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Colorado Could Improve Its Electronic Visit Verification System and Claimed Federal Medicaid Reimbursement for Millions of Dollars in Personal Care Services That Did Not Comply With Federal and State Requirements

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Why OIG Did This Audit

- As required by the 21st Century Cures Act, Colorado uses an Electronic Visit Verification (EVV) system to verify that a personal care services (PCS) attendant has arrived on the job and assisted a Medicaid enrollee with Medicaid-approved tasks.
- EVV was developed to address weaknesses in the PCS program that contribute to improper payments, questionable quality of care, and notable amounts of fraud.
- This audit examined whether Colorado implemented an EVV system in accordance with Federal and State requirements and complied with Federal and State requirements when claiming PCS.

What OIG Found

Colorado implemented an EVV system but did not verify that all PCS visits were recorded and verified in that system. Additionally, Colorado did not always comply with Federal and State requirements when claiming PCS. Specifically, of the 160 sampled PCS claims, we identified the following:

EVV Compliance Issues	**91**
Estimated number of PCS claims with EVV compliance issues: **682,947**	
Unallowable PCS Errors	**39**
Estimated unallowable Medicaid reimbursement for PCS errors: **$8.0M Federal share**	
PCS Errors Set Aside	**43**
Estimated Medicaid reimbursement set aside for additional PCS errors: **$45.7M Federal share**	

What OIG Recommends

We make six recommendations to Colorado related to its EVV system and provision of PCS, including that it refund $8.0 million (Federal share) in estimated overpayments to the Federal Government and that it work with CMS to determine the allowability of the estimated $45.7 million (Federal share) that we set aside. We also make procedural recommendations regarding system edits, improved monitoring of providers, and the establishment of policies and procedures. The full recommendations are in the report.

Colorado disagreed with most of our findings and recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

All States are required to implement Electronic Visit Verification (EVV) for personal care services (PCS) as of January 1, 2020, in accordance with 21st Century Cures Act (Cures Act) requirements.[1] EVV is a State-implemented telephone- and computer-based technology system used to verify electronically that a PCS attendant has arrived on the job and assisted an enrollee in performing PCS tasks that are approved under Medicaid.[2] Essentially, EVV requires attendants to login electronically to prove the time and location of their visits.

EVV was developed to address weaknesses in the PCS program that contribute to improper payments, questionable quality of care, and notable amounts of fraud. As part of its oversight activities, the Office of Inspector General (OIG) is auditing EVV to determine whether States are operating their EVV systems in accordance with requirements. We selected Colorado as the second State in a series of planned EVV audits.[3]

OBJECTIVES

The objectives of our audit were to determine whether the Colorado Department of Health Care Policy and Financing (State agency): (1) implemented an EVV system in accordance with Federal and State requirements and (2) complied with Federal and State requirements when claiming PCS.

BACKGROUND

Medicaid Program

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

[1] Colorado requested and was approved for a 1-year good-faith-effort extension for PCS, extending its date of implementation of EVV for PCS to January 1, 2021.

[2] The individuals who perform the PCS for enrollees are variously referred to as service workers, direct care workers, caregivers, or attendants. We refer to these individuals as "attendants" throughout the report.

[3] We previously issued report A-07-23-03255, *Kansas's Implemented Electronic Visit Verification System Could Be Improved*, on Aug. 20, 2024. See also Appendix B for a list of previous OIG audits of the PCS program.

Medicaid Home and Community-Based Services Waiver

The Social Security Act (the Act) authorizes the Medicaid Home and Community-Based Services Waiver (HCBS waiver) program (the Act § 1915(c)). This program permits a State to furnish an array of services that assists Medicaid enrollees to live in the community and avoid institutionalization. Waiver services complement and supplement the services that are available through the Medicaid State plan and other Federal, State, and local public programs as well as through the supports that families and communities provide to individuals. Each State has broad discretion to design its HCBS waiver program to address the needs of the waiver's target population.

Federal Requirements for Electronic Visit Verification and Personal Care Services

Electronic Visit Verification

Section 12006(a) of the Cures Act mandates that States implement EVV by January 1, 2020, for all Medicaid PCS that require an in-home visit by an attendant.[4] This statute also provides that States that have not implemented EVV by that date are subject to incremental Federal medical assistance percentage (FMAP) reductions of up to 1 percent, unless the State has both made a good-faith effort to comply and encountered unavoidable delays. (See footnote 1 regarding Colorado's approved 1-year good-faith-effort extension for PCS).

Section 12006(a)(5)(A) of the Cures Act defines EVV with respect to PCS as a system under which visits conducted as part of such services are electronically verified with respect to six required data points, including the type of service performed, the individuals receiving and providing the service, the date and location of the service, and the times that the service begins and ends.

Personal Care Services

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

[4] The 21st Century Cures Act, P.L. No. 114-255 (Dec. 13, 2016). The original date for EVV implementation for in-home PCS was January 1, 2019, but that date was delayed to January 1, 2020 (see P.L. No. 115-222 (July 30, 2018)). EVV is also required for home health care services as of January 1, 2023, but we did not evaluate EVV implementation of those services for this audit.

Implementing Federal regulations reiterate the Act's language and add that PCS may be provided only to individuals who are not inpatients at a hospital or residents of a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institution for mental disease (42 CFR § 440.167(a)).

Federal regulations state that a Medicaid enrollee's person-centered service plan (PCSP) must reflect the services and supports that are important for the enrollee to meet the needs identified through an assessment of functional need and must reflect what is important to the enrollee with regard to preferences for the delivery of such services and supports (42 CFR § 441.301(c)(2)).

Federal regulations also state that a PCSP must prevent the provision of unnecessary or inappropriate services and supports (42 CFR § 441.301(c)(2)(xii)).

Colorado Medicaid Program and Personal Care Services

In Colorado, the State agency administers the Medicaid program, called Health First Colorado. The State agency uses the Medicaid Management Information System, a computerized payment and information reporting system, to process and pay Medicaid claims. The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation (FFP) or Federal share, is determined by the FMAP, which varies based on a State's relative per capita income. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase or decrease FMAPs at any time. During our audit period, Colorado's FMAP ranged from 50.00 percent to 52.50 percent.

PCS are available to Colorado Medicaid enrollees through the State agency's HCBS waiver program. In Colorado, HCBS waiver services are reimbursed on a fee-for-service basis in which providers are paid directly for each covered service rendered to a Medicaid enrollee. Our audit covered only the PCS that the State agency provided under the Elderly, Blind, and Disabled HCBS waiver (the Waiver).[5] The Waiver identifies two types of PCS: (1) PCS that are directed by the provider and (2) PCS that are directed by the enrollee or the enrollee's authorized representative.

- Provider-directed PCS allow for some input from the enrollee, but the State agency is ultimately responsible for the provision of services. An enrollee who receives provider-directed PCS is required to have a PCSP that is generally referred to as a plan of care.

- PCS that are directed by the enrollee are referred to as "consumer-directed attendant support services" (i.e., consumer-directed PCS). Consumer-directed PCS give more control and flexibility to the enrollee to manage their provision of services, which

[5] The Waiver provides assistance to enrollees aged 18 and older who require long-term supports and services to remain in their own home, in the family residence, or in the community. During our audit period, the Waiver accounted for approximately 85 percent of Colorado's PCS EVV claims.

includes hiring, training, and managing their own attendants. An enrollee who receives consumer-directed PCS is required to have a specific PCSP that is referred to as an attendant support management plan (ASMP). The enrollee cannot begin to receive PCS until the ASMP has been developed by the enrollee and approved by the case manager.

Throughout the remainder of the report, when not specifically referring to provider-directed or consumer-directed PCS, we will collectively refer to both service types as PCS.

Colorado Electronic Visit Verification System

An EVV system is a paperless, web-based tool for scheduling, monitoring, reporting, and confirming claims for PCS visits. The State agency uses an open vendor model, which offers a free EVV system through a contracted vendor at no cost to Medicaid providers. Providers may also use their own EVV system (provider choice EVV system), if it meets technical and program requirements.

