily rate for that day so that providers can meet their fixed costs, including staffing."[8]

The UOIG discussed service documentation practices with each of the DSPD providers included in the onsite audits. The UOIG explained that billing Medicaid based upon a plan or schedule was insufficient to support billing; a provider should document each service provided with enough detail to support service provision. Provider responses varied; some expressed surprise and reported that they would speak with DSPD about it, while other providers disagreed. Provider G stated that the UOIG was incorrect, and that DSPD had never required that type of documentation. Despite the varying levels of response to UOIG's assertion regarding the need to document service provision, the providers unanimously reported that their current service documentation practices met DSPD and OQD guidelines.

Each provider the UOIG spoke with reported that their contract with DSPD governed the services they provided, as well as their standard service record documentation and billing practices. Providers further reported that DSPD and OQD auditors gave them verbal direction regarding acceptable or expected service record documentation and retention processes. Of

[8] Email from Director, Division of Services for People with Disabilities, to the UOIG, June 2021. Provided by UOIG Nurse Investigator, June 2021

DSPD DEFINITIONS OF A SERVICE RECORD DO NOT MATCH MEDICAID DEFINITIONS

DSPD and OQD definitions of a "service record" differ from UOIG and Medicaid definitions of a service record.

DSPD directs providers to focus upon the wellbeing and satisfaction of the recipient in their service record documentation. Meanwhile, Medicaid requires service record documentation with sufficient information to support Medicaid reimbursement for service provision.

DSPD Providers presently document service provision in accordance with DSPD and OQD expectations, but do not include sufficient details in their documentation to support the provision of a specific Medicaid service, in a specific quantity, on a specific date.

the providers included in the Audit Sample, fifteen reported to the UOIG that DSPD and OQD staff directed them to document service provision exclusively in USTEPS, while five others reported that DSPD had directed them to destroy their service records. When the UOIG questioned those five providers about the need to destroy records, the providers reported that DSPD believed it was a HIPPA violation to allow providers to retain service records or information about the Individuals receiving service. DSPD staff confirmed the provider's assertions regarding DSPD HIPAA concerns.

In 2021, OQD leadership changed, and DHS introduced a new OQD Director. Prior to that change, the OQD Director agreed with provider reports regarding their service record documentation and retention practices. He stated, "Providers document service in checkmarks and that is expected", and that "they document the way DSPD and DHS has instructed them to document". In discussions with the UOIG, the former OQD Director repeatedly asked that the UOIG take DHS and DSPD instruction to providers into account and make allowances for provider documentation practices because of DSPD and OQD direction. He indicated that a lack of detailed service documentation was normal and allowable.

UOIG SHADOWED ANNUAL DSPD PROVIDER AUDITS

Due to the discrepancy in the UOIG onsite audit outcomes with reported DSPD and OQD annual provider audit outcomes, the UOIG elected to shadow 12 OQD staff during a provider audit. This served to assist the UOIG in observing and understanding DHS provider audit processes. The DHS provider audit utilized FY19 OQD audit tools, and sought to examine provider compliance with DSPD, DCFS, JJS, and DHS Office of Licensing (OL) contractual requirements for the last year.

Upon arrival, the UOIG noted that Provider A had gathered over 40 large three-ring binders full of documentation for the OQD staff to audit. The binders filled a large conference room table, while additional binders waited in banker's boxes on the floor along the walls of the conference room. The provider disclosed information and about the OQD audit process, and confirmed DSPD and OQD reports of the evolution of the audit process during the transfer of responsibilities from DSPD to OQD.

OQD staff narrated their actions for UOIG and the provider's benefit. OQD elected to start with a review of the assembled provider binders, to ensure that the binders contained all pertinent information. This information included records regarding each individual's current condition and diagnosis, a photo of the individual, a copy of the PSCP, and in some instances documentation regarding doctor or dental visits. Once complete, the majority of OQD staff member selected a binder and began to audit its contents, while the staff dedicated to the OL and DCFS portion of the audit followed Provider A's staff into smaller rooms to begin OL and DCFS-specific audits. OQD staff paused periodically to talk about the next steps, or to answer questions by the UOIG or Provider A's staff.

Although each OQD auditor followed the FY19 audit tool, some auditors began their individual audit of the binders with different sections of the audit tool. For example, one OQD auditor began with the section concerning PBA records, while another started by verifying that the provider's staff received the required training. Despite the different starting point of each individual audit, the auditors adhered to the FY19 audit tool exactly; each auditor looked at the same type of records, and spent a comparable amount of time on each section of the audit.

OQD auditors spent the majority of each individual audit in a review of the provider's fiscal accounting of each Individual's personal monetary accounts, to ensure that no discrepancies existed in the personal finances of the Individuals receiving service. One OQD auditor explained that historically, Individuals had had their personal belongings and finances stolen by provider's staff members. As a result, DSPD prioritizes a review of an inventory of any personal belongings, as well as a review of receipts for spending of the Individual's personal finances, to prevent any future reoccurrence of theft.

By contrast to the length of time spent tallying receipts, OQD auditors spent very little time reviewing Provider A's monthly summary log notes. Of the approximately 35-45 minutes on average spent per Individual audit, OQD auditors spent about 2-4 minutes looking at the monthly summaries. The summaries did not include information about a specific service, in a specific quantity, on a specific day. One newly hired OQD auditor asked the OQD audit supervisor present if they could "drill down on this log to see what happened", as part of the audit, due to the lack of service information in the log note. The OQD audit supervisor replied that if any log note existed, its existence "met [the service provider's] contract minimum" requirements, and that it was therefore unnecessary to drill down and find out what service occurred; a log note meant the provider could bill for a service.

After the UOIG observed six OQD staff complete an audit on six of the binders, the UOIG asked the OQD audit supervisor about the dearth of service records reviewed during the OQD provider audit. The OQD audit supervisor disagreed; she reported that the contents of each binder qualified as service records. It became apparent that DSPD and OQD definitions of a "service record" differ from UOIG and Medicaid definitions of a service record. The UOIG explained that although the contents of the binders did contain records to support provider compliance with DSPD requirements for PCSP planning, individual satisfaction, and goal setting, the contents of the binders did not support the provision of a specified service, in a specified quantity, on a specified date, or at a specified level of intensity. The UOIG explained that Medicaid service records should contain sufficient information to support Medicaid claims submissions. Any DSPD provider service record should therefore include enough detail to support Medicaid billing, in addition to any other DSPD compliance requirements that the OQD auditors were looking for. OQD staff reported that they must follow the audit tool, and

complete the audit as designed. They reported that DSPD set the documentation expectations, and that a review of log notes detailing satisfaction levels served as proof that the provider delivered a service.

The OQD provider audit continued in this manner through the end of the audit, at which point the OQD audit supervisor and the OQD lead auditor asked all of Provider A's managerial staff to return to the conference room. OQD reviewed the outcome of the audit, and offered feedback to the provider. OQD reported that one Individual had a $114.96 discrepancy with their personal spending receipts, so Provider A needed to reimburse the Individual that amount. Another Individual needed assistance in obtaining an ID, which the provider pledged to do. Provider A also needed to add a missing signature to a third Individuals medication form. OQD reported that Provider A complied with all contractual requirements, and congratulated the provider on their excellent work. OQD made no mention of Medicaid or service record documentation.

HIGHLY VARIABLE QUANTITIES OF SERVICE EACH MONTH

In addition to shadowing an OQD onsite traditional service provider audit, the UOIG elected to shadow OQD during the completion of an SCE provider desk audit. While shadowing the work of OQD staff during the SCE audit, the UOIG observed the staff member access a service summary page for the Individual identified in the audit. The summary detailed the monthly service levels provided to that Individual over the span of several years. The UOIG observed a pattern of highly variable levels of service from month-to-month, which jumped between single digit units of monthly service to quantities of service approximately eight times that amount. The UOIG inquired about the needs of the individual, and whether or not such highly variable levels of service provision from one month to the next was common, both for that particular individual, and for individuals receiving DSPD services in general. OQD staff reported that in this case, the logs did not contain information that would indicate a need for a large variation in the quantity of service each month. The staff member then added that sometimes things occurred, which may necessitate increased or decreased levels of care. OQD staff provided an example about environmental or social factors that may influence the individual's needs and wishes, and thus affect the level of service provision in a given month. When asked if it was common for levels of service provision to increase by several magnitude one month, and then decrease by several magnitude the next month, back-and-forth each month, over a two-year period, OQD staff reported that they did not know; it was not something that staff looked at or tracked. The UOIG asked if seeing similar patterns would raise questions or concern during one of their audits, but OQD again reported that it was outside of the desk audit scope; the audit tool that OQD staff followed told them what to look at, and staff had to follow the audit tool. Therefore, service level or a variation in service level was not something that OQD or DSPD paid attention to. OQD again referenced their SCE audit tool and the SCE audit tool guide and reiterated that they followed the tool; they only looked at what the tool asked for.

OQD staff completed the desk audit in just over two hours; however, the amount of time spent looking at service provision and billing overall took less than 5 minutes, while the amount of time spent reviewing the variation in levels of service provision took less than 60 seconds. There was therefore a comparatively small portion of time during the desk audit dedicated to a review of appropriate and/or matched levels of service vs. billing for the service. During the audit, OQD staff explained that their main concern regarding billing and the history of service

DHS DID NOT INCORPORATE ANY OF THE PRELIMINARY FINDINGS THAT THEY REQUESTED FROM THE UOIG

In 2019, DHS requested preliminary audit findings from the UOIG. Although the UOIG does not typically disclose findings prior to the completion of an audit, DHS made a compelling case; the contracts between DHS and DSPD providers were nearing renewal, and DHS asked for access to UOIG recommendations early, in order to incorporate them into the new contracts.

The UOIG met with the OQD Director to discuss the preliminary audit outcomes in detail, and provided DHS with written copies of the preliminary recommendations. However, DHS did not incorporate any of those recommendations into their new contracts with DSPD providers.

provision was to ensure that the provider had attested to at least some amount of service each month. The auditor said that the amount of service a provider reported each month was far less important than a possible gap in service reporting would be, because a gap in service billing would indicate that a provider failed to provide a needed service, and that an Individual went without.

UOIG PRELIMINARY FINDINGS, AT THE REQUEST OF OQD

In spring of 2019, OQD Management requested preliminary findings from the UOIG. The UOIG advised the OQD that the request was unusual; the UOIG does not typically disclose the findings of an audit prior to audit completion. This is because the outcome of an audit may change as the auditors identify new information or documentation during the course of the audit; a preliminary finding may not always match the end result. However, the OQD made a compelling case. They stated that the contracts between DHS and DSPD providers were about to expire in July 2019 and that the contracting process for hundreds of providers was both time-consuming and labor-intensive. Therefore, rather than execute new contracts in July 2019, and then potentially again after the completion of the Waiver audits, the OQD asked the UOIG to release preliminary findings and guidance that the OQD could incorporate during the July 2019 contract renewal period. The UOIG agreed, and in May 2019 provided DHS, DSPD, OQD, and DOH with a letter containing preliminary audit findings and contract improvement recommendations, along with a caveat that the findings reflected the audit information to-date, and as such were preliminary in nature and may be subject to amendment as the audit progressed and additional information became available. *(Article 1)*

The UOIG's preliminary contract improvement recommendations to the OQD contained an example of a currently implemented contract that lacked sufficient information about the Medicaid program, Medicaid Providers obligations, or Medicaid billing and reimbursement for service provision. UOIG recommendations further identified examples of confusing and/or contradictory service records creation and service records retention requirements in the contracts. The UOIG therefore recommended that the OQD implement changes to "DSPD contracts with Medicaid service providers, to include clear language and detailed information about the Medicaid program and Medicaid provider responsibilities, including billing and documentation requirements".

After the July 2019 contract renewal period for DSPD providers had ended, the UOIG requested copies of the new contracts from

the OQD, in order to review the changes and evaluate the impact of those changes. In response, OQD's Director shared a copy of a letter that OQD had sent to DHS providers. The letter notified providers of an update to the contract process with DHS, wherein DHS would begin using an Approved Vendor List. The letter detailed the new steps that each provider must take, and DHS' reasoning for the change to their contracting process. The new contracting process was electronic, incorporated the approval of an evaluation committee, and resulted in Approved Vendor List (AVL). The letter further specified, "As changes are made in services and in the Scope of Work through the design process they will be published online"; however, during the July 2019 contract renewal period, the OQD did not incorporate any of the UOIG's recommendations into the contracts.

The incorporation of more robust and detailed information in DHS contracts about Medicaid, the Waivers, and each provider's respective responsibilities as a Utah Medicaid provider would also assist in alleviating issues identified in the Findings of this report, wherein the UOIG found that the majority of DSPD providers are unaware that they are Medicaid providers.

THE UOIG IDENTIFIED AREAS OF RISK OUTSIDE OF THE AUDIT SCOPE

The UOIG identified several areas of risk and potential non-compliance that fell outside of the audit scope for audits 2019-01 and 2019-05. The UOIG utilized strategic planning to identify the areas of highest risk, as well as to determine which areas of risk or non-compliance to include in or to exclude from this report. Although the UOIG elected to exclude the areas of risk listed below from this report, each demonstrates a lack of implemented controls by DOH, DSPD, and/or OQD. The UOIG made note of each occurrence, and may pursue them separately in a future audit.

1. DOH reported that there was a miscalculation in MMIS governing overtime for DSPD services, which resulted in a large number of denied claims. The system would see a claim for a service, and then see a second claim for the overtime associated with the service. When that occurred, the system would deny the second claim for the overtime, because it looked like a duplicate of the first claim. DOH reported that they fixed the issue, but that they were uncertain what to do about all of the historically denied claims. The denied claims are now past CMS's timely filing requirement, which prohibits DOH from paying the claims. DOH reported, however, that they might hold fair hearings for affected providers, and eventually pay the claims. The UOIG may elect to pursue this in a separate audit at a future date.

2. DHS staff and providers disclosed concerns regarding a potential conflict of interest within DHS to the UOIG that fell outside of the statutory authority of the UOIG. The UOIG referred the potential conflict to the appropriate agencies for review and possible investigation.

3. While conducting UOIG Audits 2019-01 and 2019-05, DSPD providers reported a series of complaints regarding: unfair treatment by DSPD; provider favoritism or preferential treatment of providers who were once DSPD employees by current DSPD staff; and a culture of conflicts of interest by SCE providers who used their influence to encourage Waiver Beneficiaries to select the companies of friends or family members as the service provider. DSPD Providers reported that vocalizing a complaint with DSPD often led to a loss of clients, and that DSPD selectively held some providers to a higher or

lesser standard than others, based upon friendship or other relationships. The UOIG and MFCU witnessed examples of these allegations. This is an area of potentially high risk; however, this area is outside of the direct audit scope of UOIG audits 2019-01 and 2019-05. The UOIG may elect to pursue this in a separate audit, or as part of an audit of Medicaid policies, training, and compliance at a future date.

4. In the course of UOIG Audit 2019-01, the UOIG identified a potential billing abnormality that would require sufficient provider documentation of service provision to investigate. Over the course of a year, a provider billed a particular service identified on the PCSP at a consistent level; the monthly number of units billed contained little deviation. However, during the last month of the PSCP, the provider billed a number of service units several magnitude higher than in the preceding months of the Plan. The provider acknowledged that their records did not support the increase in billing, but claimed that it must have been necessary. Log notes for the month with the billing increase contained only occasional notations such as "made cookies", "helped bake a turkey", and "no behaviors". The month with the increase also happened to be the last month of the Plan, and monies remained available in the Individual's budget for the service that saw a billing spike. The billing spike appeared to exhaust the remaining budget for those services, at the end of the Plan cycle.

   It is possible that the provider billed excess hours during the last month of the plan in order to spend down the remaining budget before the plan ended. However, further investigation would be necessary to determine if that occurred. An investigation to determine what occurred in this instance is not possible, due to the previously mentioned lack of sufficient documentation to support billing for the service. An investigation to determine if this was a singular instance, or if this is part of a larger pattern of provider billing spikes that may occur at the end of a Plan cycle in order to spend down any remaining monies in a "use it or lose it" approach is similarly impossible without more robust service documentation by DSPD providers. This is an area of potentially high risk. The UOIG may elect to pursue this in a separate audit, or as part of an audit of Medicaid service record documentation at a future date.

5. The information provided to the UOIG throughout Audits 2019-01 and 2019-05 changed on several occasions. Staff members at each level throughout DSPD, OQD, OFO, and DOH provided information that contradicted information provided by other staff members. In some instances, a staff member directly contradicted the information that he or she originally provided to UOIG. The UOIG verified each piece of information provided, to the extent possible, but in some instances independent verification was not possible. The UOIG has identified any instances in which staff reported information, but where supporting documentation did not exist. The UOIG identified this as an area of lower risk, and therefore did not include it among the formal findings. The UOIG does however, recommend the creation of written policies, processes, and procedures governing records, retention, billing and billing submissions, and claims accuracy, as well as training to staff on these measures. This is a scope limitation for Audits 2019-01 and 2019-05. The UOIG may also elect to pursue this in a separate audit, or as part of an audit of Medicaid policies, training, and compliance at a future date.

6. Section 1902(a)(32) of the Social Security Act dictates that State Plans allow Medicaid payment to limited individuals or entities. Similarly, federal regulations under 42 CFR

§ 447.10 prohibit Medicaid payment reassignment except in very limited circumstances. In the case of HCBS Waiver payments, CMS may authorize state agencies to act in a manner similar to that of a business agent, billing and receiving payment on behalf of providers. However, CMS requires that in such situations, states must give providers the choice to bill Medicaid directly, or to bill the state agency instead.

During Audit 2019-01, various providers reported to the UOIG that: they did not have a choice about billing DSPD instead of Medicaid; that DSPD incentivized providers to bill DSPD directly; and/or that they did not know they had a choice to bill Medicaid directly. DHS staff reported that 100% of the past and current DSPD-contracted providers had elected to bill DSPD instead of Medicaid. The contracts between DSPD and providers include language designed to influence the provider's decision to bill DSPD rather than Medicaid. It is possible that these factors circumvented provider's freedom of choice, although after the conclusion of the Audit DHHS reported that DSPD providers all sign a Voluntary Reassignment of Claims form. It is additionally possible that some of the Findings identified in this report would not have occurred, had DSPD providers billed Medicaid directly.

7. During Audit 2019-01, Provider I reported that all of the provider-related DSPD policies go through UACS first. Providers take their concerns directly to regularly scheduled UACS meetings to talk about issues, and brainstorm solutions. Provider I reported that the ability to take desired policy changes to UACS is why so many providers have joined the organization. Once providers reach a consensus at UACS, UACS sends the concern to DSPD, who usually acts on the issue, in accordance with the UACS request or decision. DSPD's Director and Senior Management attend UACS meetings on occasion, as well.

   Although it is beneficial to DSPD participants for DSPD to be responsive to provider concerns, providers should not write Medicaid policies; policies governing Medicaid programs should filter down from Medicaid to the providers, with provider input, as appropriate. It appears that the process may be working backward in this instance, and may have contributed to the areas of non-compliance with Medicaid policies and regulations. This is an area of high risk; however, this area is outside of the direct audit scope of UOIG audits 2019-01 and 2019-05. The UOIG may elect to pursue this in a separate audit, or as part of an audit of Medicaid policies, training, and compliance at a future date.

8. During Audit 2019-01, the UOIG examined Provider K's contract. Provider K acknowledged that transportation for Individuals might result in rides to medical appointments. The Waiver SIPs prohibit payment for transportation to medical appointments. Provider K reported that they did not maintain records of transportation, and were thus unable to disclose the precise date, location, or purpose of any given trip.

   There is a possibility that DSPD has distributed Waiver funds in violation of the Waiver SIP transportation limitations, but without sufficient records, the UOIG was unable to determine what had occurred. Additionally, Provider K received contracted payment for monthly service provision at a rate of $73.25 per month per person higher than that of the rate charged to the public. When the UOIG sought to obtain additional

information, DSPD and OQD responses to this situation contained multiple discrepancies. This is an area of high risk; however, this area is outside of the direct audit scope of UOIG audits 2019-01 and 2019-05. The UOIG may elect to pursue this in a separate audit, or as part of an audit of Medicaid policies, training, and compliance at a future date.

9. During Audit 2019-01, Provider J reported that the Utah Legislature allocated additional funding to DSPD, in an effort to increase the rate paid to direct care staff, in an effort to help retain direct care staff, and lessen the rising turnover rates for the industry. The legislative intent was to reward DSPD provider staff who work directly with Individuals. Provider J reported to the UOIG that they believe every single employee ought to receive the increased rate, and thus they bill DSPD at the direct care staff rate for every employee. Provider J theorized that even office staff and the company Director contributed indirectly to direct care; by doing their jobs, they "make service provision allowable".

   Senior Financial staff at DSPD reported that DSPD targets direct care during their annual rate setting process. This is due to the excessive levels of turnover in the direct care industry. As a result, there has been an upward trend in annual reimbursement rates. Provider J's practices appear to fall outside of Legislative Intent. This is an area of high risk; however, this area is also outside of the direct audit scope of UOIG audits 2019-01 and 2019-05. The UOIG may elect to pursue this in a separate audit, or as part of an audit of Medicaid policies, training, and compliance at a future date.

10. While conducting a NPO, both OQD and DSPD staff delivered inaccurate information to a new provider. This information incorrectly described the Medicaid Settings Rule, and incorrectly directed the provider to double bill for services if an individual moved into an institutionalized hospital setting. Although the issue of potential double billing while a Medicaid beneficiary is institutionalized does fall within the audit scope of UOIG Audit 2019-01, the audit sample did not contain any instances of it occurring. This may or may not be a result of the inaccuracies in DSPD billing and the lack of record documentation to support billing; double billing could occur, or it may not have occurred in the sample data examined in Audits 2019-01 and 2019-05. This is an area of high risk; OQD and DSPD staff may have directed countless providers to double bill. Through misinformation, OQD and DSPD staff may also have directed providers to attest to their respective compliance with the Settings Rule, when one or more providers did not actually achieve compliance with the Rule. The UOIG may elect to pursue this in a separate audit, or as part of an audit of Medicaid policies, training, and compliance at a future date.

11. In the course of UOIG Audit 2019-01, the UOIG identified an area of risk regarding anomalies in a provider's billing patterns. While reviewing a service summary that spanned several years' of service for a particular individual, the UOIG observed reported service provision and billing levels that varied greatly from month to month, over the course of two years. Log notes did not include sufficient detail to support the variation in service from month to month, but the quantity of service billed rose around eight times the amount from one month to the next, and then dropped down again. This pattern repeated, so that billing levels appeared largely varied from month to month. For example, the individual may have received 11 units of service in March, and then

86 in April, 12 in May, and 90 in June. The variation in levels of service continued throughout the two-year span included in the service summary.

UOIG AUDIT FINDINGS REMAIN RELEVANT, DESPITE A TEMPORARY AUDIT HOLD RESULTING FROM COVID

The UOIG inquired about the billing pattern; were large deviations from month to month typical? Did the individual's particular needs result in a varied service plan, from one month to the next? Had something occurred to contribute to a changing level of need each month? DHS staff admitted that they did not know; staff reported that when they looked at the summary, their primary concern was to ensure that *some* level of service occurred. DHS staff disclosed that they did not concern themselves with variation in service level each month, so long as there was no gap in service at any point. Their focus was to ensure that Individuals received services, and that the Plan listed each of those service types.

A lack of substantive changes in OQD documentation requirements submitted to the UOIG in February 2021, combined with the OQD's previous decision to postpone the implementation of any programmatic changes pending the outcome of the UOIG Medicaid Waiver audits, lead the UOIG to determine that the information and subsequent findings initially identified during the course of the Audits remains relevant, despite the temporary hold due to COVID.

DSPD and OQD's lack of follow-up regarding several large variations in an Individual's service levels each month illustrates the overall lack of DSPD reconciliation between what a provider bills, and the services that the provider may have actually provided. In this case, neither OQD nor DSPD examine unusual billing patterns. There appears to be an assumption that if the Plan allows the service, and they have not exhausted the annual budget for the service, any billing claim submitted by a provider must be valid. This approach, however, opens the door to an elevated risk of fraud, waste, and abuse of resources, as well as a risk that an Individual may actually not receive the service the provider billed.

It is possible that the provider may or may not have provided the varying levels of service they billed each month. However, an investigation to determine what occurred in this instance is not possible, due to the previously mentioned lack of sufficient documentation to support billing for the service. An investigation to determine if this was a singular instance, or if this is part of a larger pattern of provider billing with large monthly variation is similarly impossible without more robust service documentation by DSPD providers. Without documentation to support what occurred, it is impossible to determine if a potential need for highly increased and/or decreased levels of service each month drove the frequently changing service levels. This is an area of high risk. The UOIG may elect to pursue this in a separate audit, or as part of an audit in Medicaid service record documentation at a future date.

AUDITS 2019-01 AND 2019-05 TEMPORARILY PLACED ON HOLD DUE TO COVID-19

In 2020, the emergence of the COVID-19 Pandemic necessitated the reallocation and reprioritization of resources for many government agencies, including the UOIG. As a result, the UOIG chose to place Audits 2019-01 and 2019-05 on hold through 2021. The UOIG's decision was twofold. First, the decision allowed the UOIG to assist with and monitor frequently changing state and federal regulations in response to emerging COVID needs. Second, guidance from federal and state health authorities encouraged OIG offices to allow Medicaid providers to focus their efforts on service delivery as each provider adjusted to the challenges brought by COVID-19.

The UOIG returned to Audits 2019-01 and 2019-05 in late January 2021, although ongoing COVID concerns prevented a full-time return, and resulted in additional temporary pauses. In an effort to assess any changes that may have occurred in the DSPD Waiver programs during our absence, the UOIG requested information from DHS staff about the content of their contracts with DSPD providers, and about the current versions of OQD auditing tools. The UOIG also requested copies of all relevant documents. When compared to the copies of the documents obtained prior to the 2020 hold placed upon the Audit, no substantive changes had occurred to the OQD review tools or process. Likewise, the information provided by DHS staff supported that no substantive changes in procedure had occurred since the UOIG's last contact with DHS staff.

The currently executed versions of DHS contracts contained minor changes to formatting and content, in comparison to the previously reviewed versions of these contracts. Those minor content changes resulted in the addition of a new audit recommendation and in alterations to the language of another recommendation, but not of new findings, as the changes fall within a previously identified finding.

A lack of substantive changes in OQD documentation submitted to the UOIG in February 2021, combined with the OQD's previous decision to postpone the implementation of any programmatic changes pending the outcome of the Waiver Audits, has lead the UOIG to determine that the information and subsequent findings initially identified during the course of these Audits remains relevant, despite the hold.

OBJECTIVES AND SCOPE

2019-01 Audit Objectives:

1. Determine Waiver utilization, including provision of service, applicable rate, unit of service, and payment information for services provided by DSPD providers to participants on the Acquired Brain Injury (ABI), Community Supports (CS), and Physical Disabilities (PD) Waivers.
2. Determine if Waiver utilization information processed by DSPD matches the Waiver utilization information of DSPD-contracted Providers. This information includes both authorized and processed service(s), rate(s), unit(s), and payment records for individuals on the ABI, CS, and PD Waivers.
3. Determine if Waiver utilization information processed by the Department of Health (DOH) matches the Waiver utilization information of DSPD, and of DSPD-contracted Providers. This information includes both authorized and processed service(s), rate(s), unit(s), and payment records for individuals on the ABI, CS, and PD Waivers.

2019-05 Audit Objectives:

1. Determine whether DSPD Provider training and direction for contracted Providers complies with DSPD contracts and/or Medicaid regulations governing Medicaid service record documentation and records retention requirements.
2. Determine whether DSPD Provider practices comply with DSPD contracts and/or Medicaid regulations governing service record documentation and records retention requirements.

Audit Scope:

The scope of UOIG Audit 2019-01 sought to determine Medicaid Waiver utilization practices by DSPD and the Medicaid providers that DSPD contracts with, for the provision of services to individuals participating in DSPD programs. UOIG Audit 2019-05 sought to determine whether DSPD Provider training and direction for contracted Providers complied with DSPD contracts and/or Medicaid regulations governing Medicaid service record documentation and service records retention requirements during 2017-present. The Audit also sought to determine whether DSPD Provider practices during this time complied with DSPD contracts and/or Medicaid regulations governing service record documentation and records retention requirements.

Scope limitations for Audits 2019-01 and 2019-05 existed due to multiple factors. Fundamental limitations included a lack of consistent information provided by DHS staff, DSPD staff, OQD staff, and DOH staff governing all topics included in this Audit, as well as a lack of sufficient documentation to support DSPD's Medicaid billing submissions. Additional scope limitations existed due to a lack of provider training documentation by DSPD, and a lack of written processes for billing or provider onboarding by DSPD.

Utah's Department of Human Services (DHS) established the Office of Quality and Design (OQD) near the initiation of the Audits. OQD sourced staff from existing DHS departments, including DSPD. Upon formation, OQD became responsible for DHS provider contracting processes and for DHS provider compliance requirements, including provider audits. OQD reported that staff derived from DSPD would continue in very similar roles and capacities, albeit within OQD. Non-fundamental scope limitations arose from the organizational and procedural changes, as well as from the subsequent uncertainty and inconsistencies in information provided by staff regarding these processes.

The UOIG placed Audits 2019-01 and 2019-05 on hold during 2020, in response to the COVID-19 pandemic. Upon a return to the Audits in early 2021, the UOIG compared current DSPD and OQD provider contracts, audit tools, and processes with those identified prior to the hold, to ensure that Audit outcomes identified prior to the hold still remained relevant. The comparison between 2021 processes and documentation, and previously implemented versions led to minor modifications in UOIG findings and recommendations. The hold itself, the comparison of changes implemented during the hold, and the subsequent impact to the outcomes of these Audits are additional, non-fundamental audit limitations.

AUDIT METHODOLOGY

The UOIG used the following random sampling methodology in Audits 2019-01 and 2019-05:

The UOIG isolated the Medicaid recipients whose Medicaid claims submissions reflected DSPD Waiver utilization using the U4, U5, and U6 modifiers, which represent the PD, ABI, and CS Waivers, respectively. Recipients were isolated using one line for each element. The UOIG generated random numbers for each of the entries, and then sorted the claims accordingly. The UOIG then extracted claims by the generated random number, using random selection. As a result, the Audit Sample included multiple claims for some individuals enrolled on a DSPD Waiver, and none for other individuals enrolled on a DSPD Waiver.