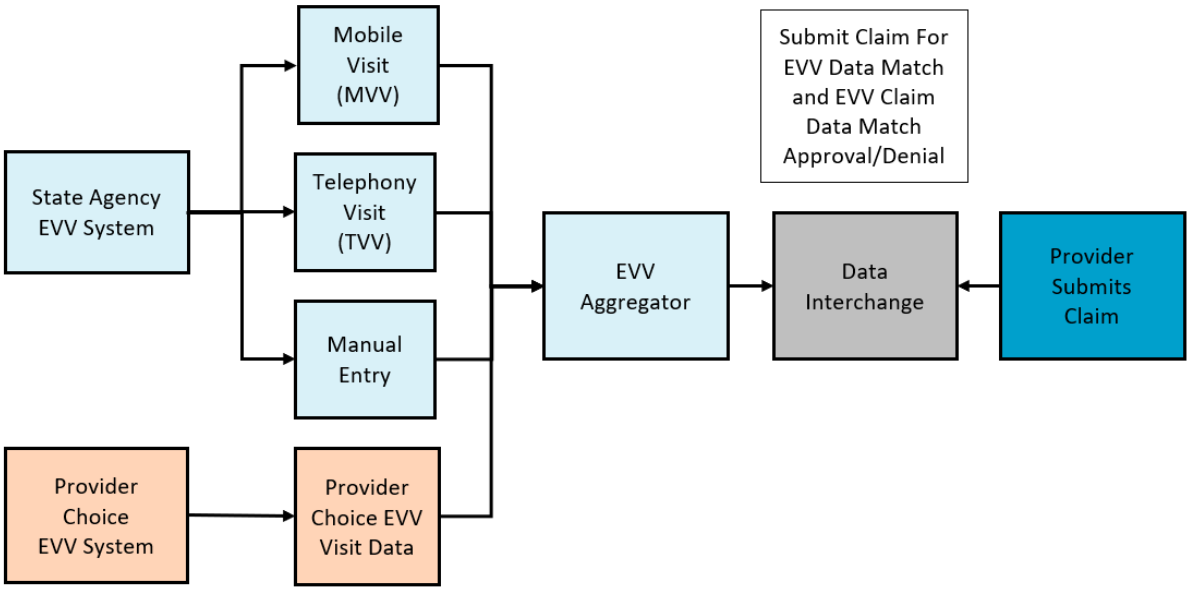
Providers review EVV records to confirm verified visits—either those without exceptions or those with resolved exceptions—thus making them eligible for claim matching.[6] The EVV system is not used to bill the State agency directly. Instead, providers submit claims through the Health First Colorado Web Portal. EVV records from the State agency and provider EVV systems are aggregated and validated by the State's EVV Aggregator and then transmitted to the Medicaid Management Information System (MMIS) for claim matching during adjudication.[7] The State agency's adjudication process involves matching verified EVV records to claims that providers have submitted to the State agency, by comparing provider identification numbers, enrollee identification numbers, type of service provided, and date(s) of service. Claims without necessary EVV records are denied.

Figure 1 on the following page describes the EVV process based on the State agency's EVV system and a provider choice EVV system:

[6] An exception is an alert that identifies a missing verification point of data. All exceptions must be corrected for an EVV record to be a verified visit. An MMIS is a system of software and hardware used to process Medicaid claims and manage information about Medicaid enrollees and services.

[7] The EVV Aggregator consolidates all EVV records from the State agency's EVV system and provider choice EVV systems.

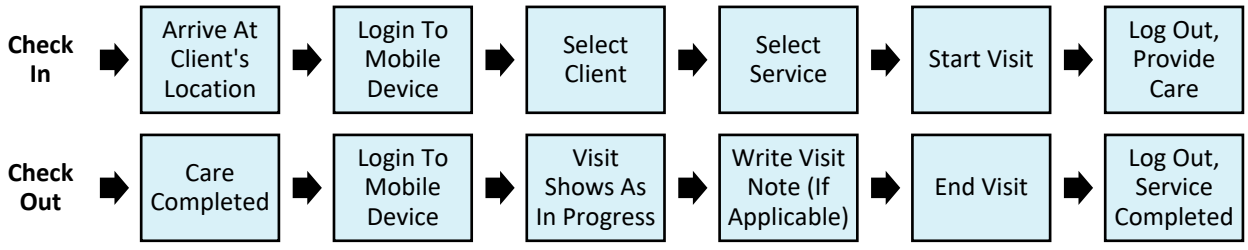
Figure 1: Electronic Visit Verification Process



There are four ways an attendant can enter a PCS visit into Colorado's EVV system: (1) mobile visit verification (MVV), (2) telephonic visit verification (TVV), (3) manual entry (provider only), and (4) other approved methods (e.g., fixed visit verification devices). Upon arriving at the enrollee's home, the attendant checks in using a mobile application or by calling the EVV system. Using GPS or caller ID, the EVV system identifies the enrollee and the authorized services. The attendant enters their worker identification number and confirms the services. The EVV system verifies the details and records the check-in time. At the end of the visit, the attendant checks out the same way, and the EVV system logs the visit.

Figure 2 shows the process for entering an EVV visit using the MVV method (the TVV process is similar, using a call-in number rather than a mobile application):

Figure 2: Mobile Application



If MVV or TVV cannot be used (for example, the enrollee's phone is out of order or the attendant does not have a mobile device), or if the attendant makes an error (for example, they forget to check out), the attendant notifies the provider and submits the required visit details.

The provider then manually enters the information into the EVV system, which creates a manual record for the PCS visit (i.e., manual entry).

The State agency's online EVV program manual (EVV manual) conveys instructions to providers on how to use the EVV system.

HOW WE CONDUCTED THIS AUDIT

Our audit period covered PCS provided and paid during the period July 1, 2023, through June 30, 2024 (State fiscal year (SFY) 2024). We used claims data that the State agency gave us to perform our work. We developed a sampling frame of 1,301,307 PCS net claim lines of $25 or more, from the Waiver, for which reimbursement totaled $299,230,641 ($152,860,012 Federal share).[8] From this sampling frame, we selected a stratified random sample of 160 PCS net claim lines, of which 50 PCS net claim lines were consumer-directed and 110 were provider-directed.

We reviewed documentation in the State agency's EVV Aggregator (footnote 7). Using the EVV Aggregator, we were able to review the details for each PCS visit (PCS net claim lines) to determine whether the visit was completed and verified electronically in accordance with Federal and State requirements. Our audit work included a site visit to the State agency in Denver, Colorado.[9]

In addition, we reviewed documentation that the State agency gave us for services rendered, attendant qualifications, and payment accuracy to determine whether each PCS visit in our sample complied with Federal and State requirements.

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

Appendix A contains details of our audit scope and methodology, Appendix B contains previously issued OIG reports, Appendix C contains our statistical sampling methodology, Appendix D contains our sample results and estimates, Appendix E contains details on the

[8] We grouped the PCS by internal control number (ICN) and first date of service (FDOS). We refer to each result of this grouping as a "net claim line." Furthermore, a single net claim line may consist of one PCS visit or multiple PCS visits, based on how the provider chose to bill those services. This grouping is the basis of our sample unit, which we refer to in this report as "PCS net claim lines."

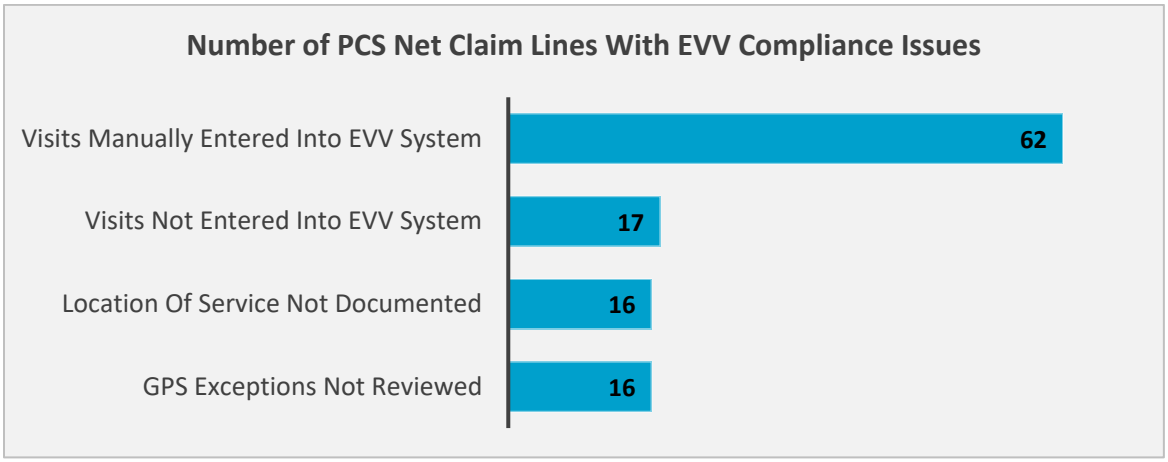
[9] During our site visit, we also met with two PCS providers, one of which used the State agency's EVV system and the other of which used a provider choice EVV system. We did this primarily to gain an understanding of the two systems and how they functioned.

Federal and State requirements related to EVV and PCS, and Appendix F summarizes the EVV compliance issues and PCS errors for each PCS net claim line.

FINDINGS

The State agency implemented an EVV system; however, it did not verify that all PCS net claim lines were recorded and verified in the EVV system in accordance with Federal and State requirements. Specifically, of the 160 PCS net claim lines in our sample, we identified 91 PCS net claim lines with at least 1 of the EVV compliance issues listed in Figure 3 (some PCS net claim lines had more than 1 compliance issue):

Figure 3: Summary of Personal Care Services Net Claim Lines With Electronic Visit Verification Compliance Issues



On the basis of our sample results, we estimate that for 682,947 of the 1,301,307 PCS net claim lines in our sampling frame (52 percent), the State agency did not comply with Federal and State requirements.[10]

Furthermore, we identified three additional issues with respect to the State agency's EVV system: (1) addresses in the system auto-populated for some TVV and for some manually entered EVV records in the State agency's data warehouse even though the corresponding EVV records did not specify a location at which PCS were rendered; (2) providers or attendants entered excessive or inaccurate reason codes (explained below) for some EVV records; and (3) the name of the attendant listed on some EVV records did not match the name of the attendant listed on the supporting timesheet.

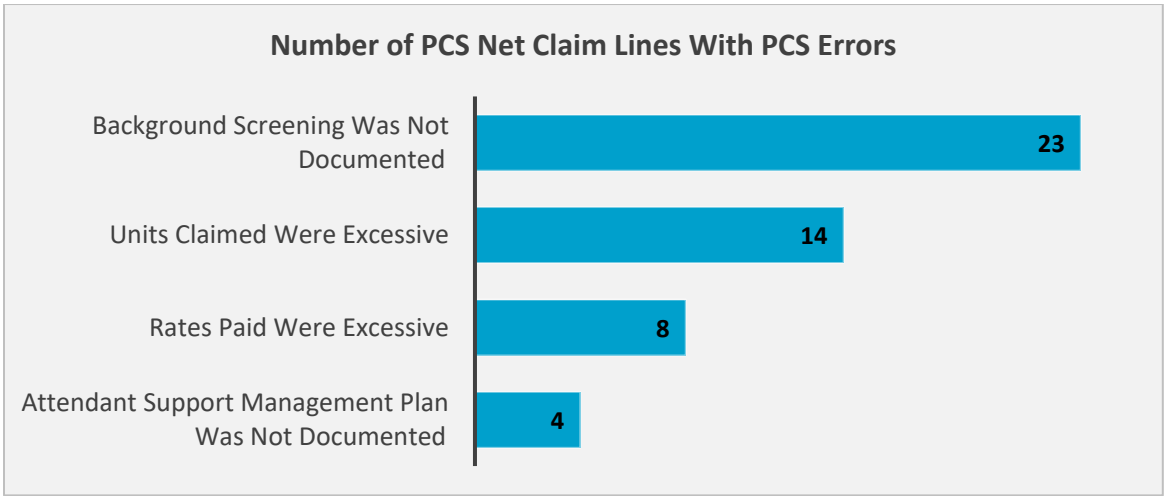
The EVV compliance issues and additional EVV-related issues we identified occurred because the State agency: (1) did not have system edits or an established policy in place to limit the

[10] The 90-percent confidence interval for the estimated PCS net claim lines with EVV compliance issues ranges from 583,125 to 782,769. See also Appendix D, Tables 2 and 3.

number of manual EVV entries made by providers; (2) did not have system edits in place to verify that all PCS services billed had corresponding EVV records; (3) did not require provider review when an attendant did not enter PCS visits into the EVV system; (4) did not have system edits in place requiring EVV records to capture the location of services provided; (5) did not have system edits in place requiring providers to review GPS exceptions and then to correct those exceptions; (6) did not require providers to monitor the use of EVV reason codes and confirm their appropriate application; and (7) did not require provider review in cases when the name of the attendant identified in the EVV record did not agree with the name of the attendant who signed the corresponding timesheet.

For our second objective, the State agency did not comply with Federal and State requirements when claiming some PCS. Specifically, 39 of the 160 PCS net claim lines were at least partially unallowable because they had at least 1 of the errors (some PCS net claim lines had more than 1 error) listed in Figure 4:

Figure 4: Summary of Errors Involving Personal Care Services Net Claim Lines



With respect to the errors related to attendant background screening and ASMP documentation, the State agency had relevant policies and procedures in place but did not always confirm that providers maintained the required documentation. The errors related to excessive units and excessive rates paid occurred primarily because the State agency did not have system edits to verify that the units paid matched the units approved on the enrollee plans of care and to verify that the rates paid were in accordance with the State's approved rates.

On the basis of our sample results, we estimate that the State agency claimed at least $15,709,911 ($8,072,870 Federal share) in unallowable Medicaid reimbursement for PCS during SFY 2024.[11]

[11] To be conservative, we estimate overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time. See also Appendix D, Tables 4 through 6.

In addition, the State agency claimed Federal Medicaid reimbursement for some consumer-directed PCS for which the timesheets used to document the services rendered did not identify the specific services that were actually performed in accordance with the enrollees' ASMPs. Specifically, the attendant timesheets for all 50 of the consumer-directed PCS net claim lines in our sample listed only basic information and did not identify the specific consumer-directed PCS that were rendered. Based on our sample results, we are setting aside an estimated $89,069,733 ($45,688,080 Federal share) for CMS resolution and potential recovery.[12, 13]

With respect to the PCS net claim lines that we are setting aside for CMS resolution and potential recovery, the State agency did not require consumer-directed PCS attendants to complete accurate and detailed timesheets in accordance with Federal and State requirements because the State agency believed that the Waiver exempted consumer-directed PCS from these requirements.

THE STATE AGENCY DID NOT VERIFY THAT ALL PERSONAL CARE SERVICES VISITS WERE RECORDED AND VERIFIED IN THE ELECTRONIC VISIT VERIFICATION SYSTEM IN ACCORDANCE WITH FEDERAL AND STATE REQUIREMENTS

With respect to our first objective, the State agency implemented an EVV system; however, it did not verify that all PCS net claim lines were recorded and verified in the EVV system in accordance with Federal and State requirements. Specifically, of the 160 PCS net claim lines in our sample, we identified 91 PCS net claim lines with at least 1 of the EVV compliance issues depicted earlier in Figure 3 and discussed below (some PCS net claim lines had more than 1 compliance issue).

Federal Requirements Regarding Electronic Visit Verification

Section 12006(a)(5)(A) of the Cures Act defines EVV with respect to PCS as a system under which visits conducted as part of such services are electronically verified with respect to:

(1) the type of service performed,
(2) the individual receiving the service,
(3) the date of the service,
(4) the location of service delivery,
(5) the individual providing the service, and
(6) the time the service began and ended.

[12] Of the 50 sampled consumer-directed PCS net claim lines, 7 had 1 of the PCS errors depicted earlier in Figure 4; therefore, our estimate of the costs we are setting aside includes only the 43 remaining PCS net claim lines.

[13] The 90-percent confidence interval for the estimated set-aside amount for consumer-directed PCS net claim lines without detailed timesheets ranges from $72,804,307 ($37,366,416 Federal share) to $105,335,159 ($54,009,743 Federal share). See also Appendix D, Tables 7 through 9.

Visits Manually Entered Into the Electronic Verification System Could Not Be Electronically Verified

The State agency's EVV system allows providers to manually enter visit records after service delivery when the system is unavailable, or when the attendant does not check in or out. However, these manual entries could not be electronically verified with respect to the six data points required by the Cures Act. According to the State agency's EVV manual, for manual entries, providers must enter all verification data, select reason code 16 ("Manual Entry of EVV"), and include the visit location as a reason note.[14] Moreover, we determined that the State agency did not have system edits to limit how often providers can use manual entries.

For 62 PCS net claim lines, providers manually entered 1 or more visits into the EVV system. In some cases, most or all of the EVV records associated with a particular enrollee were manual EVV entries. For example, for 1 PCS net claim line, all 7 EVV visits were recorded via manual entry; furthermore, we looked at an entire year of EVV records (185 EVV records) for this same enrollee and found that all EVV records were manual entries.

The State agency acknowledged that although manual entries may be necessary at times, their use should be as a variation from normal practice, with most EVV records captured in real time. Manual entries are not real-time verifications, and their use increases the risk that services were either inaccurately recorded or were not actually provided.