In order to determine Waiver utilization, including provision of service(s), and applicable rate(s), unit(s) of service, and payment information for services provided by DSPD-contracted Providers to participants on the Acquired Brain Injury (ABI), Community Supports (CS), and Physical Disabilities (PD) Waivers, the UOIG:

- Collaborated with UOIG Data Scientists to identify and determine statistical sample for Audit purposes.
- Collaborated with UOIG Nurses and Investigations staff, who previously identified information regarding ABI and CS Waiver services through DSPD, to determine steps taken and information obtained.
- Interviewed and/or Surveyed relevant personnel from DSPD, DOH, and DHS OQD to identify existing policies, procedures, and practices for Waiver Enrollment, PCSP creation, Service Authorization, Service Documentation, and Provider selection.
- Identified authorized service(s), rate(s), unit(s), and payment information, along with the associated DSPD-contracted Service Provider(s) for each service, for each individual in audit sample.
- Obtained contact information from DSPD for each identified Service Provider associated with an authorized service.
- Obtained information about Waiver-related service provision, business practices, and policies from each applicable DSPD-contracted Provider.
- Interviewed and/or Surveyed relevant personnel from the identified DSPD-contracted Providers to identify existing policies, procedures, and practices.
- Audited/Visited 10 providers on-site at their place of business, to review records, observe business practices, and learn about their policies and procedures.
- Obtained copies of Log notes, records of service provision, PCSPs, and other service provision information, including units, rates, and payment information from each provider, or each Individual identified in the Audit Sample.
- Interviewed and/or Surveyed relevant personnel from DSPD, DOH, DHS DTS, DOH DTS, DHS OFO, DHS OQD, and UHIN to identify existing policies, procedures, and practices as Medicaid Waiver Billing and Claims responsibilities moved from one organization to the next.
- Collaborated with UOIG Investigators to Review submitted Service Plans and records of Service Provision.
- Sought to determine Service Provision for each identified individual.
- Sought to determine authorized rate(s) for each service.
- Sought to determine the number of unit(s) provided for each service.
- Sought to determine the corresponding payment information for each service.

In order to determine if Waiver utilization information processed by DSPD matches the Waiver utilization information of DSPD-contracted Providers. This information includes both

authorized and processed service(s), rate(s), unit(s), and payment records for individuals on the ABI, CS, and PD Waivers, the UOIG:

- Collaborated with UOIG Data Scientists to obtain service, rate, unit, and payment information for individuals identified in Audit Sample.
- Interviewed and/or Survey relevant personnel from DSPD to gain an understanding of existing policies, procedures, and/or practices related to services, service authorization, and billing.
- Interviewed and/or Surveyed DSPD, DHS OFO, DHS DTS, DHS OQD, DOH, DOH DTS, UHIN, and UOIG Data Scientists to examine DSPD Rate Master/Crosswalk to determine how each party enters and processes Waiver billing information, how the information moves from each respective agency's system to the next system, and what the result/outcome is.
- Reviewed authorized, billed, and adjudicated claims of Medicaid Waiver utilization for each individual identified in UOIG Audit Sample.
- Compared DSPD Waiver utilization information to DSPD-contracted Provider's Waiver utilization information.
- Identified any discrepancies in Waiver utilization information between DSPD and DSPD-contracted Providers.

In order to determine if Waiver utilization information processed by the Department of Health (DOH) matches the Waiver utilization information of DSPD, and of DSPD-contracted Providers. This information includes both authorized and processed service(s), rate(s), unit(s), and payment records for individuals on the ABI, CS, and PD Waivers, the UOIG:

- Collaborated with UOIG Data Scientists to obtain service, rate, unit, and payment information for individuals identified in audit sample.
- Interviewed and/or Survey relevant personnel from DOH, DOH DTS, DSPD, DHS DTS, DHS OFO, DHS OQD, and UHIN to gain an understanding of existing policies, procedures, and/or practices related to services, service authorization, and billing.
- Collaborated with UOIG Data Scientists to examine DOH Crosswalk and MMIS, in an effort to determine how DOH processes DSPD Medicaid claims information through the system, and what the result/outcome is.
- Sought to review authorized and DOH processed Waiver utilization for each individual in audit sample.
- Compare DOH Waiver utilization information to DSPD Waiver utilization information.
- Compare DOH Medicaid Waiver utilization, claims, and billing information to DSPD-contracted Provider's Waiver utilization, claims, and billing information.
- Sought to identify any discrepancies in Waiver utilization information between DOH and DSPD, and/or between DOH and DSPD-contracted Providers

In order to evaluate current DSPD operational processes, training, and the direction provided to DSPD providers by DSPD, and to determine the compliance of such processes with Medicaid and with DSPD contractual requirements, the UOIG:

- Interviewed relevant DSPD, DHS OQD, and DOH personnel to identify DSPD- contracted provider enrollment, provider onboarding, and provider training processes.
- Attended DHS OQD New Provider Training/Onboarding.
- Attended a walk-through of DSPD's process for Medicaid Provider Enrollment.
- Reviewed and obtained copies of DSPD training and onboarding processes and guidance given to DSPD providers.

- Shadowed DHS OQD, DSPD, DHS OL, DCFS, and JJS staff on a large-scale full-day DHS Provider Audit, observed DHS OQD/DSPD provider audit processes and procedures, and interviewed staff and providers.
- Shadowed DHS OQD staff during a SCE Provider Desk Audit, observed DHS OQD/DSPD provider audit processes and procedures, and interviewed staff.
- Interviewed DOH/Medicaid personnel to identify DSPD provider enrollment and training processes.
- Interviewed DSPD Providers to identify enrollment and training processes, and any guidance given by DSPD and/or DOH/Medicaid regarding Medicaid service records documentation and retention expectations.
- Obtained copies of DHS OQD and DSPD audit tools and forms, provider NPO tools and forms, and DSPD Provider onboarding and Medicaid enrollment paperwork and forms.
- Compared the information and records provided by DSPD Providers with information and records provided by DSPD and by DOH/Medicaid.
- Compared the information provided by DSPD Providers, DSPD, and DOH/Medicaid with DSPD Contracts and Medicaid policies governing service record documentation and records retention.

In order to evaluate the compliance of DSPD Provider records documentation and retention practices with Medicaid requirements and DSPD contractual obligations, the UOIG:

- Reviewed historical and existing DHS OQD and DSPD policies and applicable contracts to determine DSPD records documentation and retention requirements.
- Reviewed Medicaid Policy, Utah Code, Federal Code, and other applicable regulatory requirements governing Medicaid records documentation and retention.
- Interviewed DSPD Providers and conducted an onsite Audit of DSPD-contracted provider service records following DSPD reported practices.
- Reviewed UOIG investigation report and results regarding DSPD and DSPD Providers' records and records retention.
- Reviewed service provision records and documentation submitted by DSPD Providers who were included in the sample of DSPD Waiver Utilization records from UOIG Audit 2019-01.
- Compared information provided by DSPD Providers with information obtained by UOIG Investigators, information from DOH/Medicaid personnel, information provided by DSPD and DHS OQD staff, information contained within DSPD and DHS OQD Contractual requirements, and with Medicaid policies and regulations governing service record documentation and records retention requirements.

The UOIG conducted this Audit in accordance with the Principles and Standards for the Offices of Inspector General (OIG), which incorporate Generally Accepted Government Auditing Standards (GAGAS) issued by the Comptroller General of the United States. 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 upon our audit objectives.

CONCLUSION

The UOIG appreciates the assistance and cooperation of Utah's DOH, DOH DTS, DHS, DSPD, OQD, DHS OFO, DHS DTS, and of their respective staff. During the course of the Audit, staff at all levels demonstrated a clear desire and willingness to assist in the audit process, and vocalized support for opportunities to improve outcomes for all involved. The UOIG recognizes their dedication to the individuals served by Utah's HCBS Medicaid Waivers. These Waivers provide key services to a vulnerable population in home and community-based settings. Taxpayer resources, and funding for these Waivers is, however, limited. Any opportunity for increased efficiency in Waiver operation would benefit all involved.

While conducting Audits 2019-01 and 2019-05, the UOIG identified numerous areas of risk and noncompliance. Although each may merit a formal finding and recommendation, the UOIG determined that prioritizing the areas of risk would best serve Utah's taxpayers, Utah's Medicaid Program, DSPD, and the individuals whom DSPD serves. As a result, this report included details and recommendations for the program areas with the greatest level of risk. The UOIG anticipates future involvement to evaluate the outcome of implemented changes that may result from these audits, and to reassess programmatic risks.

LEGISLATIVE NEED FOR THE INCLUSION OF CONTROLS IN UTAH'S MEDICAID WAIVERS

Medicaid Waivers present an opportunity for Utah to target specific demographics in need of specialized health care. However, insufficient controls governing how Utah Medicaid Waivers operate has led to heightened risks of fraud, waste, and abuse, of what are already limited resources. As a result, utilization of Utah's Waivers may not always meet the intent of the program.

An opportunity therefore exists for more robust legislative involvement in the writing of Utah Medicaid Waiver program guidelines.

FINDING 1 — DOH KNOWINGLY ACCEPTED INACCURATE DSPD MEDICAID CLAIMS

Although other Medicaid providers in Utah submit their Utah Medicaid claims directly through UHIN, DSPD-contracted providers bill DSPD, who pays their contracted providers for the services they provide to DSPD Waiver recipients. DSPD then submits claims to Medicaid on behalf of providers, for reimbursement of the monies paid out to those providers. DSPD and DOH reported that every current DSPD-contracted provider has chosen to bill DSPD, and to allow DSPD to bill Medicaid on their behalf. DSPD and DOH also reported that no provider has ever historically chosen to bill Medicaid directly. The providers that the UOIG met and spoke with during the audit reported that they were strongly encouraged to bill DSPD, and not to bill Medicaid. Some providers claimed that DSPD incentivized them to bill through DSPD, while others reported that they did not have a choice about using DSPD to bill Medicaid on their behalf. CMS has authorized DSPD to bill Medicaid on behalf of DSPD-contracted providers, but has determined those providers must have a choice in the matter. After the conclusion of the Audit, DHHS reported that DSPD providers all sign a Voluntary Reassignment of Claims form.

CMS has authorized DSPD to bill Medicaid utilizing a reassignment of claims model of billing, as outlined in Utah's Waivers. The CS Waiver SIP specifies, "1. All providers participating in this 1915 (c) HCBS Waiver must: a) fulfill the DSPD State contracting requirement as one of the waiver provider qualifications related to compliance with State law, and b) agree to bill the MMIS directly or Voluntarily Reassign Payment to DHS/DSPD." However, despite CMS approval of DSPD's Reassignment of Claims in the Waiver SIPs, it is unlikely that CMS anticipated the resultant billing inaccuracies. Further information about Reassignment of Claims is located in the Reassignment of Claims section of this report, as well as in subsequent Findings.

DSPD claims enter directly into Utah Medicaid's claims process system without the initial processing by UHIN that is typical of most other Medicaid claims in Utah. Further investigation into DSPD Medicaid claims processes determined that the payments sent to DSPD by Medicaid arrive in similar batches. The only reconciliation of claims that occurs is a verification of total dollar amount per batch, to ensure that the lump sum amount received from DOH matched the anticipated amount reported to DHS OFO by DSPD.

The UOIG identified several levels of inaccuracy and inconsistency in DSPD Medicaid claims billing and processing while conducting UOIG Audits 2019-01 and 2019-05. Adjudicated Medicaid claims paid to DSPD-contracted providers did not match the services those providers professed to providing. The quantity of service units billed by these providers also did not match the adjudicated Medicaid claims, and in some instances, the number of units billed exceeded the possible number of units within the given timeframe. Investigation determined that DOH allowed DSPD to bill Medicaid in a unique process unavailable to other Medicaid providers in Utah. Those billing processes directly contributed to the Medicaid claim discrepancies identified in UOIG Audit 2019-01.

Throughout Audits 2019-01 and 2019-05, staff within DOH, DSPD, DHS, DTS, and UHIN each provided information about DSPD's Medicaid claims and billing process that contradicted the information provided by the other agencies involved. In some instances, DHS and DSPD staff members also contradicted other DHS and DSPD staff members, and even their own previous

assertions. One key contact identified by DSPD as a subject matter expert provided the UOIG with information that directly contradicted her previously provided information nearly every time that the UOIG spoke with her. Changing information provided by DOH, DHS, and DSPD staff, combined with a lack of written internal processes resulted in levels of inconsistency regarding DSPD's Medicaid billing process.

The UOIG met with DOH and DSPD staff at multiple levels, to learn more about how DSPD and DOH crosswalk DSPD claims into HCPCS codes. Each individual reported that it begins with the annual rate setting process. This results in a standard rate per service, according to DOH, who reported that once the Legislature has allocated funding to DSPD; DSPD sets a rate per service into an Excel spreadsheet. DSPD and DOH staff referred to this spreadsheet as the Rate Master, or the Crosswalk. Some staff reported that the two names are interchangeable. There was a general lack of consistency between DOH and DHS staff when referring to either the Crosswalk or the Rate Master. For example, DHHS reported that the two have "different meanings in processes", although staff understanding of which was which varied and any explanation offered by one staff member often contradicted information provided by other staff members.

After DSPD has set the rate per service per unit, they submitted the Crosswalk to DOH, who is now to DHHS. After submission, DOH/DHHS must approve the document containing the crosswalk of service codes, and the rates per service. Upon DOH/DHHS approval, they each program the new rate into their respective systems. DOH reported that the technical crosswalk, where the service code identified by DSPD transforms into the service identified by a HCPCS code, occurs at this point. Typically, only the programmed rate per service in the Rate Master changes from year to year: DOH explained that although a HCPCS code may also change, it does not usually happen.

Despite DOH assertions regarding payment at standard rate per service, DSPD staff reported that there were several potential rates for a given service, depending upon the intensity of service provided. DSPD providers agreed with the variable rate ascertains made by DSPD. DOH reported that DSPD claims do not include traditional CPT or HCPCS modifiers that would affect the standard rate per claim. Although DSPD staff responses varied considerably regarding this topic, it appears that the Crosswalk identifies a Maximum Allowable Rate (MAR) per unit of service, and that DOH considered that the standard rate. Meanwhile, DSPD may pay less than the MAR, dependent upon the intensity of service reported by a provider.

After the conclusion of the Audit, DHHS reported, "For many services, the maximum allowable rate (MAR) is the rate the majority of providers bill, but there are also services where this is appropriately not the case. For example, the Residential Habilitation Services MAR listed in the approved SIP is $589.17/day, yet depending on the intensity of services individuals need, the average actual daily rate paid for Residential Habilitation services in recent years has been substantially less than the MAR: $250 for general residential, $190 for host home services, and $205 for professional parent services. This individualized rate approach as opposed to a one-size-fits-all results in cost savings to the state". The issue of a MAR vs. a standard rate may further contribute to the various discrepancies surrounding DSPD claims and Waiver utilization, because it adversely affects the ability to attempt to identify the service on a claim by the rate paid.

DOH and DSPD staff acknowledged that the DSPD Medicaid claims data did not match the information submitted by DSPD-contracted providers, but said that the nuance and levels of intensity of service provided by DSPD providers necessitated more codes than HCPCS has available. DSPD also believed a use of HCPCS codes could confuse both their providers and the individuals who receive these services. Although DSPD reasoning regarding nuance has validity, every one of DSPD's nuanced service codes must still eventually translate into a HCPCS code, in order to bill Medicaid and draw down the Federal Match. Removal of the middle DSPD coding step that results in so much inconsistency regarding the actual service provided and billed for, as well as inaccuracy regarding the actual quantity or duration of service, is therefore feasible.

Because DSPD service codes used by DSPD and DSPD providers do not match HCPCS codes, when questioned about service provision, DSPD providers insisted that they did not provide the services reflected in their Medicaid claims. Providers also document, to the limited extent that has become normative for DSPD providers, according to the service code they believe they are providing. Unfortunately, when the service type, unit type, or unit quantity changes during the billing process, this results in provider documentation that does not capture the extent of information necessary to support Medicaid billing. For example, a provider may document a service that he or she believes to be billable in a single daily or per diem unit. However, once the DSPD crosswalk sends that billing information to Medicaid, the Medicaid claim becomes several 15-minute units of service. Upon examination of the service record documentation, the provider does not have sufficient documentation to support the start or end times of the service, and thus cannot demonstrate that they provided the number of 15-minute units identified on the claim that Medicaid paid for. The provider also does not know that the service or unit has changed, and then refutes the Medicaid billing claim.

After the conclusion of the Audit, DHHS reported, "We acknowledge there is work to do to educate providers about their roles and responsibilities as Medicaid providers." The UOIG identified circumstances in which providers reported that they did not provide the services listed in the Medicaid claims, to which DHHS responded that the crosswalk "aligns HCPCS codes that appear on Medicaid claims with the local codes that providers use to submit claims to DSPD." They further reported, that providers "likely did not recognize the HCPCS codes because they use the local codes". DHHS accurately reported that the UOIG did not identify "evidence that Medicaid claims were submitted for services that the provider did not deliver", but this is a natural result of the lack of supporting service record documentation captured by the providers during the provision of service. Neither the UOIG, DOH, nor DSPD is currently able to review sufficiently detailed service record documentation that would allow for the identification of billing outside of actual service provision. The UOIG discusses these implications further in subsequent Findings of this report.

In addition to the billing trends identified above, the UOIG also observed several billing anomalies while conducting DSPD provider audits. Two DSPD providers included in the Audit Sample billed Medicaid for more units of service than were possible in the given timeframe associated with each respective claim. Provider B billed Medicaid once for 960 units of service, when only 672 units of service were possible, assuming around-the-clock 24-hour care. Provider B next billed Medicaid for 512 units of service during a time frame in which only 288 units of service were possible, again assuming 24-hour-a-day care. Because of DSPD's unique billing process, neither DSPD nor DOH's billing system caught either claim. As a result, both claims paid out, resulting in an overpayment of 512 combined units of service. Similarly,

Provider W billed Medicaid four times for services with a number of units that exceeded the possible number of units of service available during that period of time. Provider W's claims totaled 2,046 units of service, when only 1,920 units of service were possible, assuming 24-hour per day care, during the combined service dates. Again, the claims paid out due to the unique billing process utilized by DSPD and DOH, resulting in 126 units of service that were improperly paid.

Each of the above detailed processes falls outside of typical Utah Medicaid billing practices. DOH reported their awareness of DSPD billing discrepancies, yet chose to allow the process to continue, in favor of correcting the system. If systematic billing discrepancies were the only issue identified, it may have been possible, although not ideal, to continue to use an inaccurate billing system. However; combined with a lack of service documentation to support billing, the lack of clear policies and contracts governing the Waivers, and a pattern of billing utilizing inaccurate information, each detailed in the subsequent Findings of this report, the UOIG makes the following recommendations:

RECOMMENDATIONS

1.1 The UOIG recommends that DHHS write and implement universally applicable policies wherein all Utah Medicaid providers and billing agents must bill Utah Medicaid using a standardized process to allow documentation, training, and auditing for each respective Medicaid service industry.

1.2 The UOIG recommends that DHHS write and implement policies wherein all Utah Medicaid providers and billing agents must bill Utah Medicaid without need for a crosswalk of billing or service codes, using Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) Codes/Proprietary Laboratory Analysis (PLA) Codes.

1.3 The UOIG recommends that DHHS amend Utah Medicaid billing policies to include a prohibition against the submission of inaccurate Medicaid Claims.

1.4 The UOIG recommends that DHHS install meaningful and actionable controls to prevent non-enrolled providers or entities from billing Medicaid using the Medicaid provider IDs of enrolled providers.

FINDING 2	DSPD DIRECTS CONTRACTED PROVIDERS TO SUBMIT INACCURATE MEDICAID CLAIMS

Any review of Medicaid claims data should result in the ability of CMS, DHHS and the UOIG to determine the service provided, in what quantity, to whom, by whom, and on what date. However, the current billing model that DOH and DSPD designed does not result in Medicaid claims that accurately reflect these elements of service provision. Instead, several DSPD practices combine to result in Medicaid claims that do not match actual service provision reported by the service providers. DSPD submits, and directs contracted providers to submit inaccurate Medicaid claims. DSPD also authorizes its providers to provide service in lesser quantities than required by the Medicaid Waiver SIPs, while billing for those services at greater quantities than provided. These two practices, along with the unique billing process utilized by DSPD and detailed in the body of this report combine to result in layers of inaccuracy in DSPD Medicaid claim submissions. Consequently, adjudicated DSPD Medicaid Waiver claims do not match the service or quantity of service reportedly provided by DSPD-contracted providers.

DSPD directs its providers to submit Medicaid claims with inaccurate dates of service. Initially during UOIG's 2015 investigation, and again during Audits 2019-01 and 2019-05, DSPD presented the UOIG with a letter, which states that they have asked their FA providers to submit Medicaid claims using inaccurate dates of service in an effort to avoid denied Medicaid claims for services. DSPD and their workgroup purportedly sought to correct this situation via in-house solutions to their billing processes in 2015. However, as of the publication of this report, DSPD still directs providers to follow inaccurate billing processes.

During an onsite audit with Provider B, the provider verified that as a FA, DSPD directs them to bill all SAS services using inaccurate dates of service, in order to prevent denied Medicaid claims for service. The provider referenced a letter from DSPD that outlined the procedure, but was initially hesitant to provide a copy of the letter to the UOIG. Provider B reported that the SAS providers, whose payroll they process, frequently submit late timesheets. Provider B felt that DSPD's directive was the best way to prevent a series of denied Medicaid claims that they would later need to amend and rebill correctly.

Provider B reported that DSPD directs FA providers to bill using inaccurate dates of service. Provider B reported that in their office, they chose to submit payroll for any timesheets turned in to their office at the beginning of the month using contrived dates of service from the 1st through the 7th day of the month. Any timesheets turned in after they submitted those claims would reflect service dates of the 8th through the 12th. If a third set of timesheets arrived, Provider B said that they would "improvise". The process then repeated for the two weeks during the second half of each month. Provider B said that the actual dates of service listed on each SAS provider's timesheet did not matter; all billing submitted to DSPD by Provider B used those pre-identified periods of service, to avoid denied Medicaid claims. Provider B named a senior level Fiscal Manager at DSPD as the individual who directed FA providers to follow this process, and again referenced the letter from DSPD as evidence that their process was correct.

The UOIG asked Provider B what would occur if the number of units submitted on a timesheet exceeded the number of units possible within the assigned billing date range. The provider said that they would "stretch the billing out" as much as possible; it is possible that they would

bill some of the excess units during the 1st through the 7th, and others during the 8th through the 12th resulting in not only inaccurate dates of service but also in possible inaccurate quantities of service in the claims. The provider admitted that there was not a standard operating procedure for that eventuality, however, so it was likely that there would be inconsistencies in any such billing, both in their billing, and in any other FA provider's billing.

Provider B further disclosed that the precise billing patterns might vary for other FA providers; the dates listed above and chosen by Provider B as their pattern for billing inaccurate dates of service would likely not reflect the arbitrary billing period dates of service that any other FA provider habitually assigned to the SAS claims that they processed. It would therefore be necessary to obtain every time sheet submitted by every SAS provider, to each FA provider, in order to determine actual service provision delivered to the Medicaid beneficiary, or billed to DSPD. By obtaining copies of every single timesheet for every SAS provider, an entity could then theoretically compare the information contained in the physical timesheets to information provided by the Individual regarding any service he or she had received, as well as to the PCSP to determine authorization levels for each individual and service. Once complete, the entity could then utilize each piece of information to audit the adjudicated Medicaid claims or appropriateness, accuracy, and utilization review. Only in this manner would it be feasible to determine actual Waiver utilization for these services, and to the Individuals identified in each respective claim.

Provider B and DSPD each supplied the UOIG with a copy of DSPD's billing instruction letter to FA providers. The letters, dated August 19, 2016, contained the same content, and directed providers to deliberately bill for inaccurate dates of service. The letter further specified, "The practice has been in place for at least nine years". DSPD stated that the following SAS services are subject to billing with inaccurate dates of service:

- Chore Services (CHI);
- Companion Services (COI);
- Transportation Services (DTP);
- Homemaker Supports (HSI);
- Personal Assistance (PAI);
- Self-Directed Basic Respite Care, Hourly and Daily (RPI);
- Provider Intensive Daily Respite Care (RP5);
- Self-Directed Basic Respite Care (RP6);
- Self-Directed Basic Respite Care, Group, W/O RM/BD (RP7);
- Self-Directed Basic Respite Care, Group W/RM/BD (RP8);
- Supported Living (SLI); and
- Family Training & Preparation (TFI)

The UOIG examined Medicaid claims for these services to DSPD, going back to 2016. Between 2016 and 2020, DSPD billed Medicaid for, and then paid their providers $224,561,706 in taxpayer resources for the above named services with inaccurate Medicaid claim information. As noted in the body of this report, all DSPD-created service codes must eventually translate into HCPCS codes. Because some HCPCS codes may represent more than one DSPD service code, the following graph reflects the DSPD service, broken out by the Medicaid HCPCS code identified in each respective DSPD claim for these services from 2016-2020 *(figure 9)*.

Year	Respite (RP5, RP6, RP8)	Family Planning (TFI)	Chore (CHI)	Personal Assistance (PAI)	Homemaker (HIS)	Companion (COI)	Respite (RP1, RP7)	Supported Living (SLI)	Total
2016	$ 581,048	$ -	$ 173,099	$ 3,554,078	$ 64,577	$ 306,579	$ 6,136,799	$ 22,214,571	**$ 33,030,751**
2017	$ 581,071	$ -	$ 192,267	$ 3,530,125	$ 75,471	$ 389,507	$ 7,618,153	$ 24,642,326	**$ 37,028,920**
2018	$ 649,961	$ 430	$ 239,864	$ 3,693,492	$ 113,197	$ 449,076	$ 8,714,912	$ 29,201,264	**$ 43,062,196**
2019	$ 624,086	$ 2,268	$ 307,196	$ 3,677,814	$ 122,310	$ 454,119	$ 9,737,202	$ 33,764,677	**$ 48,689,672**
2020	$ 445,173	$ -	$ 315,303	$ 3,616,980	$ 136,296	$ 583,154	$ 9,935,772	$ 47,717,489	**$ 62,750,167**
Total	**$ 2,881,339**	**$ 2,698**	**$1,227,729**	**$18,072,489**	**$ 511,851**	**$2,182,435**	**$ 42,142,838**	**$ 157,540,327**	**$ 224,561,706**

Figure 9

After the conclusion of the Audit, DHHS provided the following explanation for the practice. "We acknowledge that to avoid denial of claims for legitimate services, and due to DHHS system limitations, we have authorized claims to be submitted using a workaround. We agree there is work to be done to address these system limitations, but in the interim it is important to note that the Financial Management Services (FMS) providers are contractually required to "develop a system to prevent payment of duplicate or overlapping claims." In practice, this involves the FMS providers reviewing the actual time sheets completed by the SAS employee and comparing it with any other time entered for the same period to confirm that the time does not overlap with any other time entries. The FMS providers complete this review and verify accuracy of time sheets prior to claims submission. In addition, we are aware that through this review process, when FMS providers find concerns, they make referrals to the Office of Internal Audit (BIRA at the time,) then these cases were shared and discussed during the monthly Medicaid Fraud Control Meetings (known as the M-Team,) which the UOIG participates in as well."

DSPD confirmed through email that they allow their providers to provide service at a lower quantity or in a lesser duration than is required by the Medicaid Waiver SIP. The UOIG identified this practice during several of the onsite audits held with providers as part of Audits 2019-01 and 2019-05. While onsite with Provider J, the provider disclosed that, in the provision of the day service most frequently utilized by DSPD, the provider did not provide the necessary six hours of service to participants each day. Despite this, Provider J reported that they always billed a per diem or daily rate for the service provided. Provider J said that, at most, they provided four hours of service per day, and often considerably less.

While conducting an onsite audit with Provider G, the provider similarly reported to the UOIG that they billed a per diem rate, but only provided between one hour and three hours of service daily, despite clear Medicaid policies that require a minimum of six (6) hours of service per day in order to bill per diem. Provider G reported that "if [the individual] gets any service, we can bill for the whole day", and that "the standard is four hours [at most]".

Both the Medicaid Waiver SIPs, as well as CMS approval for these Waivers mandate a minimum of six hours of service in a single day to qualify for the daily rate of pay. The only exception to a daily or per diem service rate is an enhanced level of care rate, which requires a minimum of 10 hours of service in a single day. Any service provided whose duration is fewer than six hours is required to be billed at either an hourly or a quarter-hour unit of

service, and the provider must then bill based upon the number of units that correspond to the quantity of time spent actually providing the service.

When questioned regarding DSPD's policy for service provision at levels less than the six-hour per diem rate, the Director of DSPD said that DSPD allows providers to bill a per diem rate whenever the individual's PCSP authorizes a full day of service. The Director went on to say that, if the individual does not attend due to illness or an appointment, DSPD authorizes the provider to submit a bill for six hours of service for that day, in order to assist the provider in meeting their business's fixed operational and staffing costs. This is a direct violation of Medicaid's policies. The Scope of Work for service provision in DSPD's ABI.ID.RC contract specifies, "The Contractor may bill from 6 to 10 hours per service day" and that "DSG programs shall be operational for at least six (6) hour days and allow for staggered arrivals and departures (Utah DHS, DSPD, 2011-2019)". It is possible that the terms outlined the ABI.ID.RC contract were misconstrued to allow provider billing for the entire day, even in the event that the recipient received fewer than six hours of service, due to an allowance for a staggered arrival or departure time. If so, this example further illustrates the need for clear, consistent policies and controls governing the Waiver programs, service provision, and billing, detailed throughout the body of this Audit report and in each of the various Audit Findings.

In 2021, the Office of Legislative Auditor (OLAG) issued Audit Report 2021-10, which discussed, in part, an anticipated 2020 DSPD budgetary shortfall. Utah Legislature authorized an additional $3.2 Million dollars for DSPD use, to cover the anticipated shortfall in resources needed to provide ongoing Medicaid services to individuals in care. Although DSPD later returned the money, this situation helps illustrate the need for DSPD to develop sufficient controls that prevent financial waste within the program. Because DSPD allows its providers to bill Medicaid for services even when the provider does not provide the duration of service listed on a claim, it is possible to conclude that DSPD's budgetary shortfall may be, at least in part, a direct result of a practices that are violations of the SIP and CMS approvals for the program and regulations such as the State and Federal False Claims Acts.

With DHHS's need to reconcile so many databases and processes into a cohesive system as a result of the DHS and DOH merger, it is an opportune time to address DSPD billing irregularities and process inconsistencies. The UOIG acknowledges the necessary dedication of time and resources to address these concerns. However, integrating meaningful and actionable controls now into the program and design of future Department of Health and Human Services databases and systems would result in a more efficient allocation of time and resources and in more effective program outcomes, which in turn would result in lower levels of risk to limited Medicaid resources and members of a vulnerable population.

RECOMMENDATIONS

2.1 The UOIG recommends that DHHS and DSPD write and incorporate Medicaid billing policies to prohibit the submission of inaccurate Medicaid Claims; Medicaid billing should accurately reflect all aspects of the provided service, including the date, type, and quantity of service provided, the individual who received the service, the individual or provider who provided the service.

2.2 The UOIG recommends that DSPD write and incorporate internal policies and actionable controls that ensure DSPD and/or DSPD-contracted Providers cannot submit inaccurate Medicaid claims.

2.3 The UOIG recommends that DSPD write and incorporate policies and actionable controls to ensure that non-enrolled providers or entities cannot bill Medicaid using the Medicaid provider IDs of enrolled providers, to ensure compliance with the Federal False Claims Act, Utah's False Claims Act, and the 21st Century Cures Act.

2.4 The UOIG recommends that DHHS and DSPD write and incorporate policies and actionable controls to ensure that DSPD-contracted providers do not bill based upon a schedule, or upon assumption of service provision, and that submitted service totals are verifiable.

2.5 The UOIG recommends the distribution of these new policies and processes to, and detailed training for, all DHHS and DSPD staff, and all DHHS and DSPD-contracted providers.