Some Visits Were Not Entered Into the Electronic Visit Verification System

For 17 PCS net claim lines, each covering multiple dates of service, 1 or more PCS visits were not entered into the EVV system. For example, 1 PCS net claim line included 29 dates of service, but only 6 of those dates had a corresponding service recorded in the EVV system. According to the State agency, this can occur because when claims contain multiple dates of service, the payment system does not match all of the dates of service to EVV records before processing the payment. State agency officials added that this issue would be addressed in an upcoming EVV newsletter to inform and educate providers on how to appropriately manage such situations.

Locations of Service Were Not Documented

The EVV system must record the service location during a PCS visit. The State agency allows use of both landlines and cell phones for TVV. According to the State agency's EVV manual, EVV systems must automatically capture the address from the phone used and locations must be updated if services are delivered elsewhere. Providers enter known phone numbers into the enrollee's EVV profile, which links to the enrollee's primary address. If a visit occurs at a

[14] Reason codes are a pre-defined list of explanations for various EVV entry correction scenarios. A reason code must be selected when making a change to EVV visit data. For reason code 16, "Manual Entry of EVV," a reason note must then be entered. The reason note field is a free-text field that should include the address at which the attendant performed PCS, but any text is accepted.

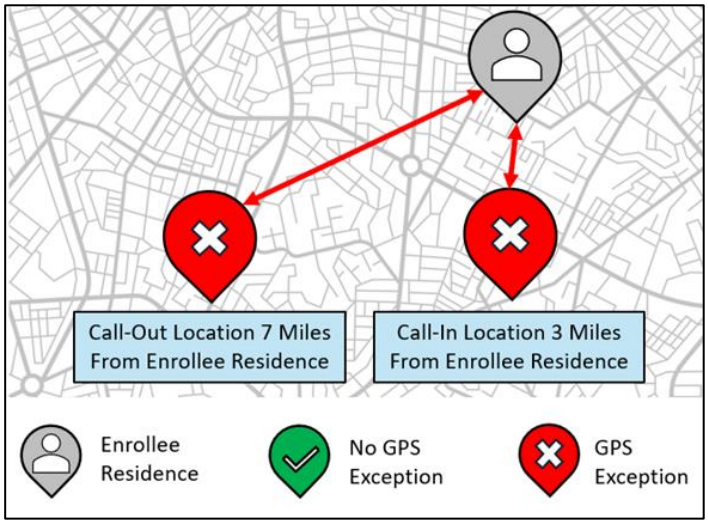
location other than the enrollee's residence, an alternate location must be noted. For manual entries, the location must be entered as a reason note (footnote 14).

For 16 PCS net claim lines, the EVV records did not identify the location of service in the EVV system. Of these, 13 PCS net claim lines included visits that were recorded via manual entry and either did not include the location entered in the reason note or had no reason note at all. The remaining three PCS net claim lines included visits that were recorded via TVV or Other method that did not populate an address or include an alternate location.

Electronic Visit Verification Records With GPS Exceptions Were Not Reviewed and Corrected

The location of service delivery is a required EVV data point. According to the State agency's EVV manual, this can be a mailing address, GPS coordinates, or a uniquely identified location. When an attendant uses MVV, GPS coordinates are captured at check-in and check-out and displayed on a map. A green checkmark indicates no GPS exception; a red X indicates that the check-in or check-out occurred away from the enrollee's residence. Figure 5 shows an example for a PCS net claim line in our sample that had GPS exceptions for both the check-in and check-out locations:

Figure 5: GPS Exception Example[15]



During our on-site visit in Colorado, we met with one provider that told us that GPS exceptions were its most common issue, each occurrence of which had to be addressed within its provider choice EVV system. The provider added that it could monitor check-ins in real time and follow up with attendants in cases when the PCS location in the EVV system differed from the enrollee's residence.

[15] This Figure is a simplified representation of the actual map that is shown in the State agency's EVV system. We removed the names of landmarks and other identifying information and used the GPS coordinates for the EVV check-in and check-out to determine the distance from the enrollee's residence.

The State agency allows PCS visits to occur both at an enrollee's residence and in the community (e.g., doctor visits, church, park). The State agency's EVV manual requires providers to ensure location accuracy and allows alternate locations to be entered after the visit if MVV is used. The EVV manual notes that the mobile application should capture a GPS location, but if the service is being delivered at a location other than what is recorded, alternate locations may be entered after the attendant has completed the visit. State agency officials told us that although GPS exceptions are flagged in the EVV system, the State agency does not require those exceptions to be corrected or addressed for a visit to be verified, as it believes that the GPS data itself satisfies the location requirement.[16]

Notwithstanding these considerations, for 16 PCS net claim lines, EVV records showed GPS exceptions that had not been reviewed and corrected to identify alternate service locations; therefore, the visit location could not be verified. For one PCS net claim line in our sample, the EVV system had recorded eight EVV visits. All eight EVV records lacked check-in GPS data, and six of the eight had check-out GPS exceptions that noted that the attendant was not at the enrollee's residence. In addition, none of the eight EVV records for this PCS net claim line identified an alternate location. Because these net claim lines had GPS exceptions that were not reviewed and corrected, the associated enrollees may not have received their required PCS, and the possibility exists that the PCS visits did not even take place.

Additional Electronic Visit Verification-Related Issues

We identified three additional issues with respect to the State agency's EVV system, as detailed below.

Addresses Auto-Populated for Some Telephonic Visit Verification and for Some Manually Entered Electronic Visit Verification Records in the State Agency's Data Warehouse

The State agency maintains a data warehouse containing all EVV data, which are used for analytics and reporting. For the 160 PCS net claim lines in our sample, the State agency gave us visit data from its data warehouse. The State agency explained that for TVV or manual entries, the enrollee's address is auto-populated unless an alternate location is entered. We found that for 55 PCS net claim lines, the visit data showed an auto-populated address, even though the corresponding EVV records did not specify a location at which PCS were rendered.

The State agency permits use of both landlines and cell phones for submitting TVV records. Providers may enter all known phone numbers into the enrollee's profile in the EVV system, and when TVV is used, the enrollee's primary address will link to those approved phone numbers. However, auto-populating addresses can increase the risk of inaccurate EVV data. For instance, an attendant could call in from their own home using an approved phone number, and the EVV

[16] The list of exceptions that are required to be corrected in the State agency's EVV system include: unknown enrollee, unknown employee, visit without any calls, visit without call-in, visit without call-out, unmatched enrollee identification or phone number, no show, missing service, and location required.

system would still assign the enrollee's address to the EVV record. This process bypasses real-time location verification and increases the risk that the recorded location is incorrect and that the PCS were not rendered.

Excessive or Inaccurate Reason Codes Entered for Some Electronic Visit Verification Records

Reason codes are predefined explanations that providers must use when modifying EVV visit data (footnote 14). Providers use reason codes when making updates to PCS visits in the EVV system, such as correcting exceptions or making manual changes. Some examples of reason codes include: staff forgot to clock in/clock out, wrong service selected, wrong enrollee selected, and service not selected.

For some PCS net claim lines, we observed excessive or inaccurate use of these codes. For example, 1 PCS net claim line included 58 verified visits that were all manually entered using reason code 2, "staff forgot to clock in/out."

We also identified 17 consumer-directed PCS net claim lines (all from the same financial management services (FMS) vendor[17]) that used MVV and that included Reason Code 15, "Location captured by MVV/TVV incorrect," even though the GPS coordinates matched the enrollee's residence. The original reason notes had been overwritten with the comment "Record moved to paid status in EVV system." According to the State agency, this occurred because of an outdated process that unnecessarily flagged visits for location issues and replaced attendant notes to indicate payment readiness. The State agency acknowledged the resulting inconsistencies and stated that it is working with the provider to update the process to eliminate unnecessary checks and note overwrites, thus aiming to improve reason code accuracy and reporting consistency.

Timesheets Did Not Agree With the Electronic Visit Verification Records

For two PCS net claim lines, we identified discrepancies between the name of the attendant identified on the EVV records and the name of the attendant who signed the corresponding timesheets. One PCS net claim line covered 5 consecutive days of service, and for each day, an EVV record was captured via MVV, documenting the attendant's name, attendant ID number, and the GPS coordinates confirming presence at the enrollee's residence. However, the corresponding timesheet was signed by a different attendant during each of these 5 days. When asked about the discrepancy, the provider stated that the attendant listed on the EVV records had car trouble, and the attendant listed on the timesheet had filled in for that week.

An additional PCS net claim line covered 7 consecutive days of service. Each day included one PCS visit, and a corresponding EVV record was manually entered for each visit. On one of those days, the name of the attendant identified on the EVV record did not match the name of the attendant who signed the timesheet. This discrepancy between EVV records and timesheets

[17] The State agency contracts with FMS vendors to serve as the financial intermediaries for consumer-directed PCS.

may indicate inaccurate service documentation and raises concerns regarding the integrity of claims submitted for reimbursement. Such inconsistencies could result in non-compliance with EVV requirements and potential overpayment or improper billing.

State Agency Procedures Did Not Ensure That Electronic Verification of Personal Care Services Visits Complied With the Cures Act

The EVV compliance issues and additional EVV-related issues we identified occurred because the State agency: (1) did not have system edits or an established policy in place to limit the number of manual EVV entries made by providers; (2) did not have system edits in place to verify that all PCS services billed had corresponding EVV records; (3) did not require provider review when an attendant did not enter PCS visits into the EVV system; (4) did not have system edits in place requiring EVV records to capture the location of services provided; (5) did not have system edits in place requiring providers to review GPS exceptions and then to correct those exceptions; (6) did not require providers to monitor the use of EVV reason codes and confirm their appropriate application; and (7) did not require provider review when the name of the attendant identified on the EVV record did not agree with the name of the attendant who signed the corresponding timesheet.

Estimated Number of Personal Care Services Net Claim Lines That Did Not Comply With Federal Requirements

On the basis of our sample results, we estimate that for our audit period, 682,947 of the 1,301,307 PCS net claim lines in our sampling frame (52 percent) did not comply with Federal and State EVV requirements (footnote 10).

THE STATE AGENCY CLAIMED FEDERAL REIMBURSEMENT FOR UNALLOWABLE PERSONAL CARE SERVICES

With respect to our second objective, the State agency did not comply with Federal and State requirements when claiming some PCS. Specifically, 39 of the 160 PCS net claim lines were at least partially unallowable because they had at least 1 of the errors listed earlier in Figure 4 and discussed below (some PCS net claim lines had more than 1 error).

Background Screening for Attendants Was Not Documented

The Waiver requires all attendants who provide PCS to submit to a Colorado Bureau of Investigation criminal history record check (CBI screening) prior to employment. For consumer-directed attendants who have a high-risk crime identified on their CBI screening that would initially prohibit employment, the Waiver allows an exception process through which the enrollee may provide a written acknowledgement to the State agency that the enrollee understands the reason for the attendant's initial ineligibility but still chooses to hire that attendant. In addition, the Waiver requires all provider-directed attendants to submit to a

Colorado Adult Protective Services abuse registry check (CAPS screening).[18] Furthermore, the Waiver also requires all consumer-directed attendants to be checked against the OIG List of Excluded Individuals/Entities (OIG exclusion list) (Colorado HCBS Waiver Application (Waiver Application), Appendix C: *Participant Services*, section C-2, "General Service Specifications").

Additionally, State regulation requires providers to compare all PCS attendant names against the OIG exclusion list prior to employment, effective March 16, 2024 (10 Code of Colorado Regulations (CCR) 2505-10 8.7409.E).

For 23 PCS net claim lines, the State agency either could not provide documentation that a background screening had been completed before the date of service, or provided incomplete background screening documentation, for 1 or more attendants. (Some net claim lines had errors for multiple attendants and some net claim lines had attendants who had not completed more than one type of background screening.) Specifically:

- 17 PCS net claim lines included PCS provided by provider-directed attendants for whom the provider did not have documentation that the attendants' CAPS screenings had been completed before the date of service;

- 6 PCS net claim lines included PCS provided by attendants for whom the provider did not have documentation that the attendants' CBI screenings had been completed before the date of service;

- 3 PCS net claim lines included PCS provided by attendants for whom the providers did not have documentation that the providers had checked the OIG exclusion list before the date of service; and

- 1 PCS net claim line included PCS provided by an attendant for whom the provider had documentation that the attendant's CBI screening was completed before the date of service. However, the screening identified felony and misdemeanor charges, and the provider could not locate the written acknowledgement that is required for consumer-directed attendants who have a high-risk crime in their history.

For each of these 23 PCS net claim lines, we questioned only the units of service rendered by the attendants who had not completed one or more background screenings.

Units of Service Claimed for Personal Care Services Were Excessive

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

[18] Consumer-directed attendants are exempt from the CAPS screening.

In addition, Section 2497.1 of the CMS *State Medicaid Manual* states that expenditures require adequate supporting documentation to be allowable for Federal reimbursement.

For 14 PCS net claim lines, the providers claimed PCS units of service that exceeded the units supported by the corresponding timesheets, and in some instances, the average PCS units claimed exceeded 24 hours per day. For example, for 1 PCS net claim line, the provider claimed 3,876 PCS units for 8 dates of service, an average of approximately 121 hours per day. However, the corresponding attendant timesheets documented only 161 PCS units for those same 8 dates of services, or approximately 5 hours per day. Additionally, the same provider submitted 5 of the other 13 PCS net claim lines with excessive units. The provider said that it had experienced prolonged delays in renewing enrollee eligibility, beginning in September 2023 and continuing through March 2024. The provider added that when those issues were resolved, it submitted claims for all previously rendered services using dates of service from March 2024, rather than the actual dates the services were delivered. The State agency's system edits did not identify these excessive units of service and therefore did not prevent reimbursement to the provider.

For each of these 14 PCS net claim lines, we questioned only the units of service that were not supported by the timesheets.

Rates Paid for Personal Care Services Exceeded State-Approved Rates

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

In addition, Section 2497.1 of the CMS *State Medicaid Manual* states that expenditures require adequate supporting documentation to be allowable for Federal reimbursement.

The State agency's approved payment rates for the services rendered under the Waiver are documented on the State agency's website. The PCS rates for our audit period included an enhanced rate for Denver County and a lower rate for all other counties within the State of Colorado. According to State agency officials, HCPF [Health Care Policy and Financing] OM [operational memo] 23-041 provides billing guidance to HCBS providers and says that rates are to be billed based on the county in which PCS are rendered and not on the enrollee's county of residence.

For eight provider-directed PCS net claim lines, the State agency claimed the higher Denver County rate for services rendered to an enrollee whose residential address was located outside Denver County and for whom the check-in and check-out location data (as recorded in the EVV data) were outside of Denver County.

For example, for one provider-directed PCS net claim line, the enrollee address and check-in and check-out location data were in Weld County (which is roughly 50 miles north of Denver

County). Additionally, the supporting timesheet listed the following services performed: homemaking only, assist with walking, patient laundry, light housekeeping, do patient shopping and errands, monitor patient safety, and trash disposal. Of these services, shopping and errands appear to have been the only services that would have been performed outside of the residence; therefore, it does not appear reasonable that the higher Denver County rate should have been charged for all services provided.

For each of these eight provider-directed PCS net claim lines, we questioned only the difference between the Denver rate and the lower rate.

Attendant Support Management Plans Were Not Documented

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

Enrollees who receive consumer-directed PCS must have an approved ASMP that describes, among other things, a detailed list of the amount, scope, and duration of services to be provided to the enrollee. The Waiver says that consumer-directed PCS may not begin until the ASMP is approved by the case manager (Waiver Application, Appendix E: *Participant Direction of Services*, section E-1, "Overview (1 of 13)").

In addition, State regulations state: "[Consumer-directed PCS] shall not begin until the Case Manager approves the [ASMP] and provides a start date to the [FMS vendor]" (10 CCR 2505-10 8.510.5.A). Furthermore, "[t]he FMS vendor will not reimburse attendants for services provided prior to the [consumer-directed PCS] start date" (10 CCR 2505-10 8.510.11.D).

For four consumer-directed PCS net claim lines, the State agency could not give us an ASMP that had been approved before the date of service. Specifically, for each of three net claim lines, the State agency was unable to obtain from providers any supporting documentation of an ASMP that had been completed before the date of service. For the remaining one net claim line, the provider furnished an ASMP that was signed by the case manager after the date of service and after we requested that documentation for our audit.

For each of these four PCS net claim lines, we questioned all units of service that had been rendered to the enrollees.

The State Agency Did Not Comply With State and Federal Requirements for Personal Care Services

With respect to the errors related to attendant background screening and ASMP documentation, the State agency had relevant policies and procedures in place but did not always confirm that providers maintained the required documentation. The errors related to

excessive units and excessive rates paid occurred primarily because the State agency did not have system edits to verify that the units paid matched the units approved on the enrollees' plans of care and to verify that the rates paid were in accordance with the State's approved rates.

Effect of Unallowable Personal Care Services Claims

As a result of the errors and causative factors we discuss above, providers billed the State agency (and received payment) for some unallowable PCS. The State agency then claimed Federal Medicaid reimbursement for PCS that did not comply with Federal and State requirements. On the basis of our sample results, we estimate that the State agency claimed at least $15,709,911 ($8,072,870 Federal share) in unallowable Medicaid reimbursement for PCS during SFY 2024 (footnote 11).