FINDING 3 — MANY DSPD-CONTRACTED PROVIDERS ARE UNAWARE THEY ARE MEDICAID PROVIDERS, AND OF THE REGULATIONS THAT APPLY TO MEDICAID PROVIDERS

In conversations and communication with 69 separate DSPD Providers, the UOIG discovered that the majority of DSPD providers identified in the audit sample were unaware that they were Medicaid Providers, or that they provided Medicaid services. Providers were equally unaware that Medicaid is the funding source for the payments made to them by DSPD, or that they are subject to Medicaid rules and regulations, such as service provision, service record documentation and record retention. Only the larger companies who provided other Medicaid services to individuals outside of DSPD expressed any familiarity with Medicaid, with the regulations governing the provision of Medicaid services, or with the Waivers.

In the body of this report, the UOIG detailed DSPD provider enrollment with Medicaid, which falls outside typical Medicaid provider enrollment practices. Rather than the Medicaid self-enrollment procedure that other providers follow, DSPD staff process Medicaid paperwork on behalf of the providers they elect to enroll with Medicaid. Consequently, DSPD providers are frequently unaware of their status as Medicaid providers; because DSPD providers are not responsible for enrolling themselves as Medicaid providers, many of those contacted in this audit reported that they did not know the process had occurred. Moreover, DSPD providers were not aware of the Medicaid training and policy resources made available to providers during the enrollment process.

In the body of this report, the UOIG also summarized the NPO training offered to DSPD-contracted providers, originally by DSPD staff, and later by OQD after OQD's formation. Other than two pieces of misinformation shared by DHS staff regarding the Medicaid Settings Rule and DSPD's direction regarding billing during an individual's hospitalization, the two-hour NPO did not discuss any Medicaid rules, policies, regulations, training, or guidance. Neither OQD nor DSPD communicated other available resources outside of the NPO that could assist new providers in their compliance efforts.

DHS and DOH staff did report to the UOIG that DSPD providers had other Medicaid training opportunities, but acknowledged that their regularly scheduled meetings and training prioritized the health and welfare of Waiver participants. Neither DOH nor DHS staff could provide the UOIG with an agenda or attendance record for any of the Medicaid-related events they mentioned, and neither could recall any training content specific to Medicaid enrollment, or a provider's overall Medicaid responsibilities. One DOH staff member, however, reported that DOH staff did discuss the Medicaid Settings Rule with providers on several occasions. Additionally, after the conclusion of the Audit, DHHS reported that DSPD offered additional training. They stated, "outside of the NPO, support coordinators/providers are required to attend the core training. This training specifically prohibits billing during hospitalization. The core training also includes a half hour of training content on the settings rule in addition to other Medicaid policies. The NPO is not the primary source of information when working with DSPD support coordinators." DHHS did not provide any documentation to support the provision of this training.

Because of their general lack of knowledge about their Medicaid provider enrollment status, DSPD providers were subsequently unaware of their responsibilities as Medicaid providers. None of the eight Providers that the UOIG met with in person was aware of, or could speak to

the Medicaid-specific rules and regulations governing service provision, documentation of service provision, service records retention, or Medicaid billing.

The UOIG conducted an onsite audit with Provider I, who was unable to supply documentation that staff provided services identified in the audit. When the UOIG asked Provider I for copies of the service records, Provider I offered the UOIG a completely blank sheet of paper. Provider I reported that they had not documented any exceptions that may have led to a missed service, so the UOIG could assume that they provided all services listed on the PCSP for the Individual in question. When the UOIG relayed information about Medicaid documentation requirements with the provider, Provider I went on to say that transportation, day services, and day programs are all considered "secondary services", and that DSPD does not expect providers to document the delivery of secondary services. The UOIG questioned the provider further regarding secondary services, and Provider I reported that DSPD also considered several other services as secondary or "add-on services". For example, "PBA [service] is just assumed", according to Provider I. When the UOIG again discussed the need for actual written records that detailed the specific service provided, the date of service provision, and the quantity or duration of service, Provider I repeated that DSPD did not require any of that information, and never had. Provider I reported that such a requirement would be burdensome to providers. The provider indicated that he felt that DSPD providers would not comply with any Medicaid documentation requirements that fell outside of DSPD directives. Provider I then took the blank page from UOIG staff and wrote that the individual received service. The UOIG discussed the prohibition against altering or creating service records after the fact, to support an audit, but Provider I again pointed to DSPD and OQD audits and guidance as their authority for these practices; OQD and DSPD knew, and said it "[made things] easier on the audit".

Similarly, when the UOIG audited Provider G onsite, the provider's records did not include sufficient information to support any particular quantity of service on any given occasion. Provider G reported to the UOIG that it "would be a nightmare" for them to document the actual service provided, the date of service, and the duration or quantity of service provided. Provider G reported that they used their historical billing information, along with each person's Plan, to determine what service Provider G provided during an audit. They further reported that DSPD had never required them to document the start or end time of a service, because if the Plan identified a full day of service for an individual, then DSPD allowed them to bill for a full day of service. Medicaid SIPs and DHS contracts define a full day of service as a per diem rate of 6 hours or more, although discrepancies do exist. For example, during the majority of the Audit Scope, the Medicaid CS SIP identified DSG per diem services as "six hours or longer", but in 2021, that changed to "Day supports are offered on a 15-minute unit and intermittent basis as well as on a daily basis." Similarly, some DSPD contracts identify per diem service at six hours or more, but also then define DSG service as "as average of six hours" daily, while Day Supports Partial Day (DSP) identifies a partial day of service as "at least four hours". Most other Waiver services specify per diem billing at a rate of six hours or more daily

The UOIG relayed the above information to Provider G, who reported that it did not matter if an Individual arrived late or left early and consequently received less than 6 hours of service; the PCSP for the Individual in question specified a day of service, so that is what DSPD directed and what they bill. Later correspondence from the Director of DSPD acknowledged that DSPD allows providers to bill for a full day or service, even when the provider delivers a lesser duration of service. Based upon this information, it appears that DHHS and DSPD perception

of Waiver service limitations may not always match the service limitations identified in the Waiver SIP.

Situations similar to those detailed above repeated throughout the Audit; six DSPD providers reported that they did not provide the services listed in their Medicaid claims submissions. One DSPD provider reported that DSPD directed them to submit inaccurate Medicaid claims. Sixteen providers reported that the DSPD Person Centered Support Plan (PCSP) served as sufficient documentation to support billing for the provision of service. Provider G reported that any record of service was located in the PCSP; they documented that the person had been present that day, but did not need to document the service provided, or the quantity or duration of service, because each Plan told them "what to do". Provider B reported that they used a series of checkmarks to document service provision, and that detail about the type, quantity, or level of service provided to each individual would be located in that individual's particular PCSP.

At the conclusion of the Audit, DHHS reported, "Like the UOIG, we are very concerned with this provider response about service documentation. While exact time-in and time-out have not been required for some daily rate services, the service delivery is verified through other documentation requests including provider summaries, health documentation, and medications supports. We acknowledge we have work to do to improve our service documentation requirements and policy, but it has never been acceptable for a provider to alter or create a record in response to an audit." DHHS went on to say that they did not believe this "accurately represent[s] the work performed by OSR/OQD to review financial records. The agency routinely issues recovery letters to providers based on a provider's lack of documentation." The UOIG details this information in the body of the report as well as in subsequent Findings, but it does present additional areas of discrepancy. For example, throughout the Audit, many providers reported that they could not produce or did not have service records. The direct service records that were provided were insufficient to support the billing. The UOIG shadowed DSPD provider audits conducted by OQD. During those audits, no financial review of service records in comparison to billing occurred, and service record content appeared consistent with the insufficient records previously examined by the UOIG. It is therefore unclear what financial review process OQD followed to determine that a recovery may be necessary, or what records the OQD/OSR uses to accomplish that. Because DHHS expectations of what *should* occur do not always match the outcomes or processes witnessed by the UOIG, an opportunity exists to develop policies that contain sufficient controls designed to achieve DSPD's ideal outcomes.

Ultimately, nearly every provider that the UOIG spoke with acknowledged a general lack of specific Medicaid knowledge, of the Waivers, or of Medicaid provider responsibilities. Providers also unanimously reported a strong inclination to adhere to OQD and DSPD guidance regarding their service record documentation, even if that guidance deviated from other contractual requirements or policies. Providers asserted that any requirement for service record documentation, which identified the date, duration, and type of service, the individual who received the service and the service provider, was a direct contradiction of the guidance provided during annual DSPD and OQD provider audits.

In addition to an overall lack of understanding about Medicaid expressed by the providers identified in this audit, several of the OQD and DSPD staff that the UOIG met with were also unaware that Medicaid funded the services provided to DSPD Waiver participants. Staff

members at OQD, DSPD, and DHS reported that they had not received any training on Medicaid or the Waiver programs. The lack of substantive Medicaid training provided to DHS staff likely contributed to the misinformation that DHS staff imparted to DSPD providers during the NPO, as well as the any subsequent unintentional violations of Medicaid policies and regulations during the annual DHS provider audits.

Senior DOH management responsible for the Waiver programs admitted that DSPD providers are "probably unaware" of their relationship with Medicaid. DOH and DHS's awareness of providers overall lack of understanding about the Medicaid obligations that they contractually enter into has directly contributed to the areas of elevated risk of fraud, waste, and abuse of taxpayer resources, and the increased risk that members of a vulnerable population may not receive needed services that Medicaid paid for.

Because DSDP and OQD staff were not aware of Medicaid policies and regulations, they did not incorporate detailed information about those elements into DHS training, onboarding, or guidance to their contracted providers. As a result, DSPD and OQD training, onboarding, and guidance to Providers did not appear to contain substantive information about the Medicaid Waiver programs utilized by DSPD, Medicaid service provision, Medicaid billing and service record documentation requirements, or Medicaid records retention requirements. Instead, DSPD and OQD training, onboarding, and guidance focused on DSPD service codes, and in preparing the provider for an annual provider audit. However, due to the lack of understanding of Medicaid policies and regulations, the annual provider audits focused heavily upon qualitative elements of service satisfaction, rather than quantitative reviews of billing, documentation verification, or Medicaid policy adherence.

Recommendations

3.1 Although CMS approved DSPD to conduct "qualified provider enrollment" of their providers, the UOIG recommends that Utah Medicaid enact uniform Medicaid enrollment practices, applicable to all providers.

3.2 The UOIG recommends that DHHS and DSPD write and incorporate policies that require DHHS staff training, which details Medicaid policies, regulations, and processes relevant to their respective roles in administering Medicaid Waivers.

3.3 The UOIG recommends that DHHS incorporate substantive Medicaid information in the NPO, including written documentation and links to Medicaid regulations and program compliance resources.

3.4 The UOIG recommends that DHHS and DSPD write and incorporate policies that require DSPD Provider training, which details Medicaid policies, regulations, and processes relevant to their respective roles in providing services under Medicaid Waivers.

FINDING 4	POLICIES AND CONTRACTS GOVERNING HOME AND COMMUNITY BASED SERVICE RECORD DOCUMENTATION AND RETENTION NEED IMPROVEMENT AND/OR ARE UNENFORCED

As the Single State Agency, the Utah Division of Medicaid and Health Financing program within DHHS is responsible for establishing and enforcing policies pertaining to Medicaid[9]. This includes the approval of any policies or contracts that were developed by DHS, OQD, and DSPD in their role as administrators of Medicaid Waiver programs, as well as the implementation of any controls necessary to prevent and/or address any circumstances in which agency or provider conduct deviates from DHHS approved policies or processes. The policies governing Utah Medicaid programs are located in a variety of documents, such as the Provider Manuals, the State Implementation Plan (SIP), CMS approval letters and approved Medicaid Waiver SIPs, and in Utah Administrative Rules. Regulations at both the state and federal level also govern Medicaid. Additionally, DOH-approved contracts between DHS and DSPD providers outlined provider responsibilities under the Waivers, and each provider's respective contractual obligations.

DHHS maintains a publically accessible provider manual for each of the Utah Medicaid HCBS Waiver programs. Content varies amongst Waiver manuals; each manual reflects the specific policies that relate to each respective Waiver program. DHHS also updates the policies contained within each manual periodically, so that different versions of any given provider manual may include different policies in effect during the date identified in each version of the manual. For example, during the timespan identified in the audit, DOH published three versions of the CS Waiver provider manual. Although each version of the CS manual contained minor differences, each also specified the requirement for providers to adhere to the "service standards and limitations described in this manual, the terms and conditions of the Medicaid provider agreement, the terms and conditions of the Waiver SIP, and the terms and conditions contained in the DSPD contract (Utah DOH Medicaid, 2019)". However, as detailed in the other Findings of this report, OQD and DSPD practices did not follow these policy requirements, and DOH did not enforce them.

Utah Medicaid provider manuals also contain language regarding a requirement for provider enrollment: another example of inconsistently applied policies. According to the CS Waiver provider manual, "Waiver services are covered benefits only when delivered by qualified providers that are enrolled with the SMA to provide services as part of the Waiver. In addition

[9] A discrepancy in the definition and identification of the single state agency exists in Utah Code under the Medical Assistance Act. Utah's Medical Assistance Act was amended in 2022 to define the "Division" as "the Division of Medicaid and Health Financing within the department, established under Section 26-18-2.1". Utah Code 26-18-2.1 specifies, "There is created, within the department, the Division of Medicaid and Health Financing which shall be responsible for implementing, organizing, and maintaining the Medicaid program and the Children's Health Insurance Program established in Section 26-40-103, in accordance with the provisions of this chapter and applicable federal law." However, Utah Code 26-18-3 specifies, "The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act."

to this Medicaid provider agreement, all providers of Waiver services must also have a current contract with DHS/DSPD. (Utah DOH)."

Similarly, section 5005 of the CURES Act amended Section 1902(a) of the Social Security Act (42 U.S.C. 1396 a(a)) to include a requirement that, "not later than January 1, 2017, in the case of a State that pursuant to its State plan or waiver of the plan for medical assistance pays for medical assistance on a fee-for-service basis, the State shall require each provider furnishing items and services to, or ordering, prescribing, referring, or certifying eligibility for, services for individuals eligible to receive medical assistance under such plan to enroll with the State agency and provide to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier (if applicable), Federal taxpayer identification number, and the State license or certification number of the provider (if applicable);''. However, after the conclusion of the Audit, DHHS reported that "DSPD uses their provider ID to reimburse providers for such things as building a ramp (home modification) installing a lift on a van (vehicle modifications) or purchasing equipment or supplies online through Amazon. Based on CMS guidance, Utah has a long history of allowing DSPD to bill on behalf of these types of providers through the voluntary reassignment of claims provision for HCBS waivers." As detailed in the body of this report, an ability to reassign claims through the billing process allows a state agency to bill on behalf of providers. It does not allow states to circumvent other regulations while processes the billing. Therefore, despite the Utah Medicaid policy requirements outlined in the provider manuals, and provider enrollment requirements outlined regulation, approval by DOH for DSPD's practice of billing Medicaid for an unspecified number of non-enrolled service providers continued throughout the Audit, and appears ongoing by DHHS after the conclusion of the Audit. The UOIG discusses the outcome of this inconsistently applied policy in Findings 7 and 8.

Appendix I-1 of Utah's SIP for the ABI Waiver specifies, "During annual contract reviews, the DSPD Quality Management team reviews 100% of provider contracts. A component of the reviews includes a review of payment histories and the documentation to support those payments. This ensures the services were received and the correct payment was made." Language in the other Waiver SIPs closely matches the requirements in the ABI SIP; each outlines DHS responsibility to review provider payment history and the documentation that supports each payment during annual DHS provider reviews.

Utah Administrative Rule R414-14 governs Home Health Services in Medicaid, and discusses Client Eligibility, Program Access Requirements, Service Coverage, and Reimbursement for Services, but does not discuss service record documentation. Similarly, Utah Administrative Rule R414-38 governs Personal Care Services, but does not include information about service record documentation requirements. Utah Administrative Rule R414-61 governs Home and Community-Based Services for Waivers, and incorporates by Reference the Medicaid Waiver application (SIP) for each respective HCBS Waiver.

At the federal level, US Code 42 CFR 431.107 (b) specifies "A State plan must provide for an agreement between the Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization agrees to: (1) Keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries".

Additionally, regulatory guidance issued by the HHS OIG in the Federal Register[10] identifies seven components of effective compliance in Medicaid Home Health Agencies, including an expectation that "a claim should be submitted only when appropriate documentation supports the claim, and only when such documentation is maintained…". HHS OIG Medicaid compliance guidance on this matter states, "The documentation should record the activity leading to the record entry, the identity of the individual providing the service, and any information needed to support medical necessity and other applicable reimbursement coverage criteria".

Despite each of the policies, regulations, and contractual obligations identified above, DSPD provider outcomes do not match those respective policies, regulations, or contractual requirements. DOH routinely allowed OQD, DSPD, and DSPD-contracted providers to circumvent their own policies, such as the service record documentation requirements outlined above and contained in DSPD contracts with their providers. When questioned about the need for more robust service record documentation practices by DSPD providers, the then-DOH Assistant Division Director responsible for managing Medicaid Waivers said that a lack of documentation by DSPD Waiver providers "made sense" for some provider types. She further reported to the UOIG that it was "understandable" if DSPD providers failed to document the provision of Waiver services, especially when the service was residential in nature, although it was "less understandable" for other types of providers to fail to document the services they provided

The UOIG identified multiple other instances of DSPD providers' failure to adhere to the DOH polices regarding Medicaid Waiver service record documentation, service record retention, and provider enrollment requirements. For example, DSPD providers reported to the UOIG that they destroyed their Medicaid records upon termination as providers, at DHS behest. The UOIG discusses this situation further in Finding 5 of this report. A deletion of service record documentation would result in a practice that violates DHHS policies and Medicaid regulations. As a result, DHHS policies either remain unclear to DHHS staff and DSPD providers, and/or DOH inconsistently applied these policies to DHS or DSPD providers. There is therefore a need for revised DHHS policies that contain clear and consistent guidance, as well as the implementation of meaningful and actionable controls to ensure compliance at all levels with DHHS policies and Medicaid regulations.

Recommendations

4.1 The UOIG recommends that DHHS revise Medicaid service record documentation policies, provider manuals, and contracts to include consistent service record documentation and service record retention language throughout each respective policy and/or contract.

[10] Federal Register, Vol. 63, No. 152, 1998 Compliance Program Guidance for Home Health Agencies, https://oig.hhs.gov/authorities/docs/cpghome.pdf

4.2 The UOIG recommends that DHHS revise Medicaid service record documentation policies, provider manuals, and contracts to include a requirement to capture the following elements in the documentation of all HCBS Waiver services:

- the date the service was performed;
- the start and end time of each service;
- the type of service;
- the name of the individual receiving the service;
- the name of the individual providing the service;
- the date the service record documentation was created; and
- substantive information about the service provided, such as a log note.

4.3 The UOIG recommends that DHHS provide adequate oversight and conduct reviews of DSPD and DSPD providers, to ensure compliance with Medicaid policies and regulations, and with the recommendations identified above.

4.4 The UOIG recommends that DHHS write and implement meaningful and actionable controls to ensure DHHS policy and Medicaid regulatory compliance at all levels.

FINDING 5	POLICIES AND CONTRACTS GOVERNING DSPD PROVIDER SERVICES DO NOT ENSURE COMPLIANCE WITH STATE AND FEDERAL MEDICAID POLICIES OR WAIVER PROGRAM REQUIREMENTS

DSPD direct service providers do not sufficiently document service provision in a manner that supports billing Medicaid for reimbursement. DHS did not verify service provision by those Providers, nor do they reconcile attested service provision against Medicaid billing claims. DHS contracts with DSPD providers did not contain sufficient or clear information about Medicaid responsibilities to ensure that outcomes are compliant with more stringent Medicaid regulations and policies, which supersede the content of DSPD contracts.

DSPD direct service providers enter a monthly or quarterly summary of any progress or lack of progress by the Individual toward their goal achievement into USTEPS. The documentation details progress and satisfaction of the Individuals to whom they provide service, but providers do not document actual service provision; log notes submitted to the UOIG did not contain start or end times, or the duration or quantity of service provided. The log notes also did not include information to support a specific intensity of service, when multiple intensities of service were applicable. In some instances, DSPD providers utilized a series of X's or checkmarks as service record documentation, without additional information to explain what a mark or the lack of a mark indicated. In one instance, Provider I offered the UOIG a completely blank sheet of paper as documentation for one Individual's service provision, and then wrote information onto the blank page in front of the UOIG when questioned about the service it was meant to document. When the UOIG asked the provider to refrain from creating modifying any records involved in the audit, Provider I reported that they "do it all the time" for DSPD. Provider G also offered the UOIG a nearly blank sheet of paper, which only included the individual's personal information, but did not contain any service information. When the UOIG questioned Provider G about the service, the provider also modified the document in front of the UOIG, in an effort to "help the audit". Provider G inferred that they frequently "helped" DSPD auditors in a similar manner when questions arose during annual provider audits, and became argumentative and defensive when the UOIG attempted to educate the provider about the inappropriateness of altering service records to support historical billing. At the conclusion of the Audit, DHHS reported that their staff would not have encouraged DSPD providers to create or alter documentation to support an annual provider audit.

Rather than documenting the provision of actual service delivered to an Individual, DSPD, OQD, and DSPD providers frequently assume service provision, based upon the schedule, quantity, and services identified in each Individual's respective PCSP. Several providers submitted DSPD Plans in lieu of any service record documentation, and reported that each Plan identified the service(s) provided. The UOIG discussed the situation with providers, and communicated that it is improper to bill based upon the presumption of service provision; Medicaid billing cannot be based upon a schedule of intended future service provision, authorization for future service delivery, or upon the assumption that service delivery occurred. Any Medicaid service submitted for reimbursement requires supporting documentation that details sufficient information to support the service. Documentation must include enough information to communicate the service provided, including the intensity of service when applicable, the amount or quantity of service, the date of the service, and information about the recipient and service provider. Despite this, DSPD providers indicated

that they would continue to follow DSPD expectations and guidance, even when that guidance failed to match more stringent Medicaid policies or regulations.

Although some of the historical DSPD contracts with their providers did include elements of Medicaid policy compliance, DSPD and OQD practices, procedures, and direction to providers contradicted contractual obligations identified in the contracts. For example, in the 2011-2019 version of the most common of DSPD's multiple contract types, the ABI ID.RC contract, General Requirements specified that "The Contractor providing Medicaid reimbursed home and community-based waiver services shall document all direct services provided as identified below: (a) The name of the person served; (b) The name of the Contractor and the Contractor's staff member who delivered the service; (c) The specific service provided; (d) The date and time the service was provided; (e) The amount of time spent delivering the service; and (f) Progress notes describing the Person's response to the service (e.g. progress or the lack of progress as documented in the monthly summaries and/or progress notes.) (Utah DHS DSPD, 2019)" Content of service records submitted to the UOIG during Audits 2019-01 and 2019-05, however, did not match the contractual requirement identified above. The requirement also does not match the DSPD and OQD provider audit process, or audit tools, nor did it match standard operating procedures by DHS staff or DSPD providers.

In the body of this report, the UOIG detailed each of the different contract types between DHS and DSPD providers. DSPD providers sign contracts that correspond with the kind of service the provider performs. Each type of DHS contract utilized consistent boilerplate language to identity the elements providers must capture in the creation of service records; however, the contracts do not detail these requirements in a single location inside the various types of DSPD contracts. Instead, service record information was separated into multiple sections within each of the contact types. Different sections within the same contract fail to reference other relevant sections of the contract and the contracts contain inconsistent information throughout. As mentioned above, one portion of the boilerplate language in the ABI ID.RC contract, Part II, Section C, 16 (c) (3) identifies each of the elements that a provider must capture in their documentation of Medicaid Services, including: "The name of the Person served; The name of the Contractor and the Contractor's staff member who delivered the service; The specific service provided; The date and time the service was provided; The amount of time spent delivering the service; and Progress notes describing Person's response to the service". By contrast, the end of Section II of the same contract contains several pages that detail provider responsibilities and any applicable service or documentation processes for each of the DSPD service codes, but does not include or refer to the Medicaid documentation elements listed earlier in the contract. As a result, DSPD providers adhered to the requirements in Section II, and ignored those listed earlier in Part II, Section C.

DHHS contracts also contain contradictory information. For example, in Part I, Section D of the ABI ID.RC contract, Record Keeping and Retention of Records requirements specifies record retention for a minimum of 6 years from date of last service. Meanwhile, Part II, Section C, 16(c) (2) of the same contract identifies Record Keeping responsibilities of the provider and specifies a 5-year retention period from date of discharge.

The ABI ID.RC contract further specifies that in the event of discontinued operation, a provider must "transfer the client records to a successor agency or entity, or deliver the client records to DHS/DSPD (with prior written consent)". In practice, however, DSPD providers report that DSPD directed them to destroy their records to ensure HIPAA compliance. Consequently,

providers reported, and DHS acknowledged, that no historical record of Medicaid service provision outside of billing history or log notes recorded in USTEPS exists after an Individual transfers from one service provider to another. This resulted in multiple providers identified in the Audit Sample who were unable to provide records requested by the UOIG or support their Medicaid claims through service record documentation.

During annual provider audits, OQD and DSPD staff reviewed each provider's log notes to verify service provision, which matched OQD assertions that a review of service records occurred for each provider. The content of the log notes, however, is inadequate to document the type of service, the duration or quantity of service, the date of service, or the intensity of service. DSPD provider log notes detailed little more than "satisfied", "no behavior", or "likes the staff". The quantity of log notes is also inadequate to document service provision; DSPD providers entered log notes on a monthly or quarterly basis. No additional documentation or substantive records of service that supports Medicaid reimbursement occurs. Instead, providers often assume service provision, and DHS assumed billing accuracy through attestation or through the provider's compliance with other elements identified in the DHS provider audit tool, such as licensing or staff training completion.

A lack of understanding regarding Medicaid by both DHS staff and DSPD providers, and detailed in Finding 4, appears to have significantly contributed to the disconnect between what the DHS considered and what the UOIG considers service record documentation. Neither OQD nor DSPD used the terms "review" or "service records" in the same context that the UOIG does. The UOIG observed the service records reviewed by DSPD and OQD, which spoke to qualitative measures; no reconciliation between number of billed units per service and the documented units per service occurred. This deviates from DHHS' understanding of what a financial record review should be. However, the only aspect of DHS provider audits related to financial documentation that the UOIG witnessed was a detailed review of PBA financial accounting documentation, to ensure that providers meet fiduciary responsibilities while overseeing the personal finances of Individuals. Meanwhile, the UOIG defines a service record as documentation that supports the billing. Sufficient documentation identifies the Medicaid service provided, the service date and quantity of service, along with the provider and Medicaid beneficiary. Depending upon the type of service, Medicaid may also require additional documentation elements, but this is dependent upon Medicaid policy and specific to the respective Medicaid service and program type in question. A check of a monthly or quarterly qualitative "satisfied" log note does not suffice to support Medicaid billing in the absence of those other elements.

Throughout the Audit, UOIG discussed Medicaid policies with senior DHS leadership. As previously detailed in this report, a regulatory hierarchy exists in which federal Medicaid regulations and Utah Medicaid policy outweigh any contractual obligations located in DHHS provider contracts or guidance imparted during annual OQD provider audits. The then-Director of OQD reported, however, that although other Medicaid providers may follow the Utah Medicaid policies published in the provider manuals, DSPD providers instead looked to their DHS contracts and to DHS/DSPD to tell them what to do. Similarly, senior DSPD leadership pointed to DHS audits and DSPD provider contracts as the authority for provider practices.

The UOIG also met with DOH leadership to learn about DOH oversight over DHS Waiver practices concerning provider service records. DOH managers reported that DOH did not

focus upon provider policy compliance. The Assistant Bureau Director responsible for HCBS Waiver programs reported that when DOH examines DSPD provider audits and Waiver compliance, DOH does not typically look at the actual providers. Instead, DOH focused on DSPD by looking at each Individual's respective Plan, and whether or not billing exceeded the service quantity identified in the Plan; "It's a different focus", he said. DOH indicated that DHS bore responsibility for oversight in this area.

The lack of sufficient DSPD service record documentation to support Medicaid billing affects DHS claims cross walking, as well as their utilization of unique service codes that do not match Medicaid HCPCS coding. It is currently not feasible for CQI to reconcile provider billing with the providers documented service provision. At present, this is because DSPD does not require providers to document service provision in sufficient detail to identify the type, quantity, intensity, or date of service. However, if DHHS enforced contractual requirements for more detailed service record documentation, CQI would still require DSPD to implement standard Medicaid HCPCS coding in order to conduct a financial audit of provider service records. This is because the type and quantity of service identified in the PCSP, in USTEPS, and in theoretical provider records would not match type and quantity of service in the adjudicated Medicaid claims. CQI could therefore not effectively review provider service records in a financial audit by comparing billed totals with documented totals. Consequently, none of the entities involved in the management or oversight of DSPD Waiver programs currently verify DSPD provider billing accuracy, and are unable to do so until DSPD implements service records requirements and Medicaid HCPCS coding changes. Each of these factors alone results in an elevated level of risk, but when combined, results in a program with insufficient controls that provides increased opportunity for fraud, waste, and abuse of taxpayer resources. It also translates into a risk that the vulnerable Medicaid members who depend upon these services may not actually receive the appropriate or needed service. It would therefore be universally beneficial to install meaningful and actionable controls in each of the Waiver programs, and to adopt approved Medicaid coding and service record documentation requirements.

Written instructions from DSPD to providers regarding a historical DSPD imaging project appraised SCE providers of the necessary steps each must take to ensure their records were "correctly categorized, formatted, and successfully loaded into USTEPS/UPI" (Utah Department of Services for People with Disabilities). The process instructions specified, "Once the document has been uploaded to USTEPS/UPI, the hard copy of the document shall either be destroyed or must be protected through encryption or locked cabinet. The Contractor shall ensure its SCE staff manages the original version of Person-specific documents by: a. destroying the paper document (i.e. shredded or burned) after the SCE staff has confirmed that the documents have been successfully processed into USTEPS/UPI; b. Deleting the original scanned image stored on the Contractor or its SCE staff's computer (i.e. personal or company storage device i.e. hard drive, thumb drive, etc.) and "shredding" by using technologies and techniques that render the file completely unrecoverable from the storage media". Providers reported to the UOIG that record destruction became the norm after this point, and that the annual DSPD/OQD auditors were aware of the continued practice. For example, Provider L wrote to the UOIG that although DSPD originally directed providers to destroy records during the imaging project, "now they just ask what we do and we just say we destroy the documents". When discussing this situation with the then Deputy Director of DHS, he acknowledged the historical DHS push to ensure provider HIPAA compliance, although he denied knowledge of any record destruction. After the conclusion of the Audit, DHHS reported that they would not direct providers to destroy records. The inconsistencies between DSPD

providers understanding of the DSPD letter, provider understanding of ongoing records retention requirements, and provider contractual obligations which mandate both a 5-year and a 6-year retention period result in an additional area of high risk.

Recommendation

5.1 The UOIG recommends the amendment of DSPD provider contracts to reflect and reference federal Medicaid regulations and guidance, Utah Medicaid policies, Utah Code, Utah Administrative Rules, and other appropriate regulatory guidance governing the provision of service, documentation of service, billing, and program requirements.

5.2 The UOIG recommends the creation and incorporation of consistent policies and contracts that require the following elements in DSPD provider's Medicaid service record documentation:

- the date the service was performed;
- the start and end time of each service;
- the type of service;
- the name of the individual receiving the service;
- the name of the individual providing the service; and
- substantive information about the service provided, such as a log note

5.3 The UOIG recommends that DHHS, DSPD, and CQI amend provider audit tools and processes to include actionable controls in the review and audit of service records during normally scheduled OQD provider audits, including a financial audit of documented units of service against adjudicated Medicaid billing

5.4 The UOIG recommends the DHHS require DSPD, and CQI to provide a written report regarding the outcome of annual financial audits of Waiver service provision and billing each year, including detail of any discrepancies identified.

5.5 The UOIG recommends that DHHS, DSPD, and CQI incorporate and enforce service record documentation requirements identified in current contracts with providers.

FINDING 6	AN OPERATING AGREEMENTBETWEEN DOH AND DSPD GOVERNING THE MANAGEMENT OF MEDICAID WAIVERS IDENTIFIED IN THIS AUDIT DID NOT EXIST FROM 2015-2019

Throughout Audits 2019-01 and 2019-05, staff at all levels within DSPD, all DSPD-contracted providers, and staff at all levels within DOH each referred to their contract as the authority behind and guidance for their respective actions and processes. Although the UOIG was able to obtain copies of each type of contract held between DSPD and DSPD providers, neither DSPD nor DOH could produce a copy of a current contract between the two governmental entities. Instead, DSPD and DOH continually referenced a Memorandum of Agreement (MOA) that expired on June 30, 2015. The MOA in question had a retroactive start date of July 1, 2010, although DOH and DSPD signed it in February of 2011. The MOA also included an option for two (2) annual extensions, by means of a written Amendment to the MOA, but neither DOH nor DSPD produced a copy of an amendment or extension to the MOA.

The UOIG asked the DOH if they had extended the 2010-2015 MOA in writing, in accordance with the extension terms specified within the MOA. DOH staff reported that they had not extended the MOA with DSPD. The UOIG then asked if the DOH had executed a new contract or MOA in place of the expired one. DOH staff disclosed that no new contract existed. After multiple conversations, DSPD also disclosed that a current contract or MOA did not exist between the two parties at that time. However, on February 28, 2020, DSPD staff reported they had entered into a new MOA with DOH. The new MOA was dated effective 7/1/2015-6/30/2020, but was not created or signed until February of 2019. As a result, during the four-year span from 2015-2019, no current MOA or contract existed between the two entities to govern the responsibilities of administering these Medicaid Waivers.

The body of the 2010-2015 DOH/DSPD MOA spanned two pages, and its contents were non-specific, without the inclusion of substantive or enforceable controls over Medicaid Waiver utilization and administration. Instead, the MOA detailed the State Matching Funds Responsibilities of each entity, as well as Billings, wherein (DMHF) must provide "DSPD with a quarterly summary report of the number of individuals enrolled in the [Waiver], and the associated payments made for each person". In turn, the MOA states that DSPD agreed, "To pay DMHF, in accordance with the quarterly billings, the State Medicaid share of payment referenced in the aforementioned [report]". The MOA did not identify any additional responsibilities in administering the Waivers, nor any controls over Medicaid Waiver utilization.

It is worth noting that a requirement for the submission of a quarterly report is not, in itself, a sufficient control. Instead, what an entity *does* with such a report determines the value of the control. In this case, a quarterly count of individuals and payments would provide high-level information about Waiver utilization. The subsequent action, however, may involve leveraging that information to assist in general program management tasks, such as budgeting and forecasting. For example, DSPD and DOH have an opportunity to utilize the quarterly and annual high-level counts of utilization, by comparing the quarterly and annual budget, service authorized, service provided, quantity of service, and rate of service for each Individual. A comparison of those metrics, over time, combined with information about with each individual's personal health and service needs, allows DSPD and DOH to begin to forecast

future budgeting needs for each individual. To do so, however, the entity must first analyze and compare the information in the report to historical utilization counts, and factor in current health and welfare information for each individual. Several actions are required; in this case, the actions involve a detailed analysis, to identify trends and inform upon likely future trajectories. Taking this example a step further, DSPD could additionally utilize the information to identify the approximate number of every type of service provider necessary for DSPD to contract with, in order to ensure uninterrupted service delivery to the number of program participants identified in the Waiver utilization report, and that corresponded to the likely future Waiver utilization trajectories. Again, an action in the form of comparison of historical analysis and current utilization trends is necessary; simply submitting a quarterly report does little to benefit the program, because the report alone is not a sufficient control. Utilizing the report's contents in a meaningful way to benefit to the program and its participants would result in a sufficient control.

The information contained in the quarterly report also provides both DOH and DSPD opportunities for internal quality assurance and program integrity measures. One such example involves utilizing information about the evolution of a Waiver participant's service needs. Once DOH and DSPD have identified an individual's average service need exists, and forecasted a future trajectory of those needs, the program could then monitor his or her service utilization, not only to ensure the model used to forecast future needs remained valid, but also to better identify any service utilization or billing anomalies as they arise. By acting upon the discovery of billing or service anomalies, each entity ensures that, the service provision remains sufficient to meet the needs of the participant, and that the billing patterns remain accurate and appropriate. Combined with recommendations in Finding 5 regarding policies that result in financial audits of provided services against submitted billing, this provides a meaningful control resulting in positive outcomes for the program, the participant, and for taxpayers.

In addition to the need for the inclusion of meaningful controls in the MOA between DOH and DSPD, there is also a need for actionable consequences that result from a failure to implement those controls. Neither the expired 2010-2015, nor the backdated 2015-2020 MOAs include this element. In the case of the 2010-2015 MOA, there was no mention of meaningful or actionable controls at all. In the 2015-2020 MOA, limited information exists in 4.7, under Monitoring Quality Assurance and Quality Improvement. However, the MOA reads more like a series of assurances, with emphasis on a checklist of items that DSPD must submit to DOH; it does not include information about any action(s) that may result from the reports, nor does it provide detail about any actionable consequence that will result from a failure to meet most requirements.

Of the few actionable consequences included in the 2015-2020 MOA between DOH and DSPD, nearly all revolve around responsibility to pay Federal Financial Participation (FFP) disallowances that result from a failure of either party to comply with various aspects of the Waiver programs. FFP means the federal government's share of the total Medicaid expenditures for the state, or the federal portion of the FMAP. For example, the MOA specifies that DSPD's failure to comply with Federal regulations, Utah's State Medicaid Plan, the respective Providers Manuals, Administrative Rules, and contractual obligations governing the Waiver programs will result in their responsibility to pay all associated FFP disallowances. DSPD would further be responsible for any disallowance of FFP resulting from their failure to

comply with Medicaid regulatory requirements, such as the provisions of the SIP, and/or the Medicaid Provider Manuals.

The ABI SIP application and CMS approval mandates an Interagency Agreement for Operations and Administration of the HCBS Waiver, that "sets forth the respective responsibilities for the administration and operation of this waiver" (CMS, 2019). The SIPs for both the CS Waiver and the PD Waivers also include similar language and requirements.

Similar to the actionable consequences identified in the 2015-2020 MOA for DSPD, the MOA also identifies role accountability and FFP disallowances that DOH would be responsible for, in the event that DOH fails to notify DHS of any "federal or state directives, regulations/rules, policies, interpretations or corrective action requirements that affect the provision of [HCBS Waiver] services and the operation of the program or (b) manage individual waivers in a manner that allows operation, management, evaluation, and reporting of each waiver as a unique program, separate from all other waivers and Medicaid programs (Utah Department of Health, 2015-2020)."

Although a contract or MOA did not exist between DOH and DSPD for the four-year span of 2015-2019, an MOA between these entities does now exist, as previously mentioned. It does not, however, contain meaningful and actionable controls over several elements of HCBS Waiver Administration, such as service record documentation, detailed billing processes, claims submission accuracy or Medicaid claims review. Similarly, any written policies and procedures governing these responsibilities do not appear to exist, and staff understanding of these processes varies greatly and contains multiple levels of inconsistency. An effective MOA should include all necessary information for the successful operation and administration of the program, and thus should include information about these processes and each party's responsibility and role.

In order to avoid duplication of information in this report, Finding 5 provides detail regarding the need for effective and actionable policies and processes regarding service record documentation, detailed billing procedures, DSPD Medicaid claims submission and accuracy, and Medicaid claims review.

Recommendation

6.1 The UOIG recommends that the DOH and DHS prioritize and actively maintain a current contract, MOA, or SOP, in which the roles and responsibilities of each entity is specified.

6.2 The UOIG recommends the identification of controls governing Medicaid Waiver utilization, including meaningful and actionable controls over service record documentation, billing processes, claims accuracy and reviews, and general administration of the Waivers.

6.3 The UOIG recommends the inclusion of the recommended controls identified in 6.2 in an actively maintained MOA between DOH and DHS.

FINDING 7 — DOH ALLOWED DSPD TO VIOLATE POLICIES REQUIRING MEDICAID ENROLLMENT BY MEDICAID HCBS PROVIDERS

While examining the Sample of Medicaid Claims Data pulled for Audit 2019-01, the UOIG identified nine Medicaid claims listing DHS DSPD State Office as the direct service provider. The service was listed as "Waiver Services, Not Otherwise Specified", using CPT code T2025. Claim amounts varied from between $14.56 to $291.20, and totaled $1,354.08 in the audit sample data.

The UOIG met with DSPD to obtain information, along with copies of service record documentation for the Audit. DSPD provided a series of conflicting responses about the process, but eventually disclosed information about the claims that the UOIG had identified in the Audit Sample. DSPD stated that they billed Medicaid using their own assigned Medicaid provider ID numbers as the service provider on those claims. They reported that, with the exception of occasional, time-limited transitional SCE services, DSPD staff do not provide any direct services to individuals enrolled on the CS, ABI, or PD Waivers. They do however; bill Medicaid as the provider of massage therapy, specialized medical equipment, home modification, and vehicle modification services. DSPD advised the UOIG that DOH approved the practice, in order to enable DSPD to pay the actual service providers, who are non-enrolled providers, and thus did not have their own assigned Medicaid provider ID numbers.

Multiple DSPD staff and program managers denied knowledge of any records of service provision retained by DSPD outside of their USTEPS database. Of the nine individuals in the Audit Sample whose Medicaid claims identified DSPD as the service provider, USTEPS notes contained information regarding massage services for six of them. According to the notes, four individuals received massages from entities outside of DHS/DSPD, and two individuals received massages, but the log notes did not identify the service provider. The remaining three individuals' log notes did not reflect any massages or any other services other than those already billed for by another provider.

Of the log notes that contained information about a massage, two notes contained contradictory information about the quantity of service provided, and the subsequent billable Medicaid unit of service. DSPD staff researched log notes with the UOIG for each of the Individuals identified in the Audit Sample whose billing reflected "Waiver Services, Not Otherwise Specified", in an attempt to determine what service each individual had received, and which provider had provided the service. Although the log notes did not clearly identify massage therapy services for some of those Individuals, DSPD surmised that each of the nine Individuals had received massages, because three other individuals' log notes said, "Massage". Although DSPD presumed that each Individual received a massage, the units of service documented in the log notes differed from person to person. One individual received "a massage", but the Medicaid claim reflected several units. Another's UPSTEPS log notes documented several units of massage therapy, but the Medicaid claim reflected one unit. There is therefore a likely disconnect between adjudicated Medicaid claims and at least some DSPD provider service provision, although this cannot be determined due to a lack of sufficient documentation. Additional information about the lack of documentation in USTEPS log notes in provider service records is located in the other Findings of this report.

The UOIG asked DSPD and DOH for additional information governing the circumstances in which DSPD would pay providers that are non-enrolled with Medicaid, using Medicaid funds;

federal regulations identified in Section 5005 of the CURES Act (United States Code) mandate Medicaid provider enrollment by January 1, 2017 for Fee for Service (FFS) providers. DSPD and DOH responses contained inconsistencies. DSPD staff and senior leadership reported that DOH allowed the practice. DOH and DHS leadership each pointed to a letter addressed to the State of Utah Medicaid Director from 1993 regarding Voluntary Reassignment of Claims, as well as to various federal regulations governing an allowance for claims reassignment. It is debatable whether authorization to reassign Medicaid claims to DHS would also provide subsequent authorization for DSPD to pay non-enrolled providers using Medicaid funds. However, even if such an allowance did exist, the more recent regulations included in the CURES Act clearly supersedes them. DOH leadership then later reported to the UOIG that the practice should not occur at all. The Audit Report contains additional information about these circumstances in Finding 8.

The UOIG next inquired about other State and Medicaid compliance elements that normally occur during provider enrollment in Medicaid, such as whether or not the service providers and their staff held valid licenses, as applicable, to perform the services for DSPD Medicaid beneficiaries. If so, who was responsible for verifying that information? DSPD and DOH reported that DSPD staff bore responsibility to verify current licensure, and DSPD submitted limited documentation in the form of checklists to support that sporadic licensure verification had occurred. The checklists reflected the names of the non-enrolled massage therapy providers that DSPD had identified as the actual service providers through a process of elimination using the PCSP of each individual listed in the sample claims data.

Section 1902(a)(32) of the Social Security Act dictates that State Plans allow Medicaid payment to limited individuals or entities. Similarly, federal regulations under 42 CFR § 447.10 prohibit Medicaid payment reassignment except in very limited circumstances. The section titled MEDICAID PROVIDER REASSIGNMENT OF CLAIMS in the body of this report provides additional detail. Additionally, CMS issued a new Final Rule governing Reassignment of Medicaid Provider Claims, Document 2022-10225 after the conclusion of this audit.

Similarly, after the conclusion of the Audit, DHHS reported that DSPD's practice of billing Medicaid using DSPD Provider ID numbers in order to bill for non-enrolled providers "…is a recognized exception to the requirement contained in §1902(a)(32) of the Act that prohibits state payments for Medicaid services to any entity other than the provider of a service. Reassignment is typically employed when a governmental agency pays a provider for a service and reassignment is used to permit the governmental agency to recover its outlay. Reassignment arrangements must be voluntary on the part of the provider and the state must provide for the payment to providers who elect not to reassign payment."

DHHS further stated, "In the situations described above, general contractors or an entity such as Amazon would not be reasonably expected to enroll as a Utah Medicaid provider. Accordingly, Utah has long permitted DSPD to submit these types of claims through their provider number. There has been no attempt to hide this process which is allowed by CMS. "

CMS technical guidance, referenced by DHHS, and located in the "Instructions Technical Guide and Review Criteria" state, "Under the provisions of 42 CFR §447.10(e), a provider may reassign the payment for waiver services to a governmental agency. This provision is a recognized exception to the requirement contained in §1902(a)(32) of the Act that prohibits

state payments for Medicaid services to any entity other than the provider of a service. Reassignment is typically employed when a governmental agency pays a provider for a service and reassignment is used to permit the governmental agency to recover its outlay. Reassignment arrangements must be voluntary on the part of the provider and the state must provide for the payment to providers who elect not to reassign payment. Reassignment is described further in the December 20, 1993 State Medicaid Director included in Attachment D to the Instructions."

None of the technical guidance or regulations referenced by DHHS allows a Medicaid program to supersede Medicaid provider enrollment requirements outlined in Section 5005 of the CURES Act, which mandates provider enrollment in Medicaid.

While conducting the Audit, the UOIG also asked DOH and DSPD if anyone had verified whether non-enrolled providers were included on the List of Excluded Individuals and Entities (LEIE). The LEIE is a regularly updated list of individuals and entities who may not provide services to individuals on Medicare, Medicaid, or any other federal healthcare program. Inclusion on the LEIE is usually the result of a conviction related to healthcare fraud, although individuals may be included for a variety of reasons. Regardless of the reason for exclusion, however, DSPD "may not employ or contract with providers excluded from participation", in accordance with 42 CFR 438.214(d). For this reason, the UOIG recommends routine checks of the LEIE for both current and new employees of Medicaid providers. Initial checks are normally part of the DOH enrollment process for Medicaid providers, but in this case, DOH did not complete an initial check of the LEIE, due to the non-enrolled nature of the providers in question.

DOH reported that DSPD was responsible for LEIE verification for each non-enrolled provider. DSPD, however, initially denied any knowledge of the LEIE and claimed that DOH may have completed a check of the LEIE for the non-enrolled providers in a separate process. Another inconsistency occurred, when, later in the Audit the same DSPD staff members who initially denied completing LEIE checks changed their response and reported that they had personally checked the LEIE for each non-enrolled provider DSPD paid using Medicaid funds. When the UOIG asked for documentation to support that LEIE verification had occurred, DSPD provided a spreadsheet. The spreadsheet provided vague information for some, but not all of the providers that DSPD identified as likely having provided the actual services listed in the audit sample.

The UOIG asked DOH and DSPD for a copy of the contract, policy, Waiver SIP, or any regulatory guidance from CMS that authorized DSPD to bill Medicaid using their own assigned provider ID numbers, in order to pay other entities not enrolled in Medicaid for service provision. Responses by DSPD and DOH staff contained multiple inconsistencies. DSPD reported that DOH had approved the process, and in one meeting, DOH appeared to agree that that had occurred. DOH acknowledged that they were aware DSPD had paid non-enrolled providers for service provision, and pointed to a 1993 letter from CMS, addressed to State Medicaid Directors, which detailed processes for Medicaid Waiver Reassignment of Claims as authorization for the practice.

DOH reported that DSPD accepted Medicaid claims under their authority as a Business Agent, acting on behalf of the provider for whom they billed. In accordance with the exception to the prohibition against reassignment of claims, "Payment may be made to a business agent, such

as a billing service or an accounting firm, that furnishes statements and receives payments in the name of the provider, if the agent's compensations for this service is (1) related to the cost of processing the billing; (2) Not related on a percentage or other basis to the amount that is billed or collected; and (3) Not dependent upon the collection of payment (Code of Federal Regulations, 2021).

The 1993 CMS letter submitted to the UOIG by DOH further specifies several additional limitations to provider reassignment of claims. Reassignment must be voluntary; the state may not mandate any reassignment of claims to the government organization. The provider must be free to cancel the arrangement at any time, and "the provider must have a provider agreement with the Medicaid agency". It goes on to say that "Other entities, such as…. Departments of Developmental Disabilities may be co-signatories to this agreement. Their involvement is optional with the State. What is necessary is that Medicaid and the provider sign the same agreement." (CMS, 2021)

Although federal guidelines are clear in this matter, Utah Medicaid policies do not clearly prohibit payment to non-enrolled providers in the current or archived versions of the General Information Provider Manual's policies governing Unacceptable Billing Practices, nor in the requirements for enrollment with Utah Medicaid. Chapter 3 Provider Participation and Requirements of the General Information Provider Manual does specify, however, that all providers must enroll with Medicaid. Chapter 3-1(A) of the Utah Medicaid Community Supports Waiver Provider Manual for Individuals with Intellectual Disabilities or Other Related Conditions further states, "Waiver services are covered benefits only when delivered by qualified providers that are enrolled with the SMA to provide the services as part of the Waiver. In addition to this Medicaid provider agreement, all providers of Waiver services must also have a current contract with DHS/DSPD (Utah Medicaid, DOH, 2020)." Chapters 3-1(A) of the Utah Medicaid Home and Community Based Services Waiver for Individuals with an Acquired Brain Injury, and Chapter 2-1 of the Utah Medicaid Home and Community-Based Services Waiver for Individuals with Physical Disabilities mirror the requirements outlined in the Community Supports Provider Manual.

CMS allows states to let their respective government departments and divisions, such as Utah's DSPD, operate Waiver programs and bill Medicaid on behalf of the providers who supply the services and/or equipment. This authority allows DSPD to bill Utah Medicaid on behalf of DSPD-contracted providers. The 1993 letter provided by DOH, however, does not support paying non-enrolled providers; it only authorizes government entities such as DSPD, who are operating Medicaid programs, to bill Medicaid and distribute the funds to the Medicaid providers who provided each service. DOH denied any more recent guidance from CMS on this matter, and later revised their previous position, stating that DSPD providers paid with Medicaid funds "should be enrolled with Medicaid as well [as contracted with DSPD] (DOH Medicaid Manager, 2021)".

In addition to the regulations and policies governing reassignment of claims, there are several pieces of legislation at the state and federal level governing false claims. 31 United States Code (USC) §3729, the Federal False Claims Act (FCA), prohibits false claims submissions, and sets forth penalties and liabilities for false claims when "any person who, (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval. (United States Code 3729, 2021)" The Act defines a false claim as any claim made to the federal government, or to a "contractor, grantee, or other recipient if the money is to be spent on the government's

behalf and if the Federal Government provides any of the money demanded, or if the Federal Government will reimburse the contractor or grantee." It requires that the person or entity have knowledge of the actual information, but act in either deliberate ignorance or reckless disregard of the truth, or of the falsity of the information on the claim. The Act also specifies that there need not be intent to defraud the government; if the claim is false, penalties still apply. Those penalties do vary on a case-by-case basis, but any person who knowingly submits a false claim is liable for damages up to three times the amount of each false claim, in addition to fines of $5,000-$10,000 per claim. The FCA incentivizes each state to adopt its own false claims act. Utah Code 26-20 defines a false claim as, among other things, any claim that is either wholly or partially false, and prohibits individuals from making a false claim "to an employee or officer of the state for a medical benefit". Utah's Act further prohibits any conspiracy to defraud, stating, "A person may not enter into an agreement, combination, or conspiracy to defraud the state by obtaining or aiding another to obtain the payment or allowance of a false, fictitious, or fraudulent claim for a medical benefit (Utah State Code 26-20, 2021)."

Despite the various inconsistencies in DSPD and DOH staff statements about the process in which DSPD billed Medicaid for reimbursement of services by non-enrolled providers, DSPD and DOH staff all reported that the practice had ended after 2017 when the content of DHS contracts changed. They further reported that after 2017, DHS contracts required Medicaid enrollment by all contracted providers, and that DSPD no longer billed Medicaid using their assigned provider ID numbers to pay non-enrolled providers.

The UOIG examined all HCBS Waiver claims submitted by DSPD to verify the accuracy of DSPD and DOH reports of a cessation of billing Medicaid for non-enrolled providers. The data encompassed all Medicaid claims in Utah utilizing U4, U5, and U6 modifiers, by all providers, for calendar years 2017, 2018, 2019, and 2020. Contrary to reports by staff, DSPD continues to bill Medicaid using DSPD assigned Medicaid ID numbers (*figure 10, also used in Finding 8*). In 2018, DSPD billed Medicaid for $543,194.30 for services paid to other providers using DSPD assigned Medicaid provider ID numbers, in 2019 that number rose to $1,078,003.38. In 2020, they billed for $846,608.16, and as of May 2021 had billed Medicaid for $164,427.13 for claims paid to other providers using DSPD assigned Medicaid provider IDs in 2021. These totals do not include one claim submission in 2019, for $1,121, in which DSPD billed Medicaid for Waiver Transition Services. This is because DSPD does provide occasional, temporary transitional services. No other similar transitional service claims were submitted to Medicaid by DSPD from 2017-2021.

DSPD's practice of billing Medicaid using inaccurate claims information specifying that DSPD provided direct service as a means to pay non-enrolled Medicaid providers fell outside of the direct audit scope of UOIG Audits 2019-01 and 2019-05. As a result, the UOIG did not pursue documentation for all services whose claims identified DSPD provider. Similarly, the UOIG did not pursue documentation to support the completion of other compliance elements for any non-enrolled providers during these audits. The UOIG anticipates a potential future review of these compliance concerns, however.

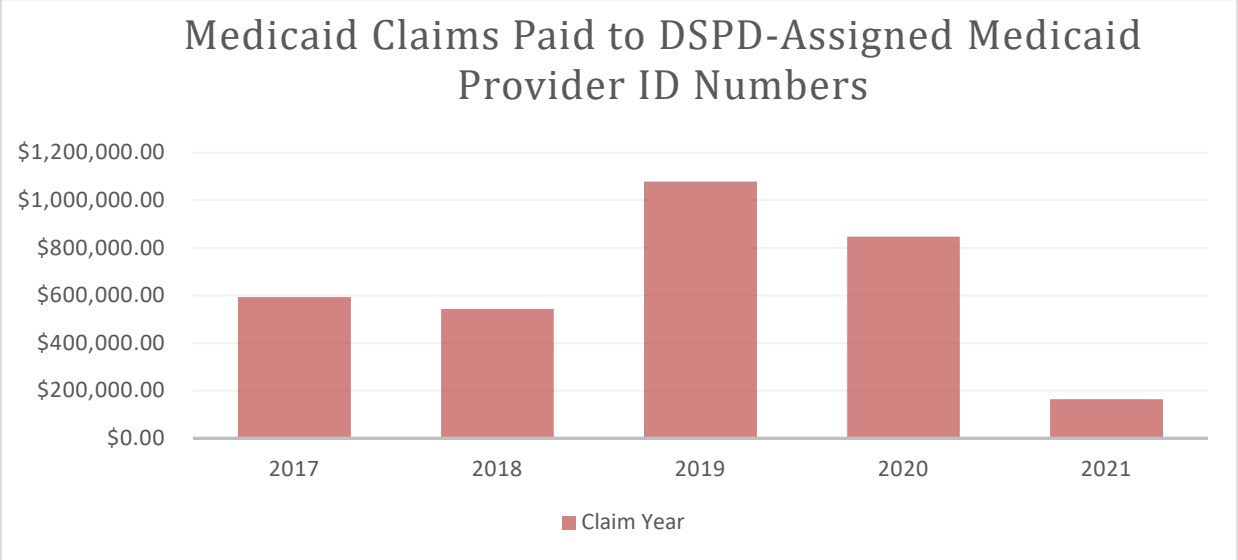

Figure 10

Recommendation

7.1 The UOIG recommends DHHS implement written policies that include meaningful and actionable controls to ensure all Medicaid claims reflect accurate information, including but not limited to:

- Service(s) Provided;
- Service Provider;
- Medicaid Beneficiary;
- Date(s) of Service;
- Unit(s) of Service, including the start and end time of service provision; and
- Rate of Service

7.2 The UOIG recommends DHHS implement written policies that include meaningful and actionable controls to ensure payment of Medicaid funds only to individuals and/or entities currently enrolled as Medicaid providers.

FINDING 8 DSPD SUBMITS INACCURATE MEDICAID CLAIMS

Throughout the course of Audits 2019-01 and 2019-05, the UOIG identified multiple instances in which DSPD submits, and/or directs contracted Providers to submit deliberately inaccurate Medicaid Claims. Finding 2 identifies one example, wherein DSPD directs their FA providers to routinely submit SAS Medicaid claims using arbitrary dates of service in an effort to avoid denied Medicaid claims. The UOIG additionally identified multiple circumstances in which DSPD submitted inaccurate Medicaid claims, using DSPD-assigned Medicaid provider ID numbers as the service provider.

While examining the Sample of Medicaid Claims Data pulled for Audit 2019-01, the UOIG identified nine Medicaid claims listing DHS DSPD State Office as the service provider. The service was listed as "Waiver Services, Not Otherwise Specified", using CPT code T2025. Claim amounts varied from between $14.56 to $291.20, and totaled $1,354.08 in the audit sample data. Finding 7 further details this information, and pertains to DOH oversight over the practice.

The UOIG met with DSPD staff to inquire about service provision by DSPD staff to individuals enrolled in DSPD-administered Waiver services, in order to obtain copies of the records as part of the audit methodology. DSPD senior financial staff members denied any direct service provision by DSPD, and directed the UOIG to speak with additional DSPD staff that may have further knowledge about the billing discrepancy. The UOIG met with several additional DSPD and DHS staff members at all levels, who each directed the UOIG back to the original DSPD staff person as a more appropriate point-of-contact.

The UOIG asked DSPD to view the USTEPS log notes for each individual identified in the audit sample whose Medicaid billing reflected service provision by DSPD, according to the Medicaid claims submitted by DSPD. DSPD retrieved the relevant notes from their USTEPS database, and reviewed them with the UOIG.

The UOIG was unable to identify sufficient information in the log notes to determine who provided what service and in what quantity for any of the nine individuals in the audit sample. Log notes for four of the individuals identified in the sample indicated massage services from entities outside of DSPD, but the notes lacked sufficient information to support the quantity of service. Two individuals' log notes mentioned a massage, but did not identify either a service provider or the quantity of service, and the remaining three individuals' log notes did not reflect any massages or any other services other than those already billed for by another provider.

DSPD acknowledged the lack of supporting information in USTEPS log notes, but pointed to each individuals respective PCSP. DSPD reported that the provider would be one of several listed in the PSCP, and that based upon that information it was possible to identify the service through a process of elimination. DSPD suggested that once they eliminated other providers listed on the PCSP, and reviewed the possible service(s) offered by the remaining provider; it was possible to identify the number of units of service by dividing the total amount of the claim by the cost per unit of the service(s) the provider provided. Using this method, DSPD said that they could tell that the individuals in the audit sample had "probably received massage therapy" services.

After DSPD denied providing direct service to individuals on Medicaid Waivers, and after staff provided conflicting responses regarding billing processes, the UOIG expanded the audit sample to include all claims paid to DSPD Medicaid Provider ID numbers in 2017, and identified over 2,025 claims totaling $593,395.90. The UOIG then met with the Director of DSPD to enquire about the process of billing Medicaid to pay non-enrolled Medicaid providers. The Director brought in a staff member who provided information about the process. The OIG asked again if DSPD ever provided any direct service to Individuals. DSPD reported that the only service they provided was occasional temporary transition services, provided when an individual moved off the DSPD Wait List and into care. During the transition, DSPD had a handful of DSPD employees that provided SCE services, in order to assist in the transition. Individuals were then responsible to select a contracted SCE provider for ongoing care. DSPD reported that the number of such instances was time-limited and negligible. The UOIG asked if DSPD staff ever provided massage therapy services, or home or vehicle modifications. DSPD reported that they did not have any employees qualified to provide those services, nor would they attempt to provide those services. The UOIG asked if DSPD ever purchased any type of medical equipment, and then distributed the equipment to an individual, or multiple individuals in care. DSPD again denied any participation in such practices. The UOIG asked DSPD if there were any other occurrences, in which a DSPD employee might provide a direct service to an individual. DSPD reported that outside of occasional temporary SCE services to an individual in transition, there was not any situation in which their staff members would provide direct service to individuals in care.

After meeting with DSPD's Director, the DSPD staff members who had initially denied using Medicaid funds to pay non-enrolled providers, provided the UOIG with information contrary to their original response. They reported that DSPD contracted with providers to provide services such as home and vehicle modifications, or massage therapy services, but that these providers had not enrolled as Medicaid providers. DSPD further reported that in these instances, DSPD submitted Medicaid claims using DSPD's assigned Medicaid Provider ID numbers, of which there were several, and then used the funds to pay the non-enrolled providers. This practice was necessary, they said, because the non-enrolled providers lacked Medicaid ID numbers; the only way for DSPD to bill Medicaid for each service was to use DSPD-assigned Medicaid provider ID numbers.

The UOIG met with DSPD and DOH staff to learn more about the circumstances in which DSPD would pay providers that are non-enrolled with Medicaid, using Medicaid funds. The UOIG inquired about the nature of the process, and asked questions about other State and Medicaid compliance elements, such as whether or not the service providers and their staff held valid licenses to perform the services in question. If so, who was responsible for verifying that information? DSPD and DOH reported that DSPD staff bore responsibility to verify current licensure, and DSPD submitted documentation in the form of checklists to support that it had occurred. The checklists reflected the names of the non-enrolled massage therapy providers that DSPD had previously identified through a process of elimination using the PCSP of each individual listed in the sample claims data.