THE STATE AGENCY DID NOT REQUIRE CONSUMER-DIRECTED ATTENDANTS TO DOCUMENT ON THEIR TIMESHEETS THE SPECIFIC PERSONAL CARE SERVICES PERFORMED AS APPROVED IN THE ATTENDANT SUPPORT MANAGEMENT PLANS

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

In addition, section 2497.1 of the CMS *State Medicaid Manual* states that expenditures require adequate supporting documentation to be allowable for Federal reimbursement.

State regulations state that consumer-directed PCS attendants must be able to perform the tasks listed on the enrollee's ASMP for which they are being reimbursed, and that the attendant timesheets submitted for approval must be accurate and reflect time worked (10 CCR 2505-10 8.510.8.D. and E.).

Additionally, State regulations require consumer-directed PCS enrollees (or their authorized representatives) to review all attendant timesheets for time worked and completeness. These regulations also state that timesheets should reflect the actual time spent providing services (10 CCR 2505-10 8.510.6.A.16. and 17.).

During our audit period, the State agency claimed Federal Medicaid reimbursement for some consumer-directed PCS for which the timesheets used to document the services rendered did not identify the specific services that were actually performed in accordance with the enrollees' ASMPs. Specifically, the attendant timesheets for all 50 of the consumer-directed PCS net claim lines in our sample listed only basic information such as the date, time in, time out, and the term "CDASS," which refers to the State agency's consumer-directed attendant support services. An ASMP specifies the services that attendants should perform (i.e., eating, dressing, and bathing), the estimated frequency that each service should be performed, and the estimated

time for each service. Because the timesheets did not provide any detail on the specific tasks performed, we could not identify the specific consumer-directed PCS that were rendered or determine whether those services were allowable under the terms of each enrollee's ASMP.

The State agency did not require consumer-directed PCS attendants to complete accurate and detailed timesheets in accordance with Federal and State requirements because the State agency believed that the Waiver exempted consumer-directed PCS from these requirements.

Although these 50 sampled PCS net claim lines did not identify any specific services performed, the State agency claimed Federal Medicaid reimbursement for those consumer-directed PCS. Based on our sample results, we are setting aside an estimated $89,069,733 ($45,688,080 Federal share) for CMS resolution and potential recovery (footnote 12 and 13).

RECOMMENDATIONS

- We recommend that the State agency refund $8,072,870 (Federal share) in estimated overpayments to the Federal Government.

- We recommend that the State agency work with CMS to determine the allowability of the estimated $45,688,080 (Federal share) that we have set aside, and refund to the Federal Government any amount that is determined to be unallowable.

- We recommend that the State agency improve its EVV system by: (1) establishing system edits and/or formal policy requirements governing attendants' use of manual entries and by implementing limit thresholds for how often manual entries can be used; (2) implementing system edits to verify that all PCS visits have corresponding EVV records; (3) requiring providers to verify that all PCS visits are entered in the EVV system; (4) implementing system edits that capture the location of services provided, and establishing requirements for providers and attendants to document and verify the actual location where PCS is provided; (5) implementing system edits that require providers to review and then correct GPS exceptions; (6) requiring providers to monitor the use of EVV reason codes and confirm their appropriate application; and (7) requiring providers to verify that the names of the attendants identified on EVV records match the names of the attendants who signed the corresponding timesheets.

- We recommend that the State agency improve its procedures to verify that: (1) providers maintain documentation that attendant background screenings are completed for all attendants, and (2) providers complete and maintain ASMPs for all enrollees receiving consumer-directed PCS.

- We recommend that the State agency implement system edits to verify that: (1) units paid match the units approved on the enrollees' plans of care, and (2) rates paid are in accordance with the State's approved rates.

- We recommend that the State agency develop and implement requirements that attendants who render consumer-directed PCS document on their timesheets the level of detail necessary to support that the rendered services complied with the enrollees' ASMPs.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with most of our findings and with our first, second, and sixth recommendations. For our third recommendation, which included seven numbered subrecommendations, the State agency's responses ranged from disagreement to partial or full agreement. For our fourth and fifth recommendations (each of which contained two numbered subrecommendations), the State agency either disagreed or partially agreed.

Specifically, for our first recommendation the State agency disagreed with our methodology for statistical sampling and estimation and stated that our sampling methodology was not statistically representative of the overall population.[19] The State agency also disagreed with our findings for most of the 39 PCS net claim line errors that our draft report identified and with the recommended refund in our first recommendation.

For our second recommendation, the State agency disagreed that task-level detail is required under its consumer-directed service model and with the recommended set-aside. The State agency said that its CDASS model "operates under CMS-approved 1915(c) [HCBS] waivers, which expressly allow flexibility in documentation and verification methodologies for consumer-directed services models" (emphasis omitted).

For our third recommendation, the State agency agreed or partially agreed with six of the seven subrecommendations and disagreed with our first subrecommendation regarding the use of manual entries.

For our fourth recommendation, the State agency partially agreed with our subrecommendation related to maintaining documentation for background screenings and disagreed with our subrecommendation related to maintaining documentation for ASMPs.

For our fifth recommendation, the State agency partially agreed with our subrecommendation related to implementing system edits to verify that units paid match the units approved on the enrollees' plans of care and disagreed with our subrecommendation related to verifying that rates paid are in accordance with the State's approved rates.

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

The State agency disagreed with our sixth recommendation and stated that its CMS-approved CDASS model does not require task-level timesheet documentation and that the documentation framework already provides sufficient assurance of service authorization and delivery.

The State agency also provided technical comments, which we addressed as appropriate. The State agency's comments, excluding technical comments, are included as Appendix G.

A summary of the State agency's comments and our responses follows. After reviewing the State agency's comments, we maintain that all our findings and recommendations remain valid.

RECOMMENDED REFUND OF ESTIMATED OVERPAYMENTS

The State agency disagreed with our first recommendation and with our methodology for statistical sampling and estimation. The State agency said that many of the identified errors were administrative- or documentation-related rather than evidence of improper payments, and that "because the [State agency] disagrees with the underlying financial determination and maintains that the projected overpayment is not supported by reliable statistical methodology or evidence of improper payment, no repayment or additional corrective action is warranted beyond ongoing or planned enhancements noted in this response." We summarize the State agency's specific points of disagreement, and offer our responses to those points, below.

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

State Agency Comments

The State agency said that we based our extrapolated overpayment amount "on a sample that was not statistically representative of the claim population and disproportionately captured a small subset of provider agencies and [enrollees] with atypical billing patterns."[20] The State agency also asked us to clarify our use of the term "disallow" in the draft report. The State agency said that the draft report referred to our disallowing or partially disallowing units of service from certain claim lines, of which the State agency cited various examples.

The State agency said that our sampling results contained statistical irregularities and introduced selection bias that made the sample unrepresentative of the full population of 1.3 million net claim lines. The State agency said the distribution of sampled claims showed disproportionate concentration among a small number of enrollees and provider agencies, including 6 partially unallowable claim lines that were associated with a single enrollee and 13 of 14 excessive unit findings that were associated with a total of 3 provider agencies. According to the State agency, "This outcome indicates that a small subset of [enrollees]

[20] **Office of Inspector General Note**—We refer to individuals who receive Medicaid as "enrollees" throughout this report, in accordance with our conventions. The State agency refers to this same category of individuals as "members." For consistency, we are retaining our term in our quoted and summarized citations to the State agency's written comments on our draft report.

disproportionately drove observed error rates, which may influence extrapolation." The State agency asked us to provide additional documentation on our sampling design, stratification, and weighting to determine whether our methodology met "standards for statistically valid estimation."

The State agency further stated that clustering within the sample reduced the effective sample size, because correlated error rates among oversampled providers or enrollees were not accounted for in our estimates. The State agency added that highly correlated errors within a small number of providers would significantly reduce the statistical reliability of any projection to the full population, particularly given the already small sample size. The State agency said that "[t]his disproportionate clustering of claim lines among a limited number of provider agencies and [enrollees] demonstrates that the sample does not reflect typical statewide program behavior. Extrapolating these concentrated anomalies across the entire claim population inflates the projected error rate for the broader population."