The UOIG also asked DOH and DSPD if anyone had verified whether non-enrolled providers were included on the List of Excluded Individuals and Entities (LEIE). The LEIE is a regularly updated list of individuals and entities who may not provide services to individuals on Medicare, Medicaid, or any other federal healthcare program. Inclusion on the LEIE is usually

the result of a conviction related to healthcare fraud, although individuals may be included for a variety of reasons. The UOIG recommends routine checks of the LEIE for both current and new employees of Medicaid providers, but initial checks are normally part of the DOH enrollment process for Medicaid providers. In these instances, that check was not completed by DOH, because the providers were not enrolled in Medicaid.

DSPD initially denied any knowledge of the LEIE and reported that perhaps DOH had completed a check of the LEIE for the non-enrolled providers in a separate process. However, later in the audit the same DSPD staff members changed their response and reported that they had personally checked the LEIE for each non-enrolled provider DSPD paid using Medicaid funds. When the UOIG asked for documentation to support LEIE verification had occurred, DSPD provided a spreadsheet. The spreadsheet provided vague information for some, but not all of the providers that DSPD identified as likely having provided the actual services listed in the audit sample.

Due to the discrepancies in responses from DOH, DHS, and DSPD, regarding DSPD's practice of billing Medicaid using DSPD-assigned Medicaid ID numbers to pay non-enrolled providers, the UOIG inquired further about the practice, including any possible authorization. Had either DOH or CMS authorized DSPD to bill Medicaid using their own assigned provider ID numbers, in order to pay other entities not enrolled in Medicaid for service provision? Again, responses by DSPD and DOH staff contained multiple inconsistencies. DSPD reported that DOH had approved the process, and in one meeting, DOH appeared to agree that that had occurred. DOH leadership then pointed to a 1993 letter from CMS, addressed to State Medicaid Directors, which detailed processes for Medicaid Waiver Reassignment of Claims. Medicaid allows states to allow their respective government departments and divisions, such as DSPD, operate Waiver programs and bill Medicaid on behalf of the providers who supply the services and/or equipment, and is the same authority that DSPD utilizes to bill Medicaid on behalf of DSPD-contracted providers. The 1993 letter provided by DOH, however, does not support paying non-enrolled providers; it only authorizes government entities such as DSPD, who are operating Medicaid programs, to bill Medicaid and distribute the funds to the Medicaid providers who provided each service. DOH denied any more recent guidance from CMS on this matter, and later revised their previous position, stating that DSPD providers paid with Medicaid funds "should be enrolled with Medicaid as well [as contracted with DSPD][11]". Section 5005 of the CURES Act clearly identifies requirements for all FFS providers, including all Waiver Providers, to enroll with Medicaid no later than January 1, 2017.

Despite the various inconsistencies in DSPD and DOH staff statements about the process in which DSPD billed Medicaid for reimbursement of services by non-enrolled providers, DSPD and DOH staff all reported that the practice had ended after 2017 when the content of DHS contracts changed. They reported that after 2017, DHS contracts required Medicaid enrollment by all contracted providers, and that DSPD no longer billed Medicaid using their assigned provider ID numbers to pay non-enrolled providers.

The UOIG examined all HCBS Waiver claims submitted by DSPD to verify the veracity of DSPD and DOH reports of a cessation of billing Medicaid for non-enrolled providers. The data encompassed all Medicaid claims in Utah including the U4, U5, and U6 modifiers, by all providers, for calendar years 2017, 2018, 2019, and 2020. Contrary to reports by staff, DSPD

[11] Email from DOH Manager to UOIG 3/5/21 titled OIG Database Exclusion Checks

continues to bill Medicaid for using their own assigned Medicaid ID numbers (*figure 10*). In 2018 DSPD billed Medicaid for $543,194.30 for services paid to other providers using DSPD assigned Medicaid provider ID numbers. In 2019, that number rose to $1,078,003.38. In 2020, they billed Medicaid $846,608.16, and as of May 2021 had billed Medicaid $164,427.13 in 2021 for claims paid to other providers using DSPD's assigned Medicaid provider ID numbers. These totals do not include a single claim submission in 2019, for $1,121, in which DSPD billed Medicaid for Waiver Transition Services. This is because DSPD does provide occasional, temporary transitional services. No other similar claims were submitted to Medicaid by DSPD from 2017-2021.

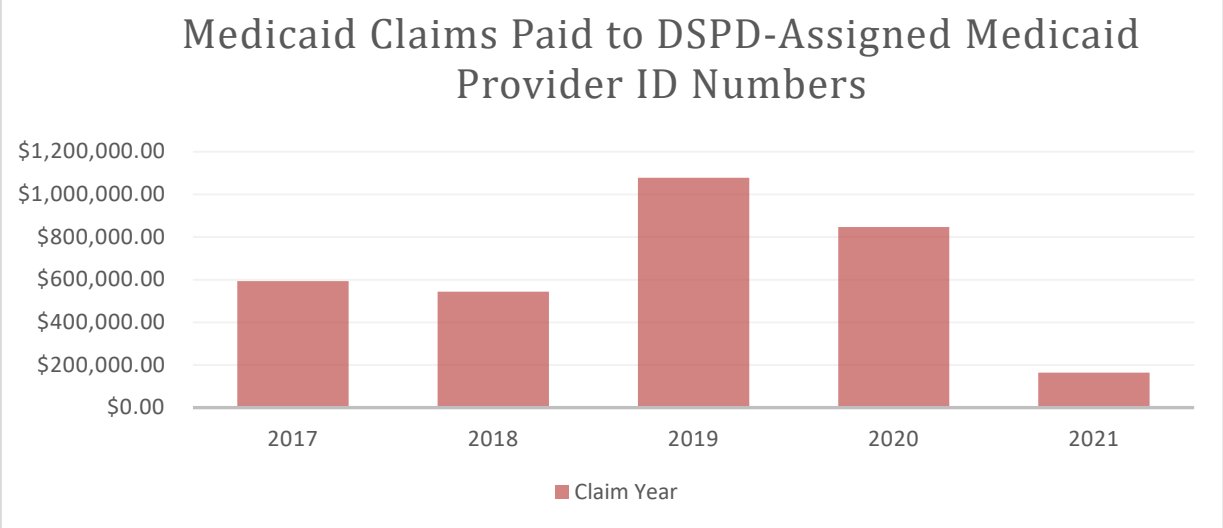

Figure 10

The number of claims submitted by DSPD each year using their assigned Medicaid ID numbers varied significantly each year. In 2017, they submitted 2,025 claims using their provider ID numbers, but in 2018, that number dropped to 106 and only 103 in 2019, but then rose to a high of 4,370 claims in 2020. As of May 2021, DSPD has submitted an additional 199 claims using their assigned Medicaid provider ID numbers (*figure 11*). It is therefore clear that DSPD and DOH claims of a cessation in DSPD's practice of using their assigned Medicaid Provider ID numbers to bill for services provided by other entities is inaccurate, and has instead increased.

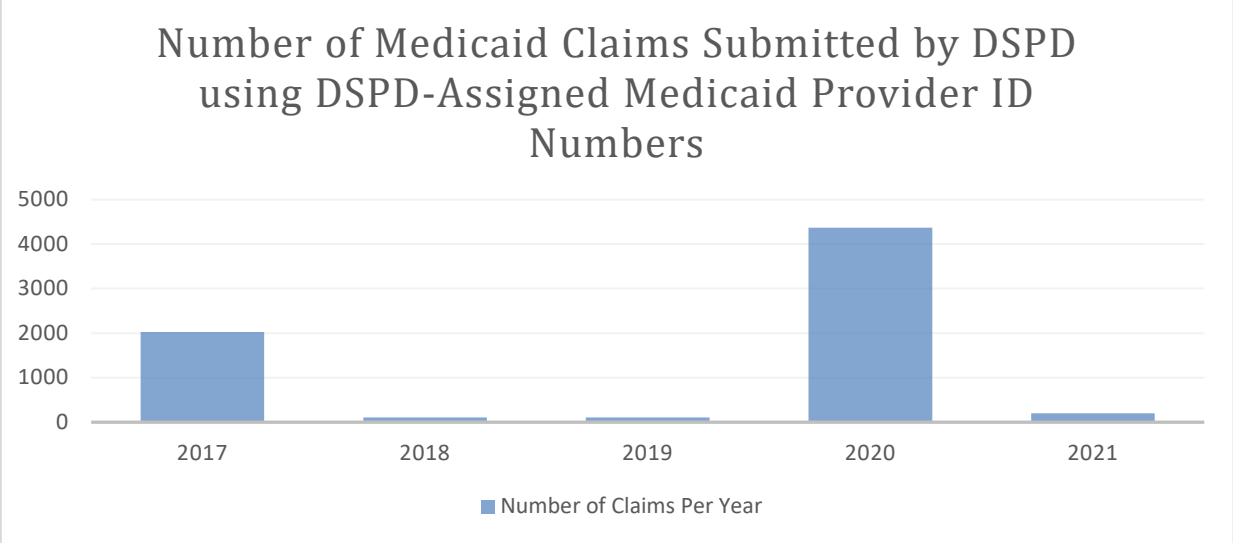

Figure 11

The number of claims submitted by DSPD to Medicaid using DSPD assigned provider ID numbers each year is disproportionate to the total Medicaid funds paid by Medicaid and associated with those claims. This is due to a large variation in average claim amount each year; in 2017, the average claim amount was $293.04. In 2018, that number rose significantly to an average of $5,124.47, and in 2019 the average claim amount doubled to $10,466.05. In 2020, the average claim paid to a DSPD-assigned provider ID dropped to $193.73. As of May 2021, the average claim paid to DSPD Medicaid provider ID numbers was $826.27 (*figure 12*).

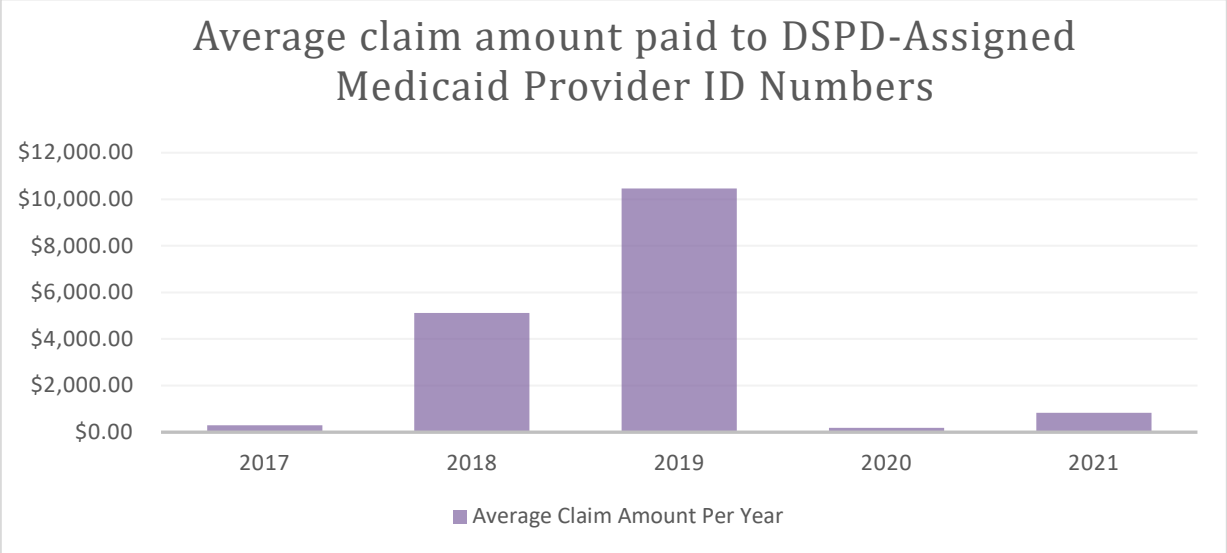

Figure 12

The services identified on the claims that DSPD submitted to Medicaid for reimbursement using their own assigned Medicaid Provider ID numbers included "Waiver Services, Not Otherwise Specified", "Vehicle Modifications", "Home Modifications", and "Specialized Medical Equipment". An examination of the claims data offered only cursory assistance in analyzing the variation between the number of claims and average claim amount from year to year, due to limitations in descriptors listed in the DSPD claims submissions. However, 98% of claims in 2017 fell under "Waiver Services, Not Otherwise Specified", or the T2025 HCPCS code. In 2018, the majority of claims fell into one of three service categories: 30% of S5165, Home Modifications; 25% of T2025, Waiver Services, Not Otherwise Specified; and 32% of T2039, Vehicle Modifications. In 2019, over 62% of claims listed Home Modifications, and in 2020, 94% of claims identified Specialized Medical Equipment, or T2029. A review of service record documentation would be necessary to ascertain any further information or causation for the variation between average claim totals, number of claims, and service types (*figure 13*).

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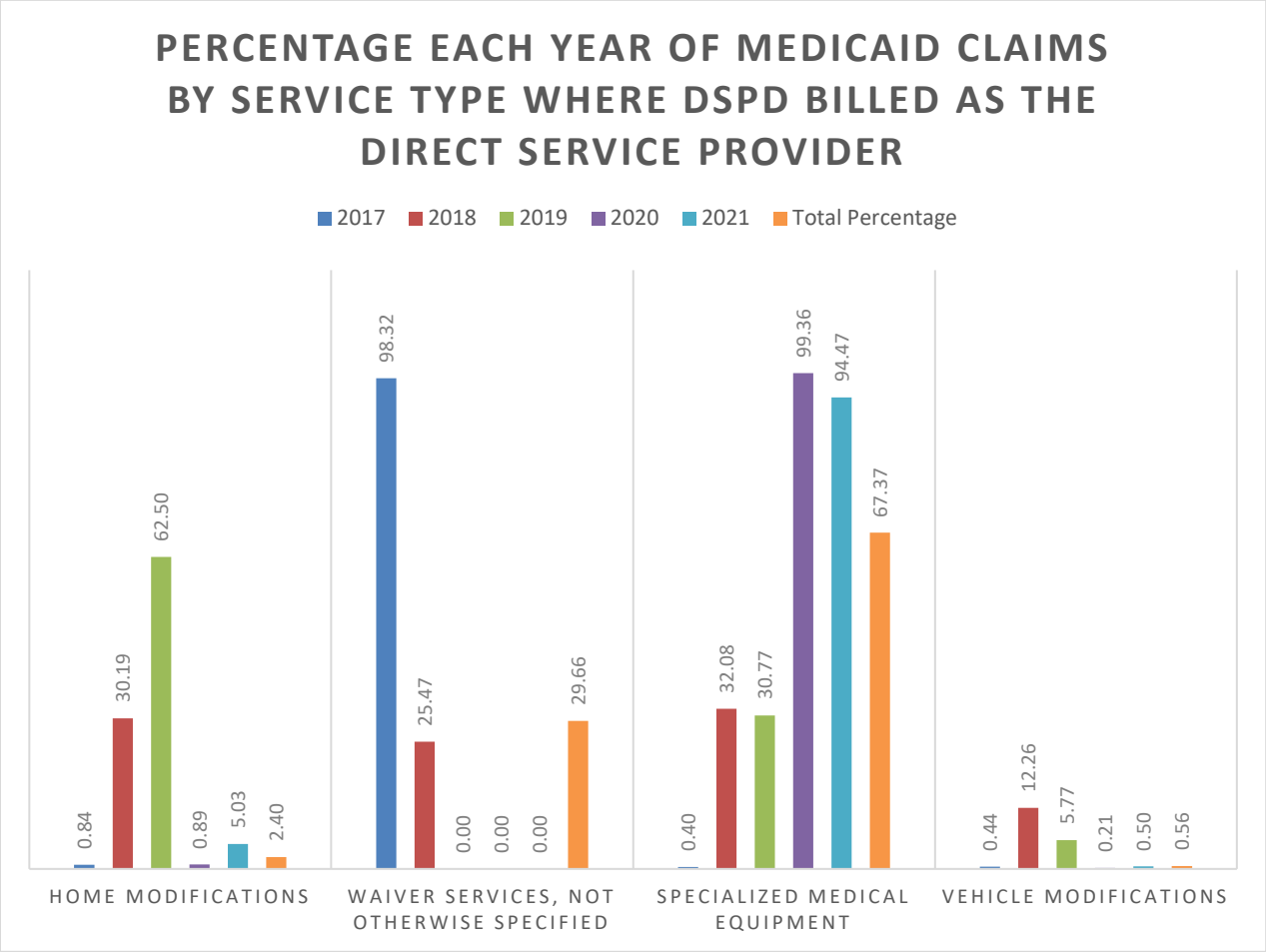


Figure13

DSPD's practice of billing Medicaid using inaccurate claims information specifying that DSPD provided direct service as a means to pay non-enrolled Medicaid providers fell outside of the direct audit scope of UOIG Audits 2019-01 and 2019-05. As a result, the UOIG did not pursue documentation for all services whose claims identified DSPD provider. Similarly, the UOIG did not pursue documentation to support the completion of other compliance elements for any non-enrolled providers during these audits. The UOIG does, anticipate a future review of these compliance concerns, however, considering the potential for violations of the Federal False Claims Act, Utah's False Claims Act, and Medicaid policies described in these Findings.

The UOIG's inadvertent identification of approximately $3.5 Million in inaccurate Medicaid claims submitted by DSPD from 2017 to May 2021, wherein DSPD claimed their Division staff provided the direct service underlines the need for accurate billing processes that result in the ability of Medicaid and the UOIG to examine claims data that accurately reflects the service provided, the Medicaid beneficiary, the service provider, the date of service, and the quantity of service. It is imperative that DOH and DSPD resolve these discrepancies and install meaningful and actionable controls to prevent any future reoccurrence. Until that is achieved, elevated levels of risk exist to Utah's Medicaid Program, taxpayer resources, and to the individuals enrolled in Waivers who depend upon these services.

Recommendations

8.1 The UOIG recommends DHHS implement written policies that include meaningful and actionable controls to ensure all Medicaid claims reflect accurate information, including but not limited to:

- Service(s) Provided;
- Service Provider;
- Medicaid Beneficiary;
- Date(s) of Service;
- Unit(s) of Service, including the start and end time of service provision; and
- Rate of Service

8.2 The UOIG recommends DSPD implement written policies that include meaningful and actionable controls, to ensure that DSPD pays Medicaid funds only to individuals and/or entities currently enrolled as Medicaid providers, in accordance with federal and state regulations, the Waiver SIPs, and Medicaid policies.

8.3 The UOIG recommends annual training requirements for DHHS and DSPD staff regarding:

- Medicaid;
- Medicaid policies;
- Medicaid Waivers;
- The prevention of Fraud, Waste, and Abuse of Medicaid funds;
- How to report suspected Fraud, Waste, or Abuse of Medicaid resources

FINDING 9 — DUE TO INACCURATE BILLING PRACTICES, ANY ANALYSIS OF DSPD MEDICAID CLAIMS OR WAIVER UTILIZATION REQUIRES A MANUAL REVIEW OF SERVICE RECORDS

As detailed in earlier Findings of this report, adjudicated DSPD Medicaid Waiver claims do not match the actual service provision for which the claims are paid. DSPD's unique billing process, which necessitates changes in service codes listed on claims, DSPD's authorization to providers to routinely bill for higher quantities of service than are actually provided, DSPD's direction to providers to bill for inaccurate dates of service, and DSPD's submission of inaccurate claims all combine to result in the inability of any entity to utilize adjudicated DSPD Medicaid Waiver claims data to determine actual Waiver utilization. These practices further prevent DOH, DHS, DSPD, OQD, and the UOIG from conducting internal or external audits of Medicaid Waiver claims to ensure program integrity, billing accuracy, or to verify actual service provision. As a result, any entity attempting to review service provision or audit Waiver utilization must conduct a manual review of each DSPD-contracted provider's individual service records, in order to determine the actual service provided, the date of the actual service, the actual quantity of service, who received the service, and who provided the service.

RECOMMENDATION

9.1 The UOIG recommends policies that result in the ongoing training and education of DHHS, and DSPD staff regarding Medicaid service record documentation requirements.

9.2 The UOIG recommends policies that result in the ongoing training and education of DSPD-contracted providers regarding Medicaid service record documentation requirements.

9.3 The UOIG recommends DHHS enforcement of DSPD compliance with current DHHS-approved DSPD Provider contractual obligations, which require providers to document the following elements in each record of Medicaid Waiver service provision:

- The name of the person served;
- The name of the contractor and the contractor's staff member who delivered the service;
- The amount of time spent delivering the service; and
- Any progress notes describing the Person's response to the service (e.g. progress or lack of progress as documented in monthly summaries and progress notes) (State of Utah DHS, 2019)".

9.4 The UOIG recommends DHHS enforcement of additional DSPD Provider contractual requirements to document the following elements in each record of Medicaid Waiver service provision:

- The name of the person served;
- the name of the contractor and the contractor's staff member who delivered the service;
- the specific service provided;
- the date the service was provided;
- the amount of time spent delivering the service, including the start and end time of service; and
- progress notes describing the Person's response to the service (e.g. progress or lack of progress as documented in monthly summaries and progress notes) (State of Utah DHS, 2019)".

9.5 The UOIG recommends DHHS disallow span-date or date-range billing practices for Home and Community Based Waiver Services except in the case of per diem (daily) or monthly services where the date range identified does not include an interruption in service.

FINDING 10	DUE TO INSUFFICIENT SERVICE RECORD DOCUMENTATION PRACTICES, A MANUAL REVIEW OF DSPD SERVICE RECORDS IS NOT POSSIBLE

As detailed in the previous Findings of this report, DSPD-contracted providers do not document Medicaid Waiver service provision to an extent sufficient to allow any entity to determine the actual service, intensity, or quantity of service provided. DSPD provider practices are a direct contradiction of their contractual obligations, but are in alignment with DOH, DSPD, and OQD expectations and verbal instructions. It is similarly impossible to determine service provision through Medicaid claim submissions, due to a variety of factors, including the unique billing system utilized by DSPD, and the inaccurate information included in Medicaid claims by DSPD and DSPD-providers. It is therefore both necessary to conduct a review of manual records to determine actual DSPD Medicaid Waiver service provision, and an impossibility to do so, as the records are generally insufficient to support the claims.

Although it is not currently possible to determine service provision through a manual review of provider service records, DOH and DSPD inferred that this method would assist the UOIG in our efforts to reconcile Medicaid claims with DSPD service provision. However, were it possible to conduct a manual review of DSPD-contracted provider service records to determine service provision, it would not be an efficient use of time or resources to do so. Medicaid claim information is readily accessible; it should not be necessary to request and then review additional records or data in order to attempt to determine what occurred in each individual Medicaid claim.

DOH and DSPD have created an inaccurate and inefficient system by allowing continued DSPD Medicaid claim payment and processing, while those claims contain inaccurate and/or false information. Neither DOH, DSPD, OQD, nor UOIG has the time or resources to pursue lengthy manual reviews of every DSPD Medicaid claim. It is unlikely that, even if the involved parties addressed the identified deficiencies in DSPD service record documentation, and the content of future DSPD service records contained sufficient information for an auditor or staff member to conduct a manual review, that DSPD Medicaid manual claims reviews would occur frequently enough to ensure accurate claim submission or to monitor for program integrity. For that reason, any DOH or DSPD process correction, which incorporates only an increased ability to conduct manual claims reviews, without consideration of, and correction to DSPD's inaccurate claim submission practices, is an inadequate solution to the variated areas of concern identified in Audits 2019-01 and 2019-05.

RECOMMENDATION

10.1 The UOIG recommends DHHS and DSPD, write and implement processes and policies with meaningful and actionable controls to ensure that Medicaid claims submissions accurately detail all elements of service provision.

10.2 The UOIG recommends that DHHS and DSPD, write and implement policies and processes with meaningful and actionable controls that result in Medicaid service record documentation that accurately reflect all elements of service provision:

- the date the service was performed;
- the start and end time of each service;
- the type of service;
- the name of the individual receiving the service;
- the name of the individual providing the service; and
- substantive information about the service provided, such as a log note.

OBSERVATION 1	SERVICE PROVISION REPORTED BY DSPD PROVIDERS OFTEN DOES NOT MATCH SERVICE AUTHORIZATION IN CARE PLANS, AND RETROACTIVE APPROVAL IS NORMAL

As detailed in the Findings of this report, discrepancies exist between the services identified by DSPD-contracted providers, and the corresponding adjudicated Medicaid claims. There is also a lack of sufficient Medicaid service record documentation to support the claim, in direct violation of DSPD providers' contractual obligations. The lack of service record documentation has become normative for DSPD and DSPD-contracted providers; of the records submitted to the UOIG during Audits 2019-01 and 2019-05, the service record documentation was largely insufficient to support any particular service, or any duration of service. Despite this, both DSPD staff and providers reported the provision service at levels that exceeded PCSP allowance.

DSPD providers reported that they always receive payment for service provision, even when that service provision exceeds the type or quantity authorized on an Individual's PCSP. Providers acknowledged that they typically identify a needed change in service type, in service intensity, and/or in the quantity or frequency of service provision, and then alter service delivery to match the identified needed change. Only after service provision and impact to the PCSP budget occurs do providers seek retroactive approval from DSPD through the RFP process. Similarly, DSPD staff reported that the RFP process often results in retroactive approval of payment for services provided. DSPD and Providers reported that in the event DSPD denies an RFP, the provider typically resubmits the request with additional information, in order to obtain approval.

It is expected that an Individual's needs may occasionally change, necessitating the alteration of their PCSP. However, a conflict arises when a provider contracted to perform a service has the option to unilaterally increase the level and/or amount of service, and then demand reimbursement for the increase. Meaningful and actionable controls should exist to ensure that retroactive approval of increases ordered by the same entity who will financially benefit from the increase are not the norm, and that any identified change in need is clearly demonstrated through adequate documentation to support that need.

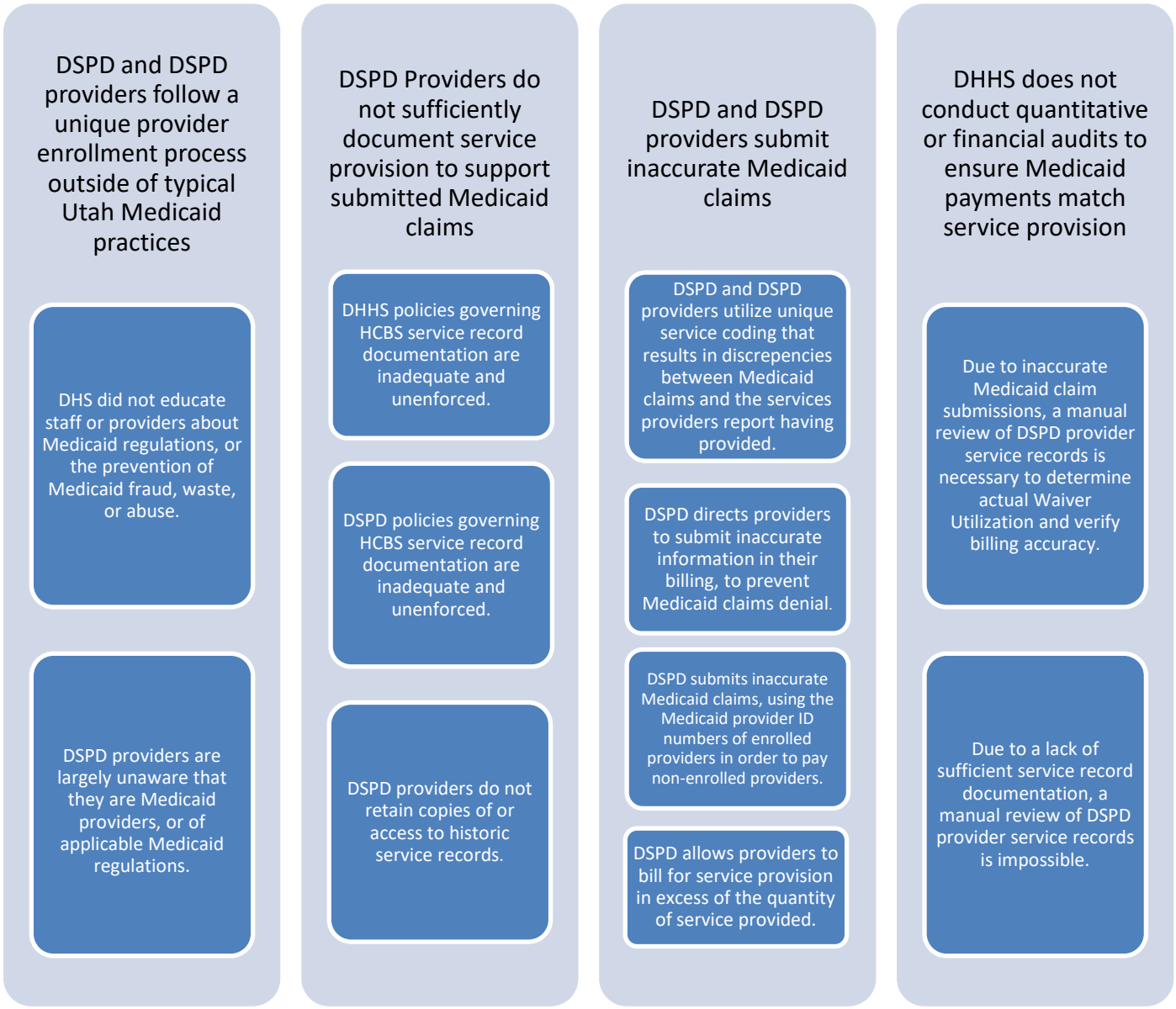
There is an opportunity for DSPD and OQD to incorporate meaningful controls, not only in daily operations, but also in annual provider audits. The UOIG therefore concurs with findings identified by the Office of the Utah Legislative Auditor General (OLAG) in a 2014 Performance Audit of DSPD: insufficiencies exist in DSPD processes that govern a request for additional service. Similarly, the UOIG concurs with 2021 Audit Findings of DSPD by OLAG: The RFS Committee is crucial to assessing client needs and reducing overspending in client budget. Although DSPD has formalized their internal processes for the approval of additional service through the Request for Service (RFS) Committee, current practices do not appear to coincide with the intent of those processes. A need exists for additional an actionable controls to ensure that service authorization processes adhere to written policies and program intent. Additional information regarding these implications is located in the Findings section of this report.

OBSERVATION 2	DHS DOES NOT EDUCATE STAFF OR PROVIDERS ABOUT, OR REPORT INSTANCES OF SUSPECTED FRAUD, WASTE, OR ABUSE OF MEDICAID FUNDS TO THE UTAH OFFICE OF INSPECTOR GENERAL

Although Utah Code 63A-13 mandates a report of any suspected fraud, waste, or abuse of Medicaid funds to the Utah Office of Inspector General, the UOIG has no record of any such report from DHS in the last five years. During Audits 2019-01 and 2019-05, DHS staff acknowledged multiple incidents of suspected fraud, waste, and abuse of Medicaid funds that DHS neglected to report to the UOIG. Utah Code 63A-13-204 limits the UOIG to a three-year period in the pursuit of overpayments to Medicaid providers. When DHS eventually disclosed the suspected incidents of fraud, waste, and abuse or resources to the UOIG during the Audits, the three-year window had expired. A failure to report suspected fraud, waste, or abuse of resources may result in a loss of taxpayer resources, as well as a loss of potential services to individuals who may otherwise have received services using those funds.

There exists a distinct opportunity to educate DHS staff in the duties and powers of the UOIG, as well as the areas in which the UOIG could be a resource to DHHS staff and providers. Collaboration between DHHS and the UOIG may lead to the identification of potential additional overpayments, or the identification of potential areas of waste that, once resolved, would result in an opportunity to utilize those funds to provide additional services to individuals in care. Opportunities also exist to utilize any theoretical savings that result from the implementation of efficiencies or from recoupment of inappropriately billed Medicaid claims, to bring individuals off the DSPD Wait List and into service.

KEY TAKEAWAYS FROM UOIG AUDITS 2019-01, 2019-05



The number of Individuals awaiting service on DSPD's Wait List continues to grow each year. Limited resources prevent DSPD from moving the majority of these Individuals into care. DSPD's current service model allows provider payment in full for any service identified on an Individual's PCSP, whether or not a provider fulfilled that service. Due to a systemic lack of quantitative service record documentation, and due to DSPD and DSPD provider's inaccurate Medicaid billing practices, it is impossible to quantify the precise amount of improperly paid resources for services not rendered. It is possible, however, to correct process deficiencies and reallocate improperly paid resources toward bringing Individuals off the DSPD Wait List.

The recent merger between DOH and DHS provides a unique opportunity to refine current practices, to ensure programmatic efficiency and regulatory Medicaid compliance, and to prevent any additional improper Medicaid payments.

GLOSSARY OF TERMS

Term	Description
ABI	Utah Medicaid HCBS Acquired Brain Injury Waiver. This Waiver is a 1915(c) HCBS Waiver and provides targeted services through DSPD to Individuals with an acquired brain injury.
ABI.IDRC	Acquired Brain Injury, Intellectual Disability, and Related Conditions
BCI, BC2, BC3	DSPD Service Codes for levels of Behavioral Consultation
CAPS	Internal payment system with DSPD's USTEPS database program. DSPD staff often refer to CAPS as USTEPS.
CHA	DSPD Service Code for Chore Services
CHI	DSPD Service Code for Chore Services
COI	DSPD Service Code for Companion Services
CMS	Centers for Medicare & Medicaid Services. CMS manages the Medicare and Medicaid programs at the Federal level, sets public policy, and issues various direction and guidance tools for states, providers, and Medicaid recipients. They provide authorization for each state's respective Waiver programs.
COM	DSPD Service Code for Companion Services
CS	Community Supports Medicaid Waiver. This Waiver is a 1915(c) HCBS Waiver and offers services to individuals in DSPD care who have intellectual or other similar disabilities. The CS Waiver is presently Utah's largest HCBS Waiver, in terms of Waiver Utilization.
CQI	Continuous Quality and Improvement. OQD was absorbed by CQI, who is newly formed within DHHS.
DCFS	Utah DHS Division of Child and Family Services.
DHS	Utah Department of Human Services. DHS will merge with DOH in July 2022, but at present oversees Human Services Divisions, including, but not limited to, DSPD and OQD.

DOH	Utah Department of Health. The DOH will merge with DHS in July 2022, but at present oversees the Utah Medicaid Program and other Health Department Divisions and Bureaus.
DSPD	Utah Division of Services for People with Disabilities. The DSPD utilizes Medicaid Waivers to meet the needs of individuals with disabilities, through contracted Medicaid service providers.
DSG	DSPD Service Code for Day Supports Group
DSI	DSPD Service Code for Day Supports for an Individual
DSP	DSPD Service Code for Day Supports Partial
DSQ	DSPD Service Code for Day Supports, Full Day over 6 Hours
DTP	DSPD Service Code for Transportation Services
DTS	Utah Department of Technology Services. DOH DTS personnel are located at DOH and work directly with DOH employees. DHS DTS personnel are located at DHS and work directly with DHS employees.
DWS	Utah Department of Workforce Services. DWS determines Medicaid Eligibility for individuals who wish to apply to receive Medicaid benefits.
ELS	DSPD Service Code for Extended Living Supports
FCA	False Claims Act. There is both a federal and state version of the Act, which prohibits false claims for government healthcare benefits. The Act identifies penalties that may be levied against individuals and entities responsible for false claims. The federal False Claims Act includes Whistleblower Protections and Qui Tam incentives.
FFP	The federal government's share of total state Medicaid expenditures, or the federal share of the FMAP.
FMAP	Federal Medical Assistance Percentage. The FMAP amount varies slightly from year to year. The government determines the FMAP based upon a formula that takes into account the average per capita income relative to the national average.
FMS	DSPD Service Code for Financial Management Services
FY	Fiscal Year. Following the abbreviation for FY, is the year in question, such as FY17, for Fiscal Year 2017. In this report, FY refers to the State of Utah Fiscal Year, which runs from July 1 to June 30 of the following calendar year, unless otherwise specified. FY17 is therefore July 1, 2016 through June 30, 2017. For reference, the Federal Fiscal Year runs from October 1 of each year through

	September 30 of the following calendar year. A calendar year runs from January 1 through December 31 of the same year.
HCBS	Home and Community Based Services. Also known as 1915 (c) Waivers, these are one of the most common types of Medicaid Waivers. Utah has eight HCBS Waivers at present.
HHS	DSPD Service Code for Host Home Supports
HHS OIG	United States Department of Health and Human Services, Office of Inspector General. Federal-level OIG. The HHS OIG performs Audits and Investigations of over 300 programs within HHS in an effort to identity and combat Fraud, Waste, and Abuse.
HSI	DSPD Service Code for Homemaker Services
HSQ	DSPD Service Code for Homemaker Services
JJS	Utah DHS Juvenile Justice Services.
MMIS	Medicaid Management Information System
MTP	DSPD Service Code for Motor Transportation Payments
NPI	National Provider Identifier number. Healthcare providers acquire a unique NPI number, issued by CMS, that identifies them to their partners, and all healthcare payers, including Medicaid and commercial healthcare insurers.
OFO (DHS)	Utah Department of Human Services Office of Fiscal Operations.
OFO (DOH)	Utah Department of Health Office of Fiscal Operations.
OL	Utah DHS Office of Licensing.
OLAG	Utah Office of Legislative Auditor.
OQD	Utah DHS Office of Quality and Design.
PAI	DSPD Service Code for Personal Assistance Service
PAC	DSPD Service Code for Personal Assistance Services
PBA	DSPD Service Code for Personal Budget Assistance
PEI	Personal Emergency Response Device, or PERS
PE3	DSPD Service Code for Combination PERS and Medication Dispenser
PEP	DSPD Service Code for PERS with Equipment Purchase

PEQ DSPD Service Code for Additional Replacement Devices

PEI DSPD Service Code for Medication Dispenser

PD Physical Disabilities Medicaid Waiver. This Waiver is a 1915(c) HCBS Waiver and offers targeted services through DSPD to Individuals who have Physical disabilities.

PMI,PM2 DSPD Service Code for levels of Professional Medication Monitoring by a Licensed Practical Nurse

PPS DSPD Service Code for DSPD Service Code for Professional Parent Supports

RHS DSPD Service Code for Residential Habilitation Supports

RPI, RP6 DSPD Service Code for Respite

RP3 DSPD Service Code for Exceptional Care Respite without Room and Board

RP4 DSPD Service Code for Routine Respite with Room and Board Included

RP5 DSPD Service Code for Exceptional Care Respite with Room and Board Included

RP7, RP8 DSPD Service Code for Respite Group

RPS DSPD Service Code for Respite Session

Service Record DSPD and OQD expect service records to contain minimal documentation that supports an individual's satisfaction or progress toward stated goals; their focus is qualitative. Meanwhile, the UOIG defines a service record as documentation that supports the billing. The documentation should identify the Medicaid service provided, the service date and quantity of service, along with the provider and Medicaid beneficiary. Depending upon the type of service, Medicaid may require additional documentation elements as well, but this is dependent upon Medicaid policy and specific to the respective Medicaid service and program type in question. To the UOIG, a review of Medicaid service records involves verification that the billing matches the service record documentation provided, and that the records are sufficient to support each Medicaid claim. A qualitative "satisfied" log note or a checkmark compiled by a DSPD provider does not suffice to support Medicaid billing when it lacks those other elements.

SCE DSPD Service Code for Supported Employment with a Co-Worker, often referred to as Service Coordinator- External. This provider type is similar to the role of a caseworker, and is what DSPD calls the Medicaid service that contracted providers provide to individuals on the CS, PD, and ABI Waivers.

SED	DSPD Service Code for Supported Employment in a Group
SEE	DSPD Service Code for Supported Employment Enterprise
SEI	DSPD Service Code for Supported Employment for Individual
SLI	DSPD Service Code for Supported
SLH	DSPD Service Code for Supported Living Quarterly Hourly
SLN	DSPD Service Code for Supported Living Natural
TFI	DSPD Service Code for Family Training and Preparation
TFA	DSPD Service Code for Family Training and Preparation
TFB	DSPD Service Code for Family and Individual Training and Preparation
UACS	Utah Association of Community Services. DSPD providers formed UACS. The group meets regularly and accounts "for about 72%" of DSPD's annual budget for CS Waiver services, according to their website. DSPD providers report that policy decisions for DSPD providers typically go through UACS before DSPD adopts or implements them.
UHIN	Utah Medicaid contractor for Health Information Exchange. Processes Utah Medicaid provider claim submissions
UOIG	Utah Office of Inspector General. The UOIG works to identify and eliminate Medicaid Fraud, Waste, and Abuse.
USC	United States Code
USDC	Utah State Developmental Center. DSPD operates the USDC and provides 24-hour residential care to Individuals with mental, physical, and/or developmental disabilities.
USTEPS	DSPD's provider interface and database.
UTP	DSPD Service Code for Paratransit Daily Fare
UTA	DSPD Service Code for Adult Monthly Pass
UTA	DSPD Service Code for Paratransit Trip Fare
UTD	DSPD Service Code for Route Deviation
UTF	DSPD Service Code for Trip with Route Deviation

PROVIDER KEY

The key below details the number of claims, number of providers, and type of service included in the initial round of service records requested by the UOIG as part of Audit 2019-01's audit sample. DSPD providers included in the audit sample with Medicaid claims under multiple Medicaid Provider ID numbers appear only once as a provider in this table.

Upon discovery of limitations in DSPD providers' ability to respond to UOIG records requests, the UOIG undertook Audit 2019-05 and conducted onsite or one-on-one audits with various provider types, to determine the scope of the conflict.

Fiscal Agent	Emergency Response Device
• 3 Providers • 1096 Claims	• 2 Providers • 79 Claims

Service Coordinator	Traditional Services	Transportation
• 47 Providers • 461 Claims	• 9 Providers • 685 Claims	• 1 Provider • 78 Claims

ARTICLE 1

Utah Office of
Inspector General

Gene Cottrell
Inspector General

Preliminary Findings Letter

Justin Naylor, Director, Office of Quality and Design
Utah Department of Human Services
195 North 1950 West
Salt Lake City, Utah 84114

Dear Mr. Naylor,

Pursuant to the authority vested in the Utah Office of Inspector General (UOIG) as codified in Utah Code Title 63A Chapter 13, the UOIG has undertaken audit 2019-05 of Medicaid Records of Service Documentation and Medicaid Records Retention by the Division of Services for People with Disabilities (DSPD) and DSPD contracted Providers.

In response to your request regarding opportunities for DSPD contract improvement, the Utah Office of Inspector General has identified the following preliminary findings regarding DSPD contracts with Medicaid Providers. These findings reflect the audit information identified to-date, and as such are preliminary in nature and may be subject to amendment as the audit progresses and as additional information becomes available.

- Currently implemented contracts contain confusing and/or contradictory information. The following are examples derived from the current ID.RC/ABI Waiver Services Contract:
    - Part I, Section D, identifies Record Keeping and Retention of Records requirements and specifies retention for a minimum of 6 years from date of last service, while Part II, Section C, 16(c) (2) identifies Record Keeping responsibilities of the provider and specifies a 5-year retention period from date of discharge.
    - Part II, Section C, 16 (c) (3) identifies elements that must be captured for documentation of Medicaid Services, including: The name of the Person served; The name of the Contractor and the Contractor's staff member who delivered the

service; The specific service provided; The date and time the service was provided; The amount of time spent delivering the service; and Progress notes describing Person's response to the service. By contrast, the end of Section II contains pages that detail provider responsibilities and any applicable service or documentation processes for each of the DSPD service codes, but do not include or refer to Medicaid documentation elements listed earlier in the contract.

- Currently implemented contracts do not include detailed information about the Medicaid program, requirements for Medicaid Providers, or Medicaid billing and reimbursement for service provision. The following example is derived from the DHS Contract for Services Provider by A Utah Governmental Entity, between DHS/DSPD and UTA:
    - The contract does not contain substantive information about Medicaid, and does not allow for direct Medicaid billing by the Provider.

At this time, the UOIG preliminarily recommends changes to DSPD contracts with Medicaid service providers, to include clear language and detailed information about the Medicaid program and Medicaid provider responsibilities, including billing and documentation requirements. Additional finding information will be included in the formal audit report, upon completion of the audit.

Please contact the UOIG with any questions.

Sincerely,

Gene Cottrell, Inspector General

CC: Ann Williamson, Director, Utah Department of Human Services
Mark Brasher, Deputy Director, Utah Department of Human Services
Angella Pinna, Director, Division of Services for People with Disabilities
Emma Chacon, Director, Operations, Division of Medicaid and Health Financing

MANAGEMENT RESPONSE

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
Executive Director

NATE CHECKETTS
Deputy Director

DR. MICHELLE HOFMANN
Executive Medical Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

September 2, 2022

Gene Cottrell
Inspector General
Office of the Inspector General of Medicaid Services
P.O. Box 14103
Salt Lake City, Utah 84114

Dear Mr. Cottrell:

On behalf of the Department of Health and Human Services, thank you for the opportunity to respond to the audit titled *Medicaid Waiver Utilization, Medicaid Service Documentation, and Medicaid Records Retention Practices by DSPD and DSPD Providers*. I appreciate the effort and professionalism of you and your staff in this review. The final product reflects a significant effort and time of the DHHS staff collecting information for OIG review, answering questions, and planning changes to improve the program. This audit and its responses will result in a better, more efficient program.

DHHS largely agrees with most of the recommendations in this report. DHHS is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need improvement.

Sincerely,

Tracy S. Gruber
Executive Director
Department of Health and Human Services

State Headquarters: 195 North 1950 West, Salt Lake City, Utah 84116
telephone: (801) 538-4001 | email: dhhs@utah.gov | web: dhhs.utah.gov

Response to Recommendations

Introduction

The Department of Health and Human Services (DHHS) would like to take the opportunity to clarify the dates and time frames associated with the activities included in this response. Many of the Department's actions will require changes and analyses of DHHS billing systems, which will entail thorough planning, development, and training. Due to the upcoming implementation of Medicaid's new PRISM system, several target dates have been extended to ensure the Department can commit to the actions described. DHHS commits to improving program integrity across all DSPD waivers and systems and seeks to perform a thorough analysis, and subsequent implementation, of policies, controls, and audit activities for the actions described below. Time frames may also reflect the alignment of state fiscal years in order to appropriately prepare providers and ensure contract monitoring can be applied uniformly to all entities. The timelines also took into account the Department's obligation to complete projects and processes related to its current Settlement Agreement as well as corrective action plans from other audits.

Finding 1: *DOH knowingly accepted inaccurate DSPD Medicaid claims.*

Recommendation 1.1

The UOIG recommends that DHHS write and implement universally applicable policies wherein all Utah Medicaid providers and billing agents must bill Utah Medicaid using a standardized process to allow documentation, training, and auditing for each respective Medicaid service industry.

Department Response:

DHHS partially agrees with this recommendation. The Department agrees with the need to ensure standardized billing processes that allow documentation, training, and auditing. However, based on the wide variety of Medicaid provider types and payment arrangements, the DHHS does not agree that the policies must be universally applicable and all Utah Medicaid providers must use a single standardized process.

What: DHHS will reevaluate our current procedures and policies regarding provider billings and service record documentation to identify areas for improvement. DHHS, including DSPD, the Division of Integrated Healthcare (which includes the Utah Medicaid program and hereafter will be referred to as Medicaid) and the Office of Service Review (OSR) will complete this evaluation by reaching out to other states to identify best practices and will seek technical assistance from CMS.

When: By June 30, 2023, DHHS will report to the OIG on other states' approaches and any additional guidance provided by CMS, and will outline any new policy recommendations that result.

Contact: Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Recommendation 1.2

The UOIG recommends that DHHS write and implement policies wherein all Utah Medicaid providers and billing agents must bill Utah Medicaid without need for a crosswalk of billing or service codes, using Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) Codes/Proprietary Laboratory Analysis (PLA) Codes.

Department Response:

DHHS partially agrees with this recommendation. We agree that enhancements are needed to improve documentation, training and auditing activities, but we do not agree that a change from the current CMS approved claims submission process is needed to facilitate the improvements the UOIG is recommending.

What: DHHS will perform a thorough analysis of needed enhancements to improve documentation, training and auditing of services and to evaluate the pros and cons involved in modifying the current DSPD claims payment system (CAPS) to require providers to submit claims directly to Medicaid's new claims payment system (PRISM) rather than the CAPS.

When: By December 31, 2023, DHHS will provide the UOIG with the results of the analysis.

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Recommendation 1.3

The UOIG recommends that DHHS amend Utah Medicaid billing policies to include a prohibition against the submission of inaccurate Medicaid Claims.

Department Response:

DHHS agrees with this recommendation. While DHHS believes providers generally understand that accurate claims are required to be submitted for reimbursement and DHHS issues rules, manuals, and bulletins instructing providers on how to accurately bill Medicaid, DHHS agrees to amend billing policies to expressly state that "providers are prohibited from submitting inaccurate Medicaid claims."

In this finding, we believe the UOIG may be seeking to address the concern that DHHS has allowed providers to submit some types of claims within set date spans rather than a specific date. The reason DHHS has allowed this process for these types of claims is due to DHHS' decades-old systems that lack the ability to discern that two providers submitting claims for the same service on the same date are not duplicate claims, but rather two legitimate services delivered by two providers at different times on the same day. DHHS' current practice for these claims is not for any purpose other than to allow providers to be paid for legitimate services provided.

Until DHHS' system limitations are resolved, the state has no other mechanism to allow legitimately provided claims to be submitted for reimbursement.

What: After go-live of the PRISM system, DHHS will evaluate what additional system changes are needed, to both PRISM and DSPD systems, to allow providers to submit claims for legitimately provided services when two providers bill for the same service on the same day.

When: By June 30, 2023, DHHS will report back to the UOIG regarding what steps will be taken, including timelines, to modify the systems to address this issue.

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Recommendation 1.4

The UOIG recommends that DHHS install meaningful and actionable controls to prevent non-enrolled providers or entities from billing Medicaid using the Medicaid provider IDs of enrolled providers.

Department Response:

DHHS partially agrees with this recommendation. While DHHS believes meaningful and actionable controls are currently in place to prevent non-enrolled providers from billing Medicaid, we agree to re-evaluate controls to determine if additional safeguards are needed.

Within this finding, DHHS believes the UOIG is seeking to address the concern that DHHS has allowed DSPD to use their provider ID to reimburse certain non-Medicaid enrolled providers in limited circumstances. Examples of non-Medicaid enrolled providers are those who build wheelchair ramps, install van lifts, or when an entity like Amazon is used to purchase equipment or supplies online.

DHHS' interpretation is that in these examples, general contractors or an entity such as Amazon, would not be reasonably expected to enroll as a Utah Medicaid provider. Based on DHHS' interpretation of CMS policy, we have long permitted DSPD to submit these types of claims through the DSPD provider number.

We acknowledge that the UOIG has a different interpretation of the federal guidance and law and does not believe DHHS' current practice is permissible.

What: To further clarify federal guidance and law, DHHS contacted the CMS HCBS liaison for Utah. CMS has verified receipt of the state's question, and indicated they are researching the question with their subject matter experts.

When: CMS has not provided an exact date by which they will respond. As soon as CMS provides clarification, DHHS will share the information with UOIG. If CMS concurs with the UOIG's interpretation, DHHS will revise its processes for these certain non-enrolled providers to conform with CMS's guidance.

Contact: Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Finding 2: *DSPD directs contracted providers to submit inaccurate Medicaid claims.*

Recommendation 2.1

The UOIG recommends that DHHS and DSPD write and incorporate Medicaid billing policies to prohibit the submission of inaccurate Medicaid Claims; Medicaid billing should accurately reflect all aspects of the provided service, including the date, type, and quantity of service provided, the individual who received the service, the individual or provider who provided the service.

Department Response:

DHHS partially agrees with this recommendation.

Please see DHHS' response to finding 1.2 about implementing policies to prohibit the submission of inaccurate claims.

DHHS partially agrees with the recommendation that all aspects of service delivery must be documented. DHHS believes some flexibility is needed to make some adjustments to what documentation is required, depending on the nature of the service (e.g., residential services where someone lives there 24/7 and it would be impractical to require the provider to provide a record of the quantity provided).

What: DHHS agrees to reevaluate our current procedures and policies regarding HCBS record documentation to identify areas for improvement. DHHS, including DSPD, Medicaid and the Office of Services Review (OSR) will complete this evaluation by reaching out to other states to identify best practices and will seek technical assistance from CMS. DHHS will report the results of the evaluation to the UOIG.

When: By June 30, 2023, DHHS will report on the results of its evaluation.

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Recommendation 2.2

The UOIG recommends that DSPD write and incorporate internal policies and actionable controls that ensure DSPD and/or DSPD-contracted Providers cannot submit inaccurate Medicaid claims.

Department Response:

DHHS agrees with this recommendation.

Please see DHHS' response to finding 1.3 about implementing policies to prohibit the submission of inaccurate claims.

Recommendation 2.3

The UOIG recommends that DSPD write and incorporate policies and actionable controls to ensure that non-enrolled providers or entities cannot bill Medicaid using the Medicaid provider IDs of enrolled providers, to ensure compliance with the Federal False Claims Act, Utah's False Claims Act, and the 21st Century Cures Act.

Department Response:

DHHS partially agrees with this recommendation.

Please see DHHS' response to finding 1.4 about implementing policies about billing for non-enrolled providers.

Recommendation 2.4

The UOIG recommends that DHHS and DSPD write and incorporate policies and actionable controls to ensure that DSPD-contracted providers do not bill based upon a schedule, or upon assumption of service provision, and that submitted service totals are verifiable.

Department Response:

DHHS agrees with this recommendation. DHHS agrees that providers must not bill based upon a schedule, assumption of services, and that service delivery must be verifiable. DHHS will reevaluate our current policies and controls regarding billing requirements.

What: DHHS, including DSPD, Medicaid and the Office of Service Review (OSR) will complete this evaluation by reaching out to other states to identify best practices and will seek technical assistance from CMS.

When: By June 30, 2023, DHHS will report on the results of its evaluation.

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Recommendation 2.5

The UOIG recommends the distribution of these new policies and processes to, and detailed training for, all DHHS and DSPD staff, and all DHHS and DSPD-contracted providers.

Department Response:

DHHS agrees with this recommendation.

What: Following the construction of new policies, DHHS commits to disseminating these to contractors and will develop and provide training to all internal and external stakeholders, including contracted providers.

When: By December 31, 2023 the curriculum and training plan will be developed. By June 30, 2024 all training will be completed.

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Finding 3: *Many DSPD-contracted providers are unaware that they are Medicaid Providers, and of the regulations that apply to Medicaid providers.*

Recommendation 3.1

Although CMS approved DSPD to conduct "qualified provider enrollment" of their providers, the UOIG recommends that Utah Medicaid enact uniform Medicaid enrollment practices, applicable to all providers.

Department Response:

DHHS partially agrees with this recommendation. DHHS agrees that it needs to obtain and record standard information from providers in order to enroll them in the program. However, based on the wide variety of Medicaid providers with varying levels of sophistication, the DHHS does not agree that Medicaid provider enrollment practices must be uniform across all provider types and that DSPD should not assist some providers in this process.

What: DHHS believes UOIG's interest in having providers engage directly in the enrollment process is to heighten the provider's awareness of the fact they are Medicaid providers and subject to Medicaid's billing requirements. DHHS will review its provider training and enhance these elements in its training.

When: June 30, 2023

Contact: Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov

Recommendation 3.2

The UOIG recommends that DHHS and DSPD write and incorporate policies that require DHHS staff training, which details Medicaid policies, regulations, and processes relevant to their respective roles in administering Medicaid Waivers.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will implement policy changes that require more detailed DHHS staff training on Medicaid policies, regulations, and processes that are relevant to their respective roles in administering waivers.

When: December 31, 2023

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Recommendation 3.3

The UOIG recommends that DHHS incorporate substantive Medicaid information in the NPO, including written documentation and links to Medicaid regulations and program compliance resources.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will implement new procedures that incorporate substantive Medicaid information into the New Provider Orientation (also referred to as the Pre-solicitation meeting). Materials will include written documentation and electronic links to Medicaid regulations and program compliance resources.

When: By December 31, 2023 the curriculum and training plan will be developed. By June 30, 2024 all training will be completed.

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Recommendation 3.4

The UOIG recommends that DHHS and DSPD write and incorporate policies that require DSPD Provider training, which details Medicaid policies, regulations, and processes relevant to their respective roles in providing services under Medicaid Waivers.

Department Response:

DHHS agrees with this recommendation.

What: Consistent with responses to recommendations 3.2 and 3.3, DHHS agrees to implement new policies and procedures that incorporate substantive Medicaid information into required DSPD provider training.

When: Policy will be developed by December 31, 2023. Training will be implemented by June 30, 2024.

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Finding 4: *Policies and contracts governing Home and Community Based Service record documentation and retention need improvement and/or are unenforced.*

Recommendation 4.1

The UOIG recommends that DHHS revise Medicaid service record documentation policies, provider manuals, and contracts to include consistent service record documentation and service record retention language throughout each respective policy and/or contract.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will review and amend the language in all manuals, policies, and contracts to assure consistency and to clarify service record documentation and retention requirements.

When: December 31, 2023

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Recommendation 4.2

The UOIG recommends that DHHS revise Medicaid service record documentation policies, provider manuals, and contracts to include a requirement to capture the following elements in the documentation of all HCBS Waiver services:

- *the date the service was performed;*
- *the start and end time of each service;*
- *the type of service;*
- *the name of the individual receiving the service;*
- *the name of the individual providing the service;*
- *the date the service record documentation was created; and*
- *substantive information about the service provided, such as a log note.*

Department Response:

DHHS partially agrees with this recommendation.

DHHS agrees that all services must be adequately documented. However, DHHS believes it needs the flexibility to make some adjustments to what documentation is required, depending on the nature of the service (e.g., residential services where someone lives there 24/7 and it would be impractical to require the provider to provide a record of the quantity provided).

What: DHHS agrees to reevaluate our current procedures and policies regarding HCBS record documentation to identify areas for improvement. DHHS, including DSPD, Medicaid and the Office of Service Review (OSR) will complete this evaluation by reaching out to other states to identify best practices and will seek technical assistance from CMS. DHHS will report the results of the evaluation to the UOIG.

When: June 30, 2023

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Recommendation 4.3

The UOIG recommends that DHHS provide adequate oversight and conduct reviews of DSPD and DSPD providers, to ensure compliance with Medicaid policies and regulations, and with the recommendations identified above.

Department Response:

DHHS agrees with this recommendation.

What: Medicaid, DSPD, and Continuous Quality Improvement (CQI, which includes OSR) will collaborate to review audit tools and processes and make adjustments to address actionable controls in regularly scheduled reviews. This review will include coordination with the Office of Internal Audit (OIA) to ensure proper controls are in place with regard to financial audits and services billed against Medicaid.

When: By December 31, 2023 needed adjustments to tools and processes will be identified. By June 30, 2024 all staff training and provider notification will be completed. Provider compliance monitoring will begin on July 1, 2024.

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov;
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov;
Shannon Thoman-Black, Director, Office of Continuous Quality & Improvement, sthomanblack@utah.gov

Recommendation 4.4

The UOIG recommends that DHHS write and implement meaningful and actionable controls to ensure DHHS policy and Medicaid regulatory compliance at all levels.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will write and implement meaningful and actionable controls to ensure DHHS policy and Medicaid regulatory compliance for the items described in 4.1, 4.2, and 4.3. This will include coordination with the Office of Internal Audit (OIA) to ensure proper controls are in place with regard to financial audits and services billed against Medicaid, as identified in contract, and as directed by Medicaid. The evaluation will also include the identification of DHHS oversight entities and the frequency in which items will be audited or monitored.

When: DHHS will implement meaningful and actionable controls by December 31, 2023.

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Finding 5: ***Policies and contracts governing DSPD provider services do not ensure compliance with state and federal Medicaid policies or Waiver program requirements.***

Recommendation 5.1

The UOIG recommends the amendment of DSPD provider contracts to reflect and reference federal Medicaid regulations and guidance, Utah Medicaid policies, Utah Code, Utah Administrative Rules, and other appropriate regulatory guidance governing the provision of service, documentation of service, billing, and program requirements.

Department Response:

DHHS agrees with this recommendation.

What: DSPD will review and amend provider contracts as necessary to incorporate by reference all applicable state and federal Medicaid policy, and Utah state code, including any relevant administrative rules.

When: June 30, 2024

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Recommendation 5.2

The UOIG recommends the creation and incorporation of consistent policies and contracts that require the following elements in DSPD provider's Medicaid service record documentation:

- *the date the service was performed;*
- *the start and end time of each service;*
- *the type of service;*
- *the name of the individual receiving the service;*
- *the name of the individual providing the service; and*
- *substantive information about the service provided, such as a log note*

Department Response:

DHHS partially agrees with this recommendation.

Please see DHHS' response to finding 4.2 about implementing policies related to documentation requirements.

Recommendation 5.3

The UOIG recommends that DHHS, DSPD, and CQI amend provider audit tools and processes to include actionable controls in the review and audit of service records during normally scheduled OQD provider audits, including a financial audit of documented units of service against adjudicated Medicaid billing

Department Response:

DHHS agrees with this recommendation.

What: Medicaid, DSPD, and CQI will collaborate to review audit tools and processes and make adjustments to address actionable controls in regularly scheduled reviews. This review will include coordination with the Office of Internal Audit (OIA) to ensure proper controls are in place with regard to financial audits and services billed against Medicaid.

When: By December 31, 2023 needed adjustments to tools and processes will be identified. By June 30, 2024 all staff training and provider notification will be completed. Provider compliance monitoring will begin on July 1, 2024.June 30, 2024

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov;
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov;
Shannon Thoman-Black, Director, Office of Continuous Quality & Improvement, sthomanblack@utah.gov

Recommendation 5.4

The UOIG recommends the DHHS require DSPD, and CQI to provide a written report regarding the outcome of annual financial audits of Waiver service provision and billing each year, including detail of any discrepancies identified.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will develop into ongoing processes, a written report to the DHHS Executive Director, on the outcome of DSPD HCBS annual provider financial audits.

When: Annually each fiscal year with the first report completed by September 30, 2024 (for the preceding fiscal year).