Office of Inspector General Response

We disagree with the State agency's comments that our sampling methodology was not statistically representative of the claim population and that its results exhibited selection bias, disproportionate concentration of sampled claims, or clustering within the sample. Moreover, we used the term "disallow" in the draft report to describe an audit determination that certain units of service within a sampled PCS net claim line did not meet Federal or State Medicaid requirements, and therefore, were treated as unallowable for purposes of calculating the sample error rate and estimating questioned costs. To clarify this, we use the term "question" instead of "disallow" in this final report. The questioned amounts within the sample form the basis for our statistical estimates of unallowable Federal reimbursement and the resulting recommendations. We convey our recommendations to CMS, which is the cognizant Federal agency with final authority to determine the allowability of claims and to initiate any financial disallowance.

We maintain that our sampling and estimation (i.e., extrapolation) methodology was entirely appropriate. Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.[21] The legal standard for use of sampling and extrapolation is that it must be based on a statistically valid

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

methodology, not the most precise methodology.[22] We properly executed our statistical sampling methodology in that we defined our sampling frame and sample unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

Furthermore, regarding the State agency's statements about our sample size, we note that small sample sizes, e.g., smaller than 100, have routinely been upheld by the Departmental Appeals Board (DAB) and Federal courts.[23] The legal standard for a sample size is that it must be sufficient to be statistically valid, not that it be the most precise methodology.[24] Because absolute precision is not required,[25] any imprecision in the sample may be remedied by recommending recovery at the lower limit, which was done in this audit. This approach results in an estimate that is lower than the actual overpayment amount 95 percent of the time, and thus it generally favors the auditee.

With respect to the State agency's comments that "a small subset of [enrollees] disproportionately drove observed error rates" and that "clustering within the sample reduced the effective sample size," we note that our sample was representative of the sampling frame in that we selected the items from each stratum using a simple random sample (with the exception of stratum 4, discussed below) in which each item within each stratum had an equal probability of being selected. Because of the randomness of the sampling process, the composition of the sample may differ from the composition of the sampling frame. We accounted for such differences by using the lower limit of a two-sided 90-percent confidence interval as our basis to recommend refunds of unallowable payments.

Further, statistical independence of sample units is not a requirement for design-based sampling methods, like those used by OIG. Design-based methods make no assumptions about the distribution of the sample units. Statistical inference, i.e., computation of confidence intervals, for design-based methods is derived from the random selection process. As noted previously, we used statistical sampling software to apply the correct formulas for the extrapolation.

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

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

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

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

With respect to the 6 partially unallowable claim lines that were associated with a single enrollee and the 13 of 14 excessive unit findings that were associated with 3 provider agencies, we note that these errors were contained in stratum 4. Therefore, these errors did not influence the estimate for the remainder of the sampling frame.

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

Missing Documentation Related to Background Screenings and Attendant Support Management Plans

State Agency Comments

The State agency said that our methodology improperly treated instances of missing documentation—specifically background screenings and ASMPs—as financial disallowances, resulting in a flawed and overstated error rate. The State agency said that "these documentation gaps, in isolation, do not demonstrate that services were not rendered, were not medically necessary, or were otherwise noncompliant with waiver requirements." The State agency added: "Under 42 CFR § 431.107(b), providers must maintain records sufficient to disclose the extent of services furnished," and stated that Federal improper payment guidance[26] defines improper payments as those that should not have been made or were made in an incorrect amount. The State agency said that this missing documentation represented "administrative noncompliance" and should be addressed through corrective action, not financial disallowance.

The State agency also said that extrapolation is "only appropriate when the underlying sample identifies confirmed improper payments that are representative of the broader population. Extending extrapolation to these isolated documentation findings, absent verification of actual payment error, artificially inflates the projected error rate and overstates program risk." The State agency requested that these documentation-based findings be removed from the financial error-rate calculation and that any extrapolated disallowance be recalculated using only validated improper payments.[27]

[26] **Office of Inspector General Note**—The State agency cited to Office of Management and Budget (OMB) Circular A-123, Appendix C, *Requirements for Payment Integrity*, and the Improper Payments Information Act of 2002, P.L. No. 107-300, 116 Stat. 2350 (Nov. 26, 2002).

[27] The State agency raised similar issues about extrapolation in its comments on our fourth (procedural) recommendation. See "Recommendations Regarding Background Screenings and Attendant Support Management Plans" later in this report.

Office of Inspector General Response

We disagree with the State agency's comments on this finding. We maintain that our methodology appropriately classified the identified errors as improper payments for purposes of calculating the error rate and estimating unallowable Federal reimbursement.

The Waiver requires all attendants to submit to a CBI screening, all provider-directed attendants to submit to a CAPS screening, and all consumer-directed attendants to be checked against the OIG exclusion list. Additionally, State regulation (10 CCR 2505-10 8.7409.E) requires providers to compare all PCS attendants against the OIG exclusion list effective March 16, 2024.

The Waiver also requires that enrollees who receive consumer-directed PCS have an approved ASMP, and that consumer-directed PCS may not begin until the ASMP has been approved. Additionally, State regulations (10 CCR 2505-10 8.510.5.A) stipulate that consumer-directed PCS "shall not begin until the Case Manager approves the [ASMP] and provides a start date to the [FMS vendor]" and "[t]he FMS vendor will not reimburse attendants for services provided prior to the [consumer-directed PCS] start date" (10 CCR 2505-10 8.510.11.D).

In addition, section 2497.1 of the CMS *State Medicaid Manual* states that expenditures are allowable only to the extent that, when a claim is filed, the State agency has adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met.

With respect to the State agency's reference to Office of Management and Budget (OMB) Circular A-123's definition of improper payments, we note that this Circular also states: "In addition, when an agency's review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation, this payment must also be considered an error." In the absence of this background screening and ASMP documentation, the State agency cannot demonstrate compliance with these applicable Federal and State requirements, and the associated payments are therefore considered unallowable.

We therefore maintain that the absence of evidence demonstrating enrollee and attendant eligibility at the time of service points to a documentation deficiency that supports questioning the associated claims and including those errors in our estimation of unallowable Federal Medicaid reimbursement.

Net Claim Lines Involving Incomplete or Undocumented Background Screenings

State Agency Comments

With respect to our finding (related to our second objective) of claim lines that were at least partially unallowable, the State agency said that we made these determinations solely because background screening documentation was incomplete or unavailable, even though we did not identify any attendant with a substantiated CAPS finding or a Federal program exclusion. The

State agency said that State policy requires background screenings to be completed before service delivery and documentation to be maintained. The State agency cited Federal record retention requirements and added that the absence of older records, sometimes dating back more than a decade, does not demonstrate that screenings were not completed or that services were delivered by ineligible attendants. According to the State agency, "While documentation must be maintained, [F]ederal allowability standards should not require the long-term retention of every individual screening document as a condition of payment absent evidence of ineligible service delivery."

The State agency also stated: "In the absence of evidence that a caregiver was ineligible to provide services at the time of service delivery, OIG has not established sufficient legal basis to deem the associated claims in this sample unallowable, nor has the OIG established that those sampled claims should form the basis for extrapolations." In addition, the State agency said that the "discrete . . . variances" we identified "were limited to a small number of provider agencies and do not reflect systemic payment control deficiencies." The State agency added that it had implemented or initiated corrective actions "to strengthen claim-edit logic and targeted provider oversight." The State agency concluded, though, that because we did not identify any substantiated CAPS findings, exclusions, or other evidence of program integrity risk, "the findings reflect documentation and administrative compliance issues rather than evidence of unallowable services and do not provide a sufficient legal or statistical basis for claim disallowance or extrapolated repayment."

Office of Inspector General Response

We acknowledge the corrective actions to which the State agency referred but continue to regard the instances of missing or incomplete background screening documentation identified in the sample as payment errors under the Waiver and State regulation requirements (discussed in the previous section).

When required documentation is not available at the time of audit review, the State agency cannot demonstrate that services had been rendered by eligible attendants as required. Although the State agency described gaps in background screening records as administrative issues, the documentation in question is essential to verify attendant eligibility. Because the State agency was unable to provide the required background screening documentation for multiple sampled claim lines, we appropriately classified those payments as unallowable within the sample and, in accordance with our policy, included them in our statistical estimates. We continue to support these findings and our associated recommendation that the State agency refund the associated unallowable Federal Medicaid reimbursement.

Comparison to Prior OIG Audit Findings

State Agency Comments

The State agency said that our 2024 Kansas EVV audit (footnote 3 and Appendix B) identified similar issues, such as missing EVV data, manual entries, incomplete background screening documentation, inaccurate time reporting, and lack of task level detail, which resulted only in "technical recommendations" rather than financial recovery. According to the State agency, we explained during our audit that we did not pursue financial recovery in Kansas because its managed care delivery system limited the ability to directly attribute and quantify payment amounts associated with specific documentation findings. The State agency said that applying financial penalties in Colorado solely because it operates a fee-for-service model is therefore "arbitrary and capricious," given that the types of deficiencies identified in both audits were comparable and largely reflected documentation and system configuration issues rather than evidence of services not rendered or providers being ineligible.