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov;
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov;
Shannon Thoman-Black, Director, Office of Continuous Quality & Improvement, sthomanblack@utah.gov

Recommendation 5.5

The UOIG recommends that DHHS, DSPD, and CQI incorporate and enforce service record documentation requirements identified in current contracts with providers.

Department Response:

DHHS agrees with this recommendation.

What: CQI will evaluate its tools and process to ensure alignment with service documentation requirements in coordination with DSPD as identified in contract, and directed by Medicaid.

When: CQI will begin implementing new audit tools July 1, 2024.

Contacts:
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov;
Shannon Thoman-Black, Director, Office of Continuous Quality & Improvement, sthomanblack@utah.gov

Finding 6: *An operating agreement between DOH and DSPD governing the management of Medicaid Waivers identified in the Audit did not exist from 2015-2019.*

Recommendation 6.1

The UOIG recommends that the DOH and DHS prioritize and actively maintain a current contract, MOA, or SOP, in which the roles and responsibilities of each entity is specified.

Department Response:

DHHS agrees with this recommendation.

What: The following steps have been taken to address this recommendation. 1) A letter of agreement has been signed by DIH and DSPD directors indicating that for the period prior to July 1, 2022, the parties had an agreement in fact due to the extension of their contract. This extension is evidenced by the agencies continuing to operate under the terms of previously existing memorandums of agreement that had been in place between the Divisions since the 1990s. 2) Effective July 1, 2022, a new DHHS memorandum of agreement between DIH and DSPD has been signed. This agreement does not have a termination date and will operate on an ongoing basis.

When: The MOA was executed on August 30, 2022.

Contacts:
Jennifer Strohecker, Director, Division of Integrated Healthcare, jstrohecker@utah.gov
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov

Recommendation 6.2

The UOIG recommends the identification of controls governing Medicaid Waiver utilization, including meaningful and actionable controls over service record documentation, billing processes, claims accuracy and reviews, and general administration of the Waivers.

Department Response:

DHHS agrees with this recommendation.

What: Consolidation of the two departments into a single DHHS, and specifically, having the Division of Integrated Healthcare (State Medicaid Agency) and DSPD (operating agency) organized under the single Healthcare Administration Section will assist DHHS to develop a unified set of policies and procedures to respond directly to the recommendations.

When: December 31, 2023

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Recommendation 6.3

The UOIG recommends the inclusion of the recommended controls identified in 6.2 in an actively maintained MOA between DOH and DHS.

Department Response:

DHHS agrees with this recommendation.

What: Effective July 1, 2022, a new DHHS memorandum of agreement between DIH and DSPD has been drafted. This agreement does not have a termination date and will operate on an ongoing basis.

When: The MOA was executed on August 30, 2022.

Contacts:
Jennifer Strohecker, Director, Division of Integrated Healthcare, jstrohecker@utah.gov
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov

Finding 7: *DOH Allowed DSPD to violate policies requiring Medicaid enrollment by Medicaid HCBS providers.*

Recommendation 7.1

The UOIG recommends DHHS implement written policies that include meaningful and actionable controls to ensure all Medicaid claims reflect accurate information, including but not limited to:

- *Service(s) Provided;*
- *Service Provider;*
- *Medicaid Beneficiary;*
- *Date(s) of Service;*
- *Unit(s) of Service, including the start and end time of service provision; and*
- *Rate of Service*

Department Response:

DHHS partially agrees with this recommendation.

Please see DHHS' response to finding 4.2 about implementing policies related to documentation requirements.

Recommendation 7.2

The UOIG recommends DHHS implement written policies that include meaningful and actionable controls to ensure payment of Medicaid funds only to individuals and/or entities currently enrolled as Medicaid providers.

Department Response:

DHHS partially agrees with this recommendation.

Please see DHHS' response to finding 1.4 about implementing policies related to preventing non-enrolled providers from billing Medicaid.

Finding 8: *DSPD submits inaccurate Medicaid claims.*

Recommendation 8.1

The UOIG recommends DHHS implement written policies that include meaningful and actionable controls to ensure all Medicaid claims reflect accurate information, including but not limited to:

- *Service(s) Provided;*
- *Service Provider;*
- *Medicaid Beneficiary;*
- *Date(s) of Service;*
- *Unit(s) of Service, including the start and end time of service provision; and*
- *Rate of Service*

Department Response:

DHHS partially agrees with this recommendation.

Please see DHHS' response to finding 4.2 about implementing policies related to documentation requirements.

Recommendation 8.2

The UOIG recommends DSPD implement written policies that include meaningful and actionable controls, to ensure that DSPD pays Medicaid funds only to individuals and/or entities currently enrolled as Medicaid providers, in accordance with federal and state regulations, the Waiver SIPs, and Medicaid policies.

Department Response:

DHHS partially agrees with this recommendation.

Please see DHHS' response to finding 1.4 about implementing policies related to preventing non-enrolled providers from billing Medicaid.

Recommendation 8.3

The UOIG recommends annual training requirements for DHHS and DSPD staff regarding:

- *Medicaid;*
- *Medicaid policies;*
- *Medicaid Waivers;*
- *The prevention of Fraud, Waste, and Abuse of Medicaid funds;*
- *How to report suspected Fraud, Waste, or Abuse of Medicaid resources.*

Department Response:

DHHS agrees with this recommendation.

What: DHHS is in the process of working with Federal partners to confirm its understanding of regulations regarding the necessary data to be included in service records and on claims and will adhere to those requirements following the receipt of their technical assistance. Any resulting changes will be accompanied by updates to policy, procedure, contract language, and training.

When: DHHS will research and identify policy and regulatory items for the purpose of this training, and confirm the oversight entities responsible. The curriculum will be developed by December 31, 2023 and all staff training complete by June 30, 2024.

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Finding 9: *Due to inaccurate billing practices, any analysis of DSPD Medicaid claims or Waiver utilization requires a manual review of service records.*

Recommendation 9.1

The UOIG recommends policies that result in the ongoing training and education of DHHS, and DSPD staff regarding Medicaid service record documentation requirements.

Department Response:

DHHS agrees with this recommendation.

What: DHHS is in the process of working with Federal partners to confirm its understanding of regulations regarding the necessary data to be included in service records and will adhere to the requirements following the receipt of their technical assistance. Any resulting changes will be accompanied by updates to policy, procedure, contract language, and training for DSPD staff.

When: Policies will be developed by December 31, 2023. All training will be implemented by June 30, 2024.

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov

Recommendation 9.2

The UOIG recommends policies that result in the ongoing training and education of DSPD-contracted providers regarding Medicaid service record documentation requirements.

Department Response:

DHHS agrees with this recommendation.

What: DHHS is in the process of working with Federal partners to confirm its understanding of regulations regarding the necessary data to be included in service records and will adhere to the requirements following the receipt of their technical assistance. Any resulting changes will be accompanied by updates to policy, procedure, contract language, and training for contracted providers.

When: Policies will be developed by December 31, 2023. All training will be implemented by June 30, 2024.

Contacts:
Angie Pinna, Director, Division of Services for People with Disabilities, apinna@utah.gov;
Josip Ambrenac, Director, Office of Long Term Services and Supports, jambrena@utah.gov;
Shannon Thoman-Black, Director, Office of Continuous Quality & Improvement, sthomanblack@utah.gov

Recommendation 9.3

The UOIG recommends DHHS enforcement of DSPD compliance with current DHHS-approved DSPD Provider contractual obligations, which require providers to document the following elements in each record of Medicaid Waiver service provision:

- *The name of the person served;*
- *The name of the contractor and the contractor's staff member who delivered the service;*
- *The amount of time spent delivering the service; and*
- *Any progress notes describing the Person's response to the service (e.g. progress or lack of progress as documented in monthly summaries and progress notes) (State of Utah DHS, 2019)".*

Department Response:

DHHS partially agrees with this recommendation.

Please see DHHS' response to finding 4.2 about implementing policies related to documentation requirements.

Finding 10: *Due to insufficient service record documentation practices, a manual review of DSPD service records is not possible.*

Recommendation 10.1

The UOIG recommends DHHS and DSPD, write and implement processes and policies with meaningful and actionable controls to ensure that Medicaid claims submissions accurately detail all elements of service provision.

Department Response:

DHHS partially agrees with this recommendation.

Please see DHHS' response to finding 4.2 about implementing policies related to documentation requirements.

Recommendation 10.2

The UOIG recommends that DHHS and DSPD, write and implement policies and processes with meaningful and actionable controls that result in Medicaid service record documentation that accurately reflect all elements of service provision:

- *the date the service was performed;*
- *the start and end time of each service;*
- *the type of service;*
- *the name of the individual receiving the service;*
- *the name of the individual providing the service; and*
- *substantive information about the service provided, such as a log note.*

Department Response:

DHHS partially agrees with this recommendation.

Please see DHHS' response to finding 4.2 about implementing policies related to documentation requirements.

EVALUATION OF MANAGEMENT RESPONSE

The UOIG appreciates the Management Response to this Audit provided by DHHS. In the response, DHHS agrees with some of the recommendations made by the UOIG, and partially agrees with others. After a review of the information provided by DHHS, the UOIG stands by each of the recommendations made in this Audit report. The UOIG offers the following evaluation of the DHHS Management Response.

Finding 1: ***DOH knowingly accepted inaccurate DSPD Medicaid claims.***

Recommendation 1.1

The UOIG recommends that DHHS write and implement universally applicable policies wherein all Utah Medicaid providers and billing agents must bill Utah Medicaid using a standardized process to allow documentation, training, and auditing for each respective Medicaid service industry.

Department Response:

DHHS partially agrees with this recommendation. The Department agrees with the need to ensure standardized billing processes that allow documentation, training, and auditing. However, based on the wide variety of Medicaid provider types and payment arrangements, the DHHS does not agree that the policies must be universally applicable and all Utah Medicaid providers must use a single standardized process.

What: DHHS will reevaluate our current procedures and policies regarding provider billings and service record documentation to identify areas for improvement. DHHS, including DSPD, the Division of Integrated Healthcare (which includes the Utah Medicaid program and hereafter will be referred to as Medicaid) and the Office of Service Review (OSR) will complete this evaluation by reaching out to other states to identify best practices and will seek technical assistance from CMS.

When: By June 30, 2023, DHHS will report to the OIG on other states' approaches and any additional guidance provided by CMS, and will outline any new policy recommendations that result.

UOIG Response:

At present, a lack of DHHS policies prohibiting non-standard billing practices for Medicaid providers exists. Consequently, a series of ad hoc DSPD billing processes has resulted in practices with a significantly increased level of risk, for taxpayers, for the Medicaid program, and for DSPD Medicaid beneficiaries. Although it is understandable that each industry within Medicaid necessitates the creation of policies applicable to that particular industry, an opportunity exists to create standardized billing practices which take into account the needs of each respective industry, sufficient to allow documentation, training, and auditing for each type of Medicaid program. The UOIG maintains our original stance regarding this recommendation.

Recommendation 1.2

The UOIG recommends that DHHS write and implement policies wherein all Utah Medicaid providers and billing agents must bill Utah Medicaid without need for a crosswalk of billing or service codes, using Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) Codes/Proprietary Laboratory Analysis (PLA) Codes.

Department Response:

DHHS partially agrees with this recommendation. We agree that enhancements are needed to improve documentation, training and auditing activities, but we do not agree that a change from the current CMS approved claims submission process is needed to facilitate the improvements the UOIG is recommending.

What: DHHS will perform a thorough analysis of needed enhancements to improve documentation, training and auditing of services and to evaluate the pros and cons involved in modifying the current DSPD claims payment system (CAPS) to require providers to submit claims directly to Medicaid's new claims payment system (PRISM) rather than the CAPS.

When: By December 31, 2023, DHHS will provide the UOIG with the results of the analysis.

UOIG Response:

Due to the discrepancies in type of service, intensity of service, and quantity of service that result from the current DSPD Medicaid claims crosswalk and from the lack of service record documentation detailed later in this Audit, it is not presently possible for DHHS, the UOIG, or CMS to determine whether DSPD claims submissions match the provision of service by DSPD providers. Similarly, DSPD providers find themselves unable to defend their Medicaid claims, when the claims submitted by DSPD do not match the service that the DSPD provider attests to providing. The DSPD crosswalk therefore does not appear to benefit either Medicaid, taxpayers, or DSPD service providers. The UOIG maintains our original stance regarding this recommendation.

Recommendation 1.3

The UOIG recommends that DHHS amend Utah Medicaid billing policies to include a prohibition against the submission of inaccurate Medicaid Claims.

Department Response:

DHHS agrees with this recommendation. While DHHS believes providers generally understand that accurate claims are required to be submitted for reimbursement and DHHS issues rules, manuals, and bulletins instructing providers on how to accurately bill Medicaid, DHHS agrees to amend billing policies to expressly state that "providers are prohibited from submitting inaccurate Medicaid claims."

In this finding, we believe the UOIG may be seeking to address the concern that DHHS has allowed providers to submit some types of claims within set date spans rather than a specific date. The reason DHHS has allowed this process for these types of claims is due to DHHS' decades-old systems that lack the ability to discern that two providers submitting claims for the same service on the same date are not duplicate claims, but rather two legitimate services delivered by two providers at different times on the same day. DHHS' current practice for

these claims is not for any purpose other than to allow providers to be paid for legitimate services provided.

Until DHHS' system limitations are resolved, the state has no other mechanism to allow legitimately provided claims to be submitted for reimbursement.

What: After go-live of the PRISM system, DHHS will evaluate what additional system changes are needed, to both PRISM and DSPD systems, to allow providers to submit claims for legitimately provided services when two providers bill for the same service on the same day.

When: By June 30, 2023, DHHS will report back to the UOIG regarding what steps will be taken, including timelines, to modify the systems to address this issue.

UOIG Response:

The current process referenced in the Department Response, wherein DHHS accepts Medicaid claims from DSPD providers with intentionally inaccurate dates of service, was disclosed during the Audit and reportedly implemented in an effort to save time correcting DSPD SAS claims that arrived after the payment of similar claims on the same original date of service.

The UOIG acknowledges that it may result in additional effort to back out incorrectly billed DSPD SAS claims and then rebill the claim correctly if a second claim later arrives for the same date of service, however; other Utah Medicaid providers who must occasionally correct an improperly billed Medicaid claim utilize similar processes to successfully rebill previous inaccurate claims, as need arises. By correcting any incorrectly submitted DSPD Medicaid claim, DHHS would prevent the deliberate acceptance of additional inaccurate DSPD Medicaid claims, until such time as DHHS can resolve current system limitations that prohibit duplicate payment for same-day services.

Recommendation 1.4

The UOIG recommends that DHHS install meaningful and actionable controls to prevent non-enrolled providers or entities from billing Medicaid using the Medicaid provider IDs of enrolled providers.

Department Response:

DHHS partially agrees with this recommendation. While DHHS believes meaningful and actionable controls are currently in place to prevent non-enrolled providers from billing Medicaid, we agree to re-evaluate controls to determine if additional safeguards are needed.
Within this finding, DHHS believes the UOIG is seeking to address the concern that DHHS has allowed DSPD to use their provider ID to reimburse certain non-Medicaid enrolled providers in limited circumstances. Examples of non-Medicaid enrolled providers are those who build wheelchair ramps, install van lifts, or when an entity like Amazon is used to purchase equipment or supplies online.

DHHS' interpretation is that in these examples, general contractors or an entity such as Amazon, would not be reasonably expected to enroll as a Utah Medicaid provider. Based on DHHS' interpretation of CMS policy, we have long permitted DSPD to submit these types of claims through the DSPD provider number.

We acknowledge that the UOIG has a different interpretation of the federal guidance and law and does not believe DHHS' current practice is permissible.

What: To further clarify federal guidance and law, DHHS contacted the CMS HCBS liaison for Utah. CMS has verified receipt of the state's question, and indicated they are researching the question with their subject matter experts.

When: CMS has not provided an exact date by which they will respond. As soon as CMS provides clarification, DHHS will share the information with UOIG. If CMS concurs with the UOIG's interpretation, DHHS will revise its processes for these certain non-enrolled providers to conform with CMS's guidance.

UOIG Response:

The 21st Century Cures Act requires the enrollment of all Medicaid Providers, including Managed Care Organizations (MCOs), and Fee-for-Service (FFS), by the state Medicaid Agency.

Utah Medicaid's recent Federal FY21 Managed Care Focused Review acknowledges this requirement, stating, "To comply with §§ 438.602(b)(1) and (b)(2), 438.608(b), 455.100-106, 455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, all providers furnishing services to Utah Medicaid members, including providers participating in an ACO provider network, are required to be screened and enrolled with the SMA." and that, "The UDOH screens and enrolls providers in accordance with § 455.436."

Similarly, the Utah Medicaid Director of Long Term Services and Supports over the Waiver programs reported during the Audit that all DSPD providers, including the Massage Therapists DSPD billed for by utilizing DSPD-assigned Medicaid Provider ID numbers should be enrolled with Medicaid. He stated, "My understanding from [the UOIG's] request is that you were curious specifically about some of the Massage Therapy providers that DSPD uses in their waiver programs. I'm fairly certain all of these providers end up directly enrolled as Medicaid providers and are not using DSPD as a pass-through as an independent contractor." He added, "I think we understand that DSPD is remitting claims to Medicaid on their behalf, but they should all be enrolled with Medicaid as well."

Discrepancies exist between practices reported by DSPD and DOH during this Audit, the Federal FY21 Managed Care Focused Review, and the DHHS Management Response to this Audit.

The UOIG did not receive any written documentation of authorization by CMS for DSPD's utilization of services on behalf of Medicaid beneficiaries by home or vehicle modification contractors, Massage Therapists, or other service providers who are not enrolled in the State Medicaid program. The UOIG acknowledges that as a result of this Audit, DHHS requested additional clarification about or authorization for this practice from CMS, and the UOIG awaits CMS feedback.

Finding 2: ***DSPD directs contracted providers to submit inaccurate Medicaid claims.***

Recommendation 2.1

The UOIG recommends that DHHS and DSPD write and incorporate Medicaid billing policies to prohibit the submission of inaccurate Medicaid Claims; Medicaid billing should accurately reflect all aspects of the provided service, including the date, type, and quantity of service provided, the individual who received the service, the individual or provider who provided the service.

Department Response:

DHHS partially agrees with this recommendation.
Please see DHHS' response to finding 1.2 about implementing policies to prohibit the submission of inaccurate claims:

> **Recommendation 1.2**
> *The UOIG recommends that DHHS write and implement policies wherein all Utah Medicaid providers and billing agents must bill Utah Medicaid without need for a crosswalk of billing or service codes, using Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) Codes/Proprietary Laboratory Analysis (PLA) Codes.*
>
> **Department Response:**
> DHHS partially agrees with this recommendation. We agree that enhancements are needed to improve documentation, training and auditing activities, but we do not agree that a change from the current CMS approved claims submission process is needed to facilitate the improvements the UOIG is recommending.
>
> What: DHHS will perform a thorough analysis of needed enhancements to improve documentation, training and auditing of services and to evaluate the pros and cons involved in modifying the current DSPD claims payment system (CAPS) to require providers to submit claims directly to Medicaid's new claims payment system (PRISM) rather than the CAPS.
>
> When: By December 31, 2023, DHHS will provide the UOIG with the results of the analysis.
>
> **UOIG Response:**
> Due to the discrepancies in type of service, intensity of service, and quantity of service that result from the current DSPD Medicaid claims crosswalk and from the lack of service record documentation detailed later in this Audit, it is not presently possible for DHHS, the UOIG, or CMS to determine whether DSPD claims submissions match the provision of service by DSPD providers. Similarly, DSPD providers find themselves unable to defend their Medicaid claims, when the claims submitted by DSPD do not match the service that the DSPD provider attests to providing. The DSPD crosswalk therefore does not appear to benefit either Medicaid, taxpayers, or DSPD service providers.

DHHS partially agrees with the recommendation that all aspects of service delivery must be documented. DHHS believes some flexibility is needed to make some adjustments to what documentation is required, depending on the nature of the service (e.g., residential services where someone lives there 24/7 and it would be impractical to require the provider to provide a record of the quantity provided).

What: DHHS agrees to reevaluate our current procedures and policies regarding HCBS record documentation to identify areas for improvement. DHHS, including DSPD, Medicaid and the Office of Services Review (OSR) will complete this evaluation by reaching out to other states to identify best practices and will seek technical assistance from CMS. DHHS will report the results of the evaluation to the UOIG.

When: By June 30, 2023, DHHS will report on the results of its evaluation.

UOIG Response:
Any Medicaid claim should accurately reflect all aspects of the provided service, including the date, type, and quantity of service provided, the individual who received the service, and the individual or provider who provided the service.

Service Record documentation by providers should be sufficient to support Medicaid claims.

The UOIG maintains our original stance regarding this recommendation.

Recommendation 2.2

The UOIG recommends that DSPD write and incorporate internal policies and actionable controls that ensure DSPD and/or DSPD-contracted Providers cannot submit inaccurate Medicaid claims.

Department Response:

DHHS agrees with this recommendation.
Please see DHHS' response to finding 1.3 about implementing policies to prohibit the submission of inaccurate claims:

> **Recommendation 1.3**
> *The UOIG recommends that DHHS amend Utah Medicaid billing policies to include a prohibition against the submission of inaccurate Medicaid Claims.*
>
> **Department Response:**
> DHHS agrees with this recommendation. While DHHS believes providers generally understand that accurate claims are required to be submitted for reimbursement and DHHS issues rules, manuals, and bulletins instructing providers on how to accurately bill Medicaid, DHHS agrees to amend billing policies to expressly state that "providers are prohibited from submitting inaccurate Medicaid claims."
>
> In this finding, we believe the UOIG may be seeking to address the concern that DHHS has allowed providers to submit some types of claims within set date spans rather than a specific date. The reason DHHS has allowed this process for these types of claims is due to DHHS' decades-old systems that lack the ability to discern that two providers submitting claims for the same service on the same date are not duplicate claims, but rather two legitimate services delivered by two providers at different times on the same day. DHHS' current practice for these claims is not for any purpose other than to allow providers to be paid for legitimate services provided.
>
> Until DHHS' system limitations are resolved, the state has no other mechanism to allow legitimately provided claims to be submitted for reimbursement.
>
> What: After go-live of the PRISM system, DHHS will evaluate what additional system changes are needed, to both PRISM and DSPD systems, to allow providers to submit claims for legitimately provided services when two providers bill for the same service on the same day.
>
> When: By June 30, 2023, DHHS will report back to the UOIG regarding what steps will be taken, including timelines, to modify the systems to address this issue.
>
> **UOIG Response:**
> The current process referenced in the Department Response, wherein DHHS accepts Medicaid claims from DSPD providers with intentionally inaccurate dates of service, was disclosed during the Audit and reportedly implemented in an effort to save time correcting DSPD SAS claims that arrived after the payment of similar claims on the same original date of service.

The UOIG acknowledges that it may result in additional effort to back out incorrectly billed DSPD SAS claims and then rebill the claim correctly if a second claim later arrives for the same date of service, however; other Utah Medicaid providers who must occasionally correct an improperly billed Medicaid claim utilize similar processes to successfully rebill previous inaccurate claims, as need arises. By correcting any incorrectly submitted DSPD Medicaid claim, DHHS would prevent the deliberate acceptance of additional inaccurate DSPD Medicaid claims, until such time as DHHS can resolve current system limitations that prohibit duplicate payment for same-day services.

UOIG Response:

The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, and insufficient policies surrounding these issues.

Recommendation 2.3

The UOIG recommends that DSPD write and incorporate policies and actionable controls to ensure that non-enrolled providers or entities cannot bill Medicaid using the Medicaid provider IDs of enrolled providers, to ensure compliance with the Federal False Claims Act, Utah's False Claims Act, and the 21st Century Cures Act.

Department Response:

DHHS partially agrees with this recommendation.

Please see DHHS' response to finding 1.4 about implementing policies about billing for non-enrolled providers:

Recommendation 1.4

The UOIG recommends that DHHS install meaningful and actionable controls to prevent non- enrolled providers or entities from billing Medicaid using the Medicaid provider IDs of enrolled providers.

Department Response:

DHHS partially agrees with this recommendation. While DHHS believes meaningful and actionable controls are currently in place to prevent non-enrolled providers from billing Medicaid, we agree to re-evaluate controls to determine if additional safeguards are needed.

Within this finding, DHHS believes the UOIG is seeking to address the concern that DHHS has allowed DSPD to use their provider ID to reimburse certain non-Medicaid enrolled providers in limited circumstances. Examples of non-Medicaid enrolled providers are those who build wheelchair ramps, install van lifts, or when an entity like Amazon is used to purchase equipment or supplies online.

DHHS' interpretation is that in these examples, general contractors or an entity such as Amazon, would not be reasonably expected to enroll as a Utah Medicaid provider. Based on DHHS' interpretation of CMS policy, we have long permitted DSPD to submit these types of claims through the DSPD provider number.

We acknowledge that the UOIG has a different interpretation of the federal guidance and law and does not believe DHHS' current practice is permissible.

What: To further clarify federal guidance and law, DHHS contacted the CMS HCBS liaison for Utah. CMS has verified receipt of the state's question, and indicated they are researching the question with their subject matter experts.

When: CMS has not provided an exact date by which they will respond. As soon as CMS provides clarification, DHHS will share the information with UOIG. If CMS concurs with the UOIG's interpretation, DHHS will revise its processes for these certain non-enrolled providers to conform with CMS's guidance.

UOIG Response:

The 21st Century Cures Act requires the enrollment of all Medicaid Providers, including Managed Care Organizations (MCOs), and Fee-for-Service (FFS), by the state Medicaid Agency.

Utah Medicaid's recent Federal FY21 Managed Care Focused Review acknowledges this requirement, stating, "To comply with §§ 438.602(b)(1) and (b)(2), 438.608(b), 455.100-106, 455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, all providers furnishing services to Utah Medicaid members, including providers participating in an ACO provider network, are required to be screened and enrolled with the SMA." and that, "The UDOH screens and enrolls providers in accordance with § 455.436."

Similarly, the Utah Medicaid Director of Long Term Services and Supports over the Waiver programs reported during the Audit that all DSPD providers, including the Massage Therapists DSPD billed for by utilizing DSPD-assigned Medicaid Provider ID numbers should be enrolled with Medicaid. He stated, "My understanding from [the UOIG's] request is that you were curious specifically about some of the Massage Therapy providers that DSPD uses in their waiver programs. I'm fairly certain all of these providers end up directly enrolled as Medicaid providers and are not using DSPD as a pass-through as an independent contractor." He added "I think we understand that DSPD is remitting claims to Medicaid on their behalf, but they should all be enrolled with Medicaid as well."

Discrepancies exist between practices reported by DSPD and DOH during this Audit, the Federal FY21 Managed Care Focused Review, and the DHHS Management Response to this Audit.

The UOIG did not receive any written documentation of authorization by CMS for DSPD's utilization of services on behalf of Medicaid beneficiaries by home or vehicle modification contractors, Massage Therapists, or other service providers who are not enrolled in the State Medicaid program. The UOIG acknowledges that as a result of this Audit, DHHS requested additional clarification about or authorization for this practice from CMS, and the UOIG awaits CMS feedback.

UOIG Response:

The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, and insufficient policies surrounding these issues.

Recommendation 2.4

The UOIG recommends that DHHS and DSPD write and incorporate policies and actionable controls to ensure that DSPD-contracted providers do not bill based upon a schedule, or upon assumption of service provision, and that submitted service totals are verifiable.

Department Response:

DHHS agrees with this recommendation. DHHS agrees that providers must not bill based upon a schedule, assumption of services, and that service delivery must be verifiable. DHHS will reevaluate our current policies and controls regarding billing requirements.

What: DHHS, including DSPD, Medicaid and the Office of Service Review (OSR) will complete this evaluation by reaching out to other states to identify best practices and will seek technical assistance from CMS.

When: By June 30, 2023, DHHS will report on the results of its evaluation.

UOIG Response:
The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, and insufficient policies surrounding these issues.

Recommendation 2.5
The UOIG recommends the distribution of these new policies and processes to, and detailed training for, all DHHS and DSPD staff, and all DHHS and DSPD-contracted providers.

Department Response:
DHHS agrees with this recommendation.

What: Following the construction of new policies, DHHS commits to disseminating these to contractors and will develop and provide training to all internal and external stakeholders, including contracted providers.

When: By December 31, 2023 the curriculum and training plan will be developed. By June 30, 2024 all training will be completed.

UOIG Response:
The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, and insufficient policies surrounding these issues.

Finding 3: ***Many DSPD-contracted providers are unaware that they are Medicaid Providers, and of the regulations that apply to Medicaid providers.***

Recommendation 3.1

Although CMS approved DSPD to conduct "qualified provider enrollment" of their providers, the UOIG recommends that Utah Medicaid enact uniform Medicaid enrollment practices, applicable to all providers.

Department Response:

DHHS partially agrees with this recommendation. DHHS agrees that it needs to obtain and record standard information from providers in order to enroll them in the program. However, based on the wide variety of Medicaid providers with varying levels of sophistication, the DHHS does not agree that Medicaid provider enrollment practices must be uniform across all provider types and that DSPD should not assist some providers in this process.

What: DHHS believes UOIG's interest in having providers engage directly in the enrollment process is to heighten the provider's awareness of the fact they are Medicaid providers and subject to Medicaid's billing requirements. DHHS will review its provider training and enhance these elements in its training.

When: June 30, 2023

UOIG Response:

Many of the DSPD providers are unaware that they are Medicaid Providers, and are consequently unaware of the Medicaid regulations that apply to them in their capacity as Medicaid providers. Utah Medicaid's 2021 rollout of provider enrollment through PRISM offers providers valuable resources, including provider assistance and enrollment eLearning Courses, informational videos, provider policy and compliance resources, and more. As such, the UOIG maintains our original stance regarding this recommendation that Utah Medicaid enact uniform Medicaid enrollment practices.

Recommendation 3.2

The UOIG recommends that DHHS and DSPD write and incorporate policies that require DHHS staff training, which details Medicaid policies, regulations, and processes relevant to their respective roles in administering Medicaid Waivers.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will implement policy changes that require more detailed DHHS staff training on Medicaid policies, regulations, and processes that are relevant to their respective roles in administering waivers.

When: December 31, 2023

UOIG Response:

The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the

continuance of inaccurate claims submission, insufficient service record documentation, insufficient policies surrounding these issues, and a lack of employee training resources governing these issues.

Recommendation 3.3

The UOIG recommends that DHHS incorporate substantive Medicaid information in the NPO, including written documentation and links to Medicaid regulations and program compliance resources.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will implement new procedures that incorporate substantive Medicaid information into the New Provider Orientation (also referred to as the Pre-solicitation meeting). Materials will include written documentation and electronic links to Medicaid regulations and program compliance resources.

When: By December 31, 2023 the curriculum and training plan will be developed. By June 30, 2024 all training will be completed.

UOIG Response: The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, insufficient policies surrounding these topics, and a lack of provider training resources governing these issues.

Recommendation 3.4

The UOIG recommends that DHHS and DSPD write and incorporate policies that require DSPD Provider training, which details Medicaid policies, regulations, and processes relevant to their respective roles in providing services under Medicaid Waivers.

Department Response:

DHHS agrees with this recommendation.

What: Consistent with responses to recommendations 3.2 and 3.3, DHHS agrees to implement new policies and procedures that incorporate substantive Medicaid information into required DSPD provider training.

When: Policy will be developed by December 31, 2023. Training will be implemented by June 30, 2024.

UOIG Response: The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, and insufficient policies surrounding these topics, in order to ensure clear contractual obligations governing these issues, as well as the availability of provider training resources.

Finding 4: *Policies and contracts governing Home and Community Based Service record documentation and retention need improvement and/or are unenforced.*

Recommendation 4.1
The UOIG recommends that DHHS revise Medicaid service record documentation policies, provider manuals, and contracts to include consistent service record documentation and service record retention language throughout each respective policy and/or contract.

Department Response:
DHHS agrees with this recommendation.

What: DHHS will review and amend the language in all manuals, policies, and contracts to assure consistency and to clarify service record documentation and retention requirements.

When: December 31, 2023

UOIG Response: The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, and insufficient policies surrounding these topics, in order to ensure clear contractual obligations governing these issues.

Recommendation 4.2
The UOIG recommends that DHHS revise Medicaid service record documentation policies, provider manuals, and contracts to include a requirement to capture the following elements in the documentation of all HCBS Waiver services:

- *the date the service was performed;*
- *the start and end time of each service;*
- *the type of service;*
- *the name of the individual receiving the service;*
- *the name of the individual providing the service;*
- *the date the service record documentation was created; and*
- *substantive information about the service provided, such as a log note.*

Department Response:
DHHS partially agrees with this recommendation.
DHHS agrees that all services must be adequately documented. However, DHHS believes it needs the flexibility to make some adjustments to what documentation is required, depending on the nature of the service (e.g., residential services where someone lives there 24/7 and it would be impractical to require the provider to provide a record of the quantity provided).

What: DHHS agrees to reevaluate our current procedures and policies regarding HCBS record documentation to identify areas for improvement. DHHS, including DSPD, Medicaid and the Office of Service Review (OSR) will complete this evaluation by reaching out to other states to identify best practices and will seek technical assistance from CMS. DHHS will report the results of the evaluation to the UOIG.

When: June 30, 2023

UOIG Response:
Any Medicaid claim should accurately reflect all aspects of the provided service, including the date, type, and quantity of service provided, the individual who received the service, the individual or provider who provided the service.

Service Record documentation by providers should be sufficient to support Medicaid claims.

The UOIG maintains our original stance regarding this recommendation.

Recommendation 4.3
The UOIG recommends that DHHS provide adequate oversight and conduct reviews of DSPD and DSPD providers, to ensure compliance with Medicaid policies and regulations, and with the recommendations identified above.

Department Response:
DHHS agrees with this recommendation.

What: Medicaid, DSPD, and Continuous Quality Improvement (CQI, which includes OSR) will collaborate to review audit tools and processes and make adjustments to address actionable controls in regularly scheduled reviews. This review will include coordination with the Office of Internal Audit (OIA) to ensure proper controls are in place with regard to financial audits and services billed against Medicaid.

When: By December 31, 2023 needed adjustments to tools and processes will be identified. By June 30, 2024 all staff training and provider notification will be completed. Provider compliance monitoring will begin on July 1, 2024.

UOIG Response:
The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, and insufficient policies surrounding these topics.

Recommendation 4.4
The UOIG recommends that DHHS write and implement meaningful and actionable controls to ensure DHHS policy and Medicaid regulatory compliance at all levels.

Department Response:
DHHS agrees with this recommendation.

What: DHHS will write and implement meaningful and actionable controls to ensure DHHS policy and Medicaid regulatory compliance for the items described in 4.1, 4.2, and 4.3. This will include coordination with the Office of Internal Audit (OIA) to ensure proper controls are in place with regard to financial audits and services billed against Medicaid, as identified in contract, and as directed by Medicaid. The evaluation will also include the identification of DHHS oversight entities and the frequency in which items will be audited or monitored.

When: DHHS will implement meaningful and actionable controls by December 31, 2023.

UOIG Response:

The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, and insufficient policies surrounding these topics.

Finding 5: *Policies and contracts governing DSPD provider services do not ensure compliance with state and federal Medicaid policies or Waiver program requirements.*

Recommendation 5.1

The UOIG recommends the amendment of DSPD provider contracts to reflect and reference federal Medicaid regulations and guidance, Utah Medicaid policies, Utah Code, Utah Administrative Rules, and other appropriate regulatory guidance governing the provision of service, documentation of service, billing, and program requirements.

Department Response:

DHHS agrees with this recommendation.

What: DSPD will review and amend provider contracts as necessary to incorporate by reference all applicable state and federal Medicaid policy, and Utah state code, including any relevant administrative rules.

When: June 30, 2024

UOIG Response:

The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, and insufficient policies surrounding these topics, in order to ensure clear contractual obligations governing these issues.

Recommendation 5.2

The UOIG recommends the creation and incorporation of consistent policies and contracts that require the following elements in DSPD provider's Medicaid service record documentation:

- *the date the service was performed;*
- *the start and end time of each service;*
- *the type of service;*
- *the name of the individual receiving the service;*
- *the name of the individual providing the service; and*
- *substantive information about the service provided, such as a log note*

Department Response:

DHHS partially agrees with this recommendation.

Please see DHHS' response to finding 4.2 about implementing policies related to documentation requirements:

> **Recommendation 4.2**
>
> *The UOIG recommends that DHHS revise Medicaid service record documentation policies, provider manuals, and contracts to include a requirement to capture the following elements in the documentation of all HCBS Waiver services:*
>
> - *the date the service was performed;*
> - *the start and end time of each service;*
> - *the type of service;*
> - *the name of the individual receiving the service;*
> - *the name of the individual providing the service;*

- *the date the service record documentation was created; and*
- *substantive information about the service provided, such as a log note.*

Department Response:
DHHS partially agrees with this recommendation.
DHHS agrees that all services must be adequately documented. However, DHHS believes it needs the flexibility to make some adjustments to what documentation is required, depending on the nature of the service (e.g., residential services where someone lives there 24/7 and it would be impractical to require the provider to provide a record of the quantity provided).

What: DHHS agrees to reevaluate our current procedures and policies regarding HCBS record documentation to identify areas for improvement. DHHS, including DSPD, Medicaid and the Office of Service Review (OSR) will complete this evaluation by reaching out to other states to identify best practices and will seek technical assistance from CMS. DHHS will report the results of the evaluation to the UOIG.

When: June 30, 2023

UOIG Response:
Any Medicaid claim should accurately reflect all aspects of the provided service, including the date, type, and quantity of service provided, the individual who received the service, the individual or provider who provided the service.

Service Record documentation by providers should be sufficient to support Medicaid claims.

The UOIG maintains our original stance regarding this recommendation.

UOIG Response:

The UOIG maintains our original stance regarding this recommendation. Medicaid claims should accurately reflect all aspects of the provided service, and service Record documentation by providers should be sufficient to support Medicaid claims.

Recommendation 5.3

The UOIG recommends that DHHS, DSPD, and CQI amend provider audit tools and processes to include actionable controls in the review and audit of service records during normally scheduled OQD provider audits, including a financial audit of documented units of service against adjudicated Medicaid billing.

Department Response:

DHHS agrees with this recommendation.

What: Medicaid, DSPD, and CQI will collaborate to review audit tools and processes and make adjustments to address actionable controls in regularly scheduled reviews. This review will include coordination with the Office of Internal Audit (OIA) to ensure proper controls are in place with regard to financial audits and services billed against Medicaid.

When: By December 31, 2023 needed adjustments to tools and processes will be identified. By June 30, 2024 all staff training and provider notification will be completed. Provider compliance monitoring will begin on July 1, 2024.June 30, 2024

UOIG Response:
The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, and insufficient policies surrounding these topics.

Recommendation 5.4
The UOIG recommends the DHHS require DSPD, and CQI to provide a written report regarding the outcome of annual financial audits of Waiver service provision and billing each year, including detail of any discrepancies identified.

Department Response:
DHHS agrees with this recommendation.

What: DHHS will develop into ongoing processes, a written report to the DHHS Executive Director, on the outcome of DSPD HCBS annual provider financial audits.

When: Annually each fiscal year with the first report completed by September 30, 2024 (for the preceding fiscal year).

UOIG Response:
The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, and insufficient policies surrounding these topics.

Recommendation 5.5
The UOIG recommends that DHHS, DSPD, and CQI incorporate and enforce service record documentation requirements identified in current contracts with providers.

Department Response:
DHHS agrees with this recommendation.

What: CQI will evaluate its tools and process to ensure alignment with service documentation requirements in coordination with DSPD as identified in contract, and directed by Medicaid.

When: CQI will begin implementing new audit tools July 1, 2024.

UOIG Response:
The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, and insufficient policies surrounding these topics.

Finding 6: ***An operating agreement between DOH and DSPD governing the management of Medicaid Waivers identified in the Audit did not exist from 2015-2019.***

Recommendation 6.1

The UOIG recommends that the DOH and DHS prioritize and actively maintain a current contract, MOA, or SOP, in which the roles and responsibilities of each entity is specified.

Department Response:

DHHS agrees with this recommendation.

What: The following steps have been taken to address this recommendation. 1) A letter of agreement has been signed by DIH and DSPD directors indicating that for the period prior to July 1, 2022, the parties had an agreement in fact due to the extension of their contract. This extension is evidenced by the agencies continuing to operate under the terms of previously existing memorandums of agreement that had been in place between the Divisions since the 1990s. 2) Effective July 1, 2022, a new DHHS memorandum of agreement between DIH and DSPD has been signed. This agreement does not have a termination date and will operate on an ongoing basis.

When: The MOA was executed on August 30, 2022.

UOIG Response:

The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit.

Recommendation 6.2

The UOIG recommends the identification of controls governing Medicaid Waiver utilization, including meaningful and actionable controls over service record documentation, billing processes, claims accuracy and reviews, and general administration of the Waivers.

Department Response:

DHHS agrees with this recommendation.

What: Consolidation of the two departments into a single DHHS, and specifically, having the Division of Integrated Healthcare (State Medicaid Agency) and DSPD (operating agency) organized under the single Healthcare Administration Section will assist DHHS to develop a unified set of policies and procedures to respond directly to the recommendations.

When: December 31, 2023

UOIG Response:

The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, and insufficient policies surrounding these topics.

Recommendation 6.3
The UOIG recommends the inclusion of the recommended controls identified in 6.2 in an actively maintained MOA between DOH and DHS.

Department Response:
DHHS agrees with this recommendation.

What: Effective July 1, 2022, a new DHHS memorandum of agreement between DIH and DSPD has been drafted. This agreement does not have a termination date and will operate on an ongoing basis.

When: The MOA was executed on August 30, 2022.

UOIG Response:
The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit.

Finding 7: *DOH Allowed DSPD to violate policies requiring Medicaid enrollment by Medicaid HCBS providers.*

Recommendation 7.1

The UOIG recommends DHHS implement written policies that include meaningful and actionable controls to ensure all Medicaid claims reflect accurate information, including but not limited to:

- *Service(s) Provided;*
- *Service Provider;*
- *Medicaid Beneficiary;*
- *Date(s) of Service;*
- *Unit(s) of Service, including the start and end time of service provision; and*
- *Rate of Service*

Department Response:

DHHS partially agrees with this recommendation.

Please see DHHS' response to finding 4.2 about implementing policies related to documentation requirements:

> **Recommendation 4.2**
> *The UOIG recommends that DHHS revise Medicaid service record documentation policies, provider manuals, and contracts to include a requirement to capture the following elements in the documentation of all HCBS Waiver services:*
>
> - *the date the service was performed;*
> - *the start and end time of each service;*
> - *the type of service;*
> - *the name of the individual receiving the service;*
> - *the name of the individual providing the service;*
> - *the date the service record documentation was created; and*
> - *substantive information about the service provided, such as a log note.*
>
> **Department Response:**
> DHHS partially agrees with this recommendation.
> DHHS agrees that all services must be adequately documented. However, DHHS believes it needs the flexibility to make some adjustments to what documentation is required, depending on the nature of the service (e.g., residential services where someone lives there 24/7 and it would be impractical to require the provider to provide a record of the quantity provided).
>
> What: DHHS agrees to reevaluate our current procedures and policies regarding HCBS record documentation to identify areas for improvement. DHHS, including DSPD, Medicaid and the Office of Service Review (OSR) will complete this evaluation by reaching out to other states to identify best practices and will seek technical assistance from CMS. DHHS will report the results of the evaluation to the UOIG.
>
> When: June 30, 2023
>
> **UOIG Response:**
> Any Medicaid claim should accurately reflect all aspects of the provided service, including the date, type, and quantity of service provided, the individual who received the service, the individual or provider who provided the service.
>
> Service Record documentation by providers should be sufficient to support Medicaid claims.
>
> The UOIG maintains our original stance regarding this recommendation.

UOIG Response:
The UOIG maintains our original stance regarding this recommendation. Medicaid claims should accurately reflect all aspects of the provided service, and service Record documentation by providers should be sufficient to support Medicaid claims.

Recommendation 7.2
The UOIG recommends DHHS implement written policies that include meaningful and actionable controls to ensure payment of Medicaid funds only to individuals and/or entities currently enrolled as Medicaid providers.

Department Response:
DHHS partially agrees with this recommendation.
Please see DHHS' response to finding 1.4 about implementing policies related to preventing non-enrolled providers from billing Medicaid:

> **Recommendation 1.4**
> *The UOIG recommends that DHHS install meaningful and actionable controls to prevent non- enrolled providers or entities from billing Medicaid using the Medicaid provider IDs of enrolled providers.*
>
> **Department Response:**
> DHHS partially agrees with this recommendation. While DHHS believes meaningful and actionable controls are currently in place to prevent non-enrolled providers from billing Medicaid, we agree to re-evaluate controls to determine if additional safeguards are needed.
> Within this finding, DHHS believes the UOIG is seeking to address the concern that DHHS has allowed DSPD to use their provider ID to reimburse certain non-Medicaid enrolled providers in limited circumstances. Examples of non-Medicaid enrolled providers are those who build wheelchair ramps, install van lifts, or when an entity like Amazon is used to purchase equipment or supplies online.
>
> DHHS' interpretation is that in these examples, general contractors or an entity such as Amazon, would not be reasonably expected to enroll as a Utah Medicaid provider. Based on DHHS' interpretation of CMS policy, we have long permitted DSPD to submit these types of claims through the DSPD provider number.
>
> We acknowledge that the UOIG has a different interpretation of the federal guidance and law and does not believe DHHS' current practice is permissible.
>
> What: To further clarify federal guidance and law, DHHS contacted the CMS HCBS liaison for Utah. CMS has verified receipt of the state's question, and indicated they are researching the question with their subject matter experts.
>
> When: CMS has not provided an exact date by which they will respond. As soon as CMS provides clarification, DHHS will share the information with UOIG. If CMS concurs with the UOIG's interpretation, DHHS will revise its processes for these certain non-enrolled providers to conform with CMS's guidance.

UOIG Response:
The 21st Century Cures Act requires the enrollment of all Medicaid Providers, including Managed Care Organizations (MCOs), and Fee-for-Service (FFS), by the state Medicaid Agency.

Utah Medicaid's recent Federal FY21 Managed Care Focused Review acknowledges this requirement, stating, "To comply with §§ 438.602(b)(1) and (b)(2), 438.608(b), 455.100-106, 455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, all providers furnishing services to Utah Medicaid members, including providers participating in an ACO provider network, are required to be screened and enrolled with the SMA." and that, "The UDOH screens and enrolls providers in accordance with § 455.436."

Similarly, the Utah Medicaid Director of Long Term Services and Supports over the Waiver programs reported during the Audit that all DSPD providers, including the Massage Therapists DSPD billed for by utilizing DSPD-assigned Medicaid Provider ID numbers should be enrolled with Medicaid. He stated, "My understanding from [the UOIG's] request is that you were curious specifically about some of the Massage Therapy providers that DSPD uses in their waiver programs. I'm fairly certain all of these providers end up directly enrolled as Medicaid providers and are not using DSPD as a pass-through as an independent contractor." He added "I think we understand that DSPD is remitting claims to Medicaid on their behalf, but they should all be enrolled with Medicaid as well."

Discrepancies exist between practices reported by DSPD and DOH during this Audit, the Federal FY21 Managed Care Focused Review, and the DHHS Management Response to this Audit.

The UOIG did not receive any written documentation of authorization by CMS for DSPD's payment of Medicaid funds to non-enrolled providers for the provision of services on behalf of Medicaid beneficiaries by home or vehicle modification contractors, Massage Therapists, or other service providers who are not enrolled in the State Medicaid program. The UOIG acknowledges that as a result of this Audit, DHHS requested additional clarification about or authorization for this practice from CMS, and the UOIG awaits CMS feedback.

Finding 8: *DSPD submits inaccurate Medicaid claims.*

Recommendation 8.1

The UOIG recommends DHHS implement written policies that include meaningful and actionable controls to ensure all Medicaid claims reflect accurate information, including but not limited to:

- *Service(s) Provided;*
- *Service Provider;*
- *Medicaid Beneficiary;*
- *Date(s) of Service;*
- *Unit(s) of Service, including the start and end time of service provision; and*
- *Rate of Service*

Department Response:

DHHS partially agrees with this recommendation.
Please see DHHS' response to finding 4.2 about implementing policies related to documentation requirements:

> **Recommendation 4.2**
> *The UOIG recommends that DHHS revise Medicaid service record documentation policies, provider manuals, and contracts to include a requirement to capture the following elements in the documentation of all HCBS Waiver services:*
>
> - *the date the service was performed;*
> - *the start and end time of each service;*
> - *the type of service;*
> - *the name of the individual receiving the service;*
> - *the name of the individual providing the service;*
> - *the date the service record documentation was created; and*
> - *substantive information about the service provided, such as a log note.*
>
> **Department Response:**
> DHHS partially agrees with this recommendation.
> DHHS agrees that all services must be adequately documented. However, DHHS believes it needs the flexibility to make some adjustments to what documentation is required, depending on the nature of the service (e.g., residential services where someone lives there 24/7 and it would be impractical to require the provider to provide a record of the quantity provided).
>
> What: DHHS agrees to reevaluate our current procedures and policies regarding HCBS record documentation to identify areas for improvement. DHHS, including DSPD, Medicaid and the Office of Service Review (OSR) will complete this evaluation by reaching out to other states to identify best practices and will seek technical assistance from CMS. DHHS will report the results of the evaluation to the UOIG.
>
> When: June 30, 2023
>
> **UOIG Response:**
> Any Medicaid claim should accurately reflect all aspects of the provided service, including the date, type, and quantity of service provided, the individual who received the service, the individual or provider who provided the service.
>
> Service Record documentation by providers should be sufficient to support Medicaid claims.
>
> The UOIG maintains our original stance regarding this recommendation.

UOIG Response:
The UOIG maintains our original stance regarding this recommendation. Medicaid claims should accurately reflect all aspects of the provided service, and service Record documentation by providers should be sufficient to support Medicaid claims.

Recommendation 8.2
The UOIG recommends DSPD implement written policies that include meaningful and actionable controls, to ensure that DSPD pays Medicaid funds only to individuals and/or entities currently enrolled as Medicaid providers, in accordance with federal and state regulations, the Waiver SIPs, and Medicaid policies.

Department Response:
DHHS partially agrees with this recommendation.
Please see DHHS' response to finding 1.4 about implementing policies related to preventing non-enrolled providers from billing Medicaid.

> **Recommendation 1.4**
> *The UOIG recommends that DHHS install meaningful and actionable controls to prevent non- enrolled providers or entities from billing Medicaid using the Medicaid provider IDs of enrolled providers.*
>
> **Department Response**:
> DHHS partially agrees with this recommendation. While DHHS believes meaningful and actionable controls are currently in place to prevent non-enrolled providers from billing Medicaid, we agree to re-evaluate controls to determine if additional safeguards are needed.
> Within this finding, DHHS believes the UOIG is seeking to address the concern that DHHS has allowed DSPD to use their provider ID to reimburse certain non-Medicaid enrolled providers in limited circumstances. Examples of non-Medicaid enrolled providers are those who build wheelchair ramps, install van lifts, or when an entity like Amazon is used to purchase equipment or supplies online.
>
> DHHS' interpretation is that in these examples, general contractors or an entity such as Amazon, would not be reasonably expected to enroll as a Utah Medicaid provider. Based on DHHS' interpretation of CMS policy, we have long permitted DSPD to submit these types of claims through the DSPD provider number.
>
> We acknowledge that the UOIG has a different interpretation of the federal guidance and law and does not believe DHHS' current practice is permissible.
>
> What: To further clarify federal guidance and law, DHHS contacted the CMS HCBS liaison for Utah. CMS has verified receipt of the state's question, and indicated they are researching the question with their subject matter experts.
>
> When: CMS has not provided an exact date by which they will respond. As soon as CMS provides clarification, DHHS will share the information with UOIG. If CMS concurs with the UOIG's interpretation, DHHS will revise its processes for these certain non-enrolled providers to conform with CMS's guidance.

UOIG Response:
The 21st Century Cures Act requires the enrollment of all Medicaid Providers, including Managed Care Organizations (MCOs), and Fee-for-Service (FFS), by the state Medicaid Agency.

Utah Medicaid's recent Federal FY21 Managed Care Focused Review acknowledges this requirement, stating, "To comply with §§ 438.602(b)(1) and (b)(2), 438.608(b), 455.100-106, 455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, all providers furnishing services to Utah Medicaid members, including providers participating in an ACO provider

network, are required to be screened and enrolled with the SMA." and that, "The UDOH screens and enrolls providers in accordance with § 455.436."

Similarly, the Utah Medicaid Director of Long Term Services and Supports over the Waiver programs reported during the Audit that all DSPD providers, including the Massage Therapists DSPD billed for by utilizing DSPD-assigned Medicaid Provider ID numbers should be enrolled with Medicaid. He stated, "My understanding from [the UOIG's] request is that you were curious specifically about some of the Massage Therapy providers that DSPD uses in their waiver programs. I'm fairly certain all of these providers end up directly enrolled as Medicaid providers and are not using DSPD as a pass-through as an independent contractor." He added "I think we understand that DSPD is remitting claims to Medicaid on their behalf, but they should all be enrolled with Medicaid as well."

Discrepancies exist between practices reported by DSPD and DOH during this Audit, the Federal FY21 Managed Care Focused Review, and the DHHS Management Response to this Audit.

The UOIG did not receive any written documentation of authorization by CMS for DSPD's payment of Medicaid funds to non-enrolled providers for the provision of services on behalf of Medicaid beneficiaries by home or vehicle modification contractors, Massage Therapists, or other service providers who are not enrolled in the State Medicaid program. The UOIG acknowledges that as a result of this Audit, DHHS requested additional clarification about or authorization for this practice from CMS, and the UOIG awaits CMS feedback.

Recommendation 8.3

The UOIG recommends annual training requirements for DHHS and DSPD staff regarding:

- *Medicaid;*
- *Medicaid policies;*
- *Medicaid Waivers;*
- *The prevention of Fraud, Waste, and Abuse of Medicaid funds;*
- *How to report suspected Fraud, Waste, or Abuse of Medicaid resources.*

Department Response:

DHHS agrees with this recommendation.

What: DHHS is in the process of working with Federal partners to confirm its understanding of regulations regarding the necessary data to be included in service records and on claims and will adhere to those requirements following the receipt of their technical assistance. Any resulting changes will be accompanied by updates to policy, procedure, contract language, and training.

When: DHHS will research and identify policy and regulatory items for the purpose of this training, and confirm the oversight entities responsible. The curriculum will be developed by December 31, 2023 and all staff training complete by June 30, 2024.

UOIG Response:

The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, insufficient policies surrounding these topics, and a lack of employee training resources governing these issues.

Finding 9*: Due to inaccurate billing practices, any analysis of DSPD Medicaid claims or Waiver utilization requires a manual review of service records.*

Recommendation 9.1
The UOIG recommends policies that result in the ongoing training and education of DHHS, and DSPD staff regarding Medicaid service record documentation requirements.

Department Response:
DHHS agrees with this recommendation.

What: DHHS is in the process of working with Federal partners to confirm its understanding of regulations regarding the necessary data to be included in service records and will adhere to the requirements following the receipt of their technical assistance. Any resulting changes will be accompanied by updates to policy, procedure, contract language, and training for DSPD staff.

When: Policies will be developed by December 31, 2023. All training will be implemented by June 30, 2024.

UOIG Response:
The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, insufficient policies surrounding these topics, and a lack of employee training resources governing these issues.

Recommendation 9.2
The UOIG recommends policies that result in the ongoing training and education of DSPD-contracted providers regarding Medicaid service record documentation requirements.

Department Response:
DHHS agrees with this recommendation.

What: DHHS is in the process of working with Federal partners to confirm its understanding of regulations regarding the necessary data to be included in service records and will adhere to the requirements following the receipt of their technical assistance. Any resulting changes will be accompanied by updates to policy, procedure, contract language, and training for contracted providers.

When: Policies will be developed by December 31, 2023. All training will be implemented by June 30, 2024.

UOIG Response:
The UOIG appreciates the necessary dedication of time and resources to address the findings in this Audit. Where possible, the UOIG recommends swift implementation to prevent the continuance of inaccurate claims submission, insufficient service record documentation, and insufficient policies surrounding these topics.

Recommendation 9.3

The UOIG recommends DHHS enforcement of DSPD compliance with current DHHS-approved DSPD Provider contractual obligations, which require providers to document the following elements in each record of Medicaid Waiver service provision:
The name of the person served;
The name of the contractor and the contractor's staff member who delivered the service;
The amount of time spent delivering the service; and
Any progress notes describing the Person's response to the service (e.g. progress or lack of progress as documented in monthly summaries and progress notes) (State of Utah DHS, 2019)".

Department Response:

DHHS partially agrees with this recommendation.
Please see DHHS' response to finding 4.2 about implementing policies related to documentation requirements:

> **Recommendation 4.2**
> *The UOIG recommends that DHHS revise Medicaid service record documentation policies, provider manuals, and contracts to include a requirement to capture the following elements in the documentation of all HCBS Waiver services:*
> - *the date the service was performed;*
> - *the start and end time of each service;*
> - *the type of service;*
> - *the name of the individual receiving the service;*
> - *the name of the individual providing the service;*
> - *the date the service record documentation was created; and*
> - *substantive information about the service provided, such as a log note.*
>
> **Department Response:**
> DHHS partially agrees with this recommendation.
> DHHS agrees that all services must be adequately documented. However, DHHS believes it needs the flexibility to make some adjustments to what documentation is required, depending on the nature of the service (e.g., residential services where someone lives there 24/7 and it would be impractical to require the provider to provide a record of the quantity provided).
>
> What: DHHS agrees to reevaluate our current procedures and policies regarding HCBS record documentation to identify areas for improvement. DHHS, including DSPD, Medicaid and the Office of Service Review (OSR) will complete this evaluation by reaching out to other states to identify best practices and will seek technical assistance from CMS. DHHS will report the results of the evaluation to the UOIG.
>
> When: June 30, 2023

UOIG Response:

Any Medicaid claim should accurately reflect all aspects of the provided service, including the date, type, and quantity of service provided, the individual who received the service, the individual or provider who provided the service.

Service Record documentation by providers should be sufficient to support Medicaid claims.

The UOIG maintains our original stance regarding this recommendation.

Finding 10: ***Due to insufficient service record documentation practices, a manual review of DSPD service records is not possible.***

Recommendation 10.1

The UOIG recommends DHHS and DSPD, write and implement processes and policies with meaningful and actionable controls to ensure that Medicaid claims submissions accurately detail all elements of service provision.

Department Response:

DHHS partially agrees with this recommendation.
Please see DHHS' response to finding 4.2 about implementing policies related to documentation requirements:

> **Recommendation 4.2**
> *The UOIG recommends that DHHS revise Medicaid service record documentation policies, provider manuals, and contracts to include a requirement to capture the following elements in the documentation of all HCBS Waiver services:*
>
> - *the date the service was performed;*
> - *the start and end time of each service;*
> - *the type of service;*
> - *the name of the individual receiving the service;*
> - *the name of the individual providing the service;*
> - *the date the service record documentation was created; and*
> - *substantive information about the service provided, such as a log note.*
>
> **Department Response:**
> DHHS partially agrees with this recommendation.
> DHHS agrees that all services must be adequately documented. However, DHHS believes it needs the flexibility to make some adjustments to what documentation is required, depending on the nature of the service (e.g., residential services where someone lives there 24/7 and it would be impractical to require the provider to provide a record of the quantity provided).
>
> What: DHHS agrees to reevaluate our current procedures and policies regarding HCBS record documentation to identify areas for improvement. DHHS, including DSPD, Medicaid and the Office of Service Review (OSR) will complete this evaluation by reaching out to other states to identify best practices and will seek technical assistance from CMS. DHHS will report the results of the evaluation to the UOIG.
>
> When: June 30, 2023

UOIG Response:

Any Medicaid claim should accurately reflect all aspects of the provided service, including the date, type, and quantity of service provided, the individual who received the service, the individual or provider who provided the service.

Service Record documentation by providers should be sufficient to support Medicaid claims.

The UOIG maintains our original stance regarding this recommendation.

Recommendation 10.2

The UOIG recommends that DHHS and DSPD, write and implement policies and processes with meaningful and actionable controls that result in Medicaid service record documentation that accurately reflect all elements of service provision:

- *the date the service was performed;*
- *the start and end time of each service;*
- *the type of service;*
- *the name of the individual receiving the service;*
- *the name of the individual providing the service; and*
- *substantive information about the service provided, such as a log note.*

Department Response:

DHHS partially agrees with this recommendation.

Please see DHHS' response to finding 4.2 about implementing policies related to documentation requirements:

> **Recommendation 4.2**
>
> *The UOIG recommends that DHHS revise Medicaid service record documentation policies, provider manuals, and contracts to include a requirement to capture the following elements in the documentation of all HCBS Waiver services:*
>
> - *the date the service was performed;*
> - *the start and end time of each service;*
> - *the type of service;*
> - *the name of the individual receiving the service;*
> - *the name of the individual providing the service;*
> - *the date the service record documentation was created; and*
> - *substantive information about the service provided, such as a log note.*
>
> **Department Response:**
>
> DHHS partially agrees with this recommendation.
>
> DHHS agrees that all services must be adequately documented. However, DHHS believes it needs the flexibility to make some adjustments to what documentation is required, depending on the nature of the service (e.g., residential services where someone lives there 24/7 and it would be impractical to require the provider to provide a record of the quantity provided).
>
> What: DHHS agrees to reevaluate our current procedures and policies regarding HCBS record documentation to identify areas for improvement. DHHS, including DSPD, Medicaid and the Office of Service Review (OSR) will complete this evaluation by reaching out to other states to identify best practices and will seek technical assistance from CMS. DHHS will report the results of the evaluation to the UOIG.
>
> When: June 30, 2023

UOIG Response:

Any Medicaid claim should accurately reflect all aspects of the provided service, including the date, type, and quantity of service provided, the individual who received the service, the individual or provider who provided the service.

Service Record documentation by providers should be sufficient to support Medicaid claims.

The UOIG maintains our original stance regarding this recommendation.

UTAH OIG CONTACTS AND STAFF ACKNOWLEDGEMENT

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UTAH OIG MISSION STATEMENT

The Office of Inspector General of Medicaid Services will protect taxpayer dollars by identifying fraud, abuse, and waste risks and vulnerabilities in the State Medicaid Program and by taking action to mitigate or eliminate those risks.

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