The State agency also noted that it has already implemented corrective actions such as enhanced EVV data validation, expanded monitoring, provider training, and strengthened oversight, and stated that the root causes of our findings are "most appropriately addressed through targeted program improvements and strengthened controls to ensure ongoing compliance and program integrity."

Office of Inspector General Response

We disagree with the conclusions that the State agency drew from its comparison of this audit's results to the results we reported for our audit of Kansas's EVV program. Each Medicaid audit stands on its own and reflects the specific circumstances, evidence, and program conditions present in that State. Additionally, the State agency did not identify other OIG audits in which we recommended a refund of Federal reimbursement for unallowable PCS.[28] Furthermore, for some of the issues identified by the State agency in this portion of its written comments, such as missing EVV data and manual EVV entries, this report recommends procedural or program improvements rather than financial recovery.

We acknowledge and commend the corrective actions that the State agency said that it has undertaken to strengthen its EVV and PCS programs. Based on our findings, we continue to recommend that the State agency refund the associated unallowable Federal Medicaid reimbursement.

[28] See *New York Improved Its Monitoring of Its Personal Care Services Program But Still Made Improper Medicaid Payments of More Than $54 Million* (A-02-19-01016; Dec. 9, 2020), and *Missouri Claimed Federal Medicaid Reimbursement for Tens of Millions in Consumer-Directed Personal Care Assistance Services That Did Not Comply With Federal and State Requirements* (A-07-20-03243; Feb. 23, 2023). See also Appendix B.

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

State Agency Comments

The State agency disagreed with our finding and with the estimated Federal share of $45,688,080 that our second recommendation set aside for CMS resolution. The State agency requested clarification on our use of the term "set aside," including what actions, if any, we had taken regarding these funds and how this characterization affects CMS's ultimate authority to determine allowability. The State agency said that the finding rests on our interpretation that consumer-directed timesheets must include task-level documentation but stated that "OIG did not identify any [F]ederal statute, regulation, CMS guidance, or approved waiver provision that explicitly requires task-level documentation on consumer-directed timesheets as a condition of payment."

The State agency further stated that Colorado's documentation framework satisfies CMS-approved waiver requirements and collectively demonstrates that services were authorized and delivered. The State agency said that our finding "reflects a difference in interpretation regarding documentation format rather than a failure to meet [F]ederal allowability requirements." The State agency also said that "[b]ecause Colorado's documentation approach is consistent with CMS-approved waiver authority and satisfies [F]ederal requirements for allowability, including that costs are necessary, reasonable, and supported by sufficient documentation, the estimated set-aside is not supported. The claims at issue reflect permissible documentation differences within a consumer-directed model, not unallowable expenditures." The State agency accordingly asked that we reconsider and eliminate the amount that our second recommendation set aside.

Office of Inspector General Response

When we set aside an amount for resolution and potential recovery by the cognizant Federal agency (in this case, CMS), we associate that amount (in this case, the estimated Federal share of $45,688,080) with claims for which documentation is insufficient to verify allowability. This finding explains that for all 50 consumer-directed PCS net claim lines in our sample, the associated timesheets did not identify the specific tasks that were performed in accordance with the enrollees' ASMPs or other supporting documentation.

Although we recognize the consumer-directed design of the State agency's EVV program, we also reiterate that documentation must be sufficient to establish that paid services were rendered as authorized. Section 1902(a)(27)(A) of the Act and CMS *State Medicaid Manual* § 2497.1 require adequate supporting documentation. Because the timesheets did not provide any detail on the specific tasks that were performed, we could not determine whether recorded time was spent on allowable PCS tasks consistent with the enrollee's ASMP. Therefore, we maintain that our second recommendation, regarding the allowability and possible refund of some or all of the estimated $45,688,080 (Federal share) that we have set aside, remains valid.

RECOMMENDATIONS REGARDING ELECTRONIC VISIT VERIFICATION SYSTEM IMPROVEMENTS

For our third recommendation regarding EVV System improvements, the State agency agreed or partially agreed with six of our seven subrecommendations and disagreed with our first subrecommendation, which related to the use of manual entries. We summarize the State agency's comments, and offer our responses to those points where necessary, below.

Recommendation To Establish Requirements Governing the Use of Manual Entries

State Agency Comments

The State agency disagreed with our recommendation related to manual entries and also with "any implication that manually entered EVV records inherently indicate noncompliance or that services were not provided." The State agency added that manual entries are expressly permitted under the 21st Century Cures Act, CMS guidance, and Colorado regulations, which allow EVV data to be entered manually when real-time capture is not feasible.

The State agency also said that Federal EVV policy requires verification of six core data elements, not a specific method of entry, and emphasized that CMS guidance explicitly acknowledges circumstances in which manual submission of visit information is appropriate. The State agency said that its data show that approximately 19 to 25 percent of visits for all EVV-required services are manually entered, which differs from the 38-percent (62 of 160 claim lines) manual entry rate identified in our sample, "suggesting that the sample may not reflect typical statewide utilization patterns."

The State agency further stated that manual entries, when supported by required documentation, do not constitute missing EVV or improper payment, and added that "rigid statewide caps or automatic denial thresholds could unintentionally restrict flexibility inherent in CMS-approved agency and consumer-directed service models and may create service access disruptions." The State agency also said that it "actively monitors how many modified and manually entered visits are submitted per provider agency" and stated that its oversight framework effectively mitigates fraud risk without prohibiting a permissible EVV method.

Office of Inspector General Response

We agree that manual entries are permissible. However, our recommendation addresses the risk and scale of manual EVV entries. Our review did not cover all EVV-required services, so we cannot speak to the State agency's overall percentage of manual entries. However, in our sample, 62 of 160 PCS net claim lines contained manually entered visits, including instances in which most or all EVV records for an enrollee over extended periods were manual entries. Instances of this nature undermine EVV's purpose of real-time verification and increase the risk of inaccurate or unverifiable documentation.

We also note that although manual entries may be permissible, their use requires vigorous oversight to ensure that they are limited to appropriate scenarios and supported by adequate documentation. The State agency described multiple monitoring mechanisms, but these controls did not prevent the frequency of manual entries that we observed in our sample. Moreover, the absence of identified fraud or ineligible attendants does not eliminate program integrity risk. EVV is, by design, a preventive control intended to reduce opportunities for inaccurate or unsupported billing. For these reasons, we continue to support our finding and recommendation—which points to measures by which the State agency can improve its oversight framework—related to the use of manual entries.

Recommendations Regarding Electronic Visit Verification System Improvements With Which the State Agency Partially Agreed

State Agency Comments

The State agency partially agreed with the recommendations that all PCS visits have corresponding EVV records and that all EVV records capture the location of services provided.[29] For the 17 claim lines without corresponding EVV records, the State agency concurred that these claim lines "reflected documentation discrepancies" and said that it is addressing them. The State agency also stated that its span-billing methodology does not require a one-to-one match between claim line dates and EVV entries.[30]

Regarding EVV records with missing location data, the State agency explained that the 16 affected claim lines resulted from a system logic defect that prevented GPS coordinates from populating for MVV entries. The State agency said that it identified the defect, coordinated with its vendor, and implemented corrective system updates on July 31, 2025. The State agency stated that these measures demonstrate "that internal monitoring controls functioned as intended." Accordingly, the State agency stated that it does not believe that additional corrective action is warranted or that the issue indicates broader EVV noncompliance.

The State agency also partially agreed with the recommendations concerning GPS exception review and EVV reason code use, again attributing the issues to the same underlying system logic defect that we discussed above rather than to provider oversight failures.[31] The State agency said that the defect prevented consistent prompting for alternate location entry, leading to uncorrected GPS exceptions despite all required EVV elements being captured, and noted that remediation has been completed for State-provided EVV system users and is nearing completion for provider choice EVV system users.

[29] These are the second and fourth subrecommendations of our third recommendation.

[30] Span billing refers to reporting a continuous range of service dates on a claim as a single billed period, rather than listing each day or service separately.

[31] These are the fifth and sixth subrecommendations of our third recommendation.

Similarly, the State agency said that deficiencies in EVV reason code use were the result of system-level defects and were not indicative of provider noncompliance or broader EVV concerns. The State agency added that because both of these types of issues were largely resolved before we completed fieldwork, no additional corrective action is needed.

Office of Inspector General Response

We acknowledge the State agency's comments regarding span billing and agree that EVV records are captured at the individual visit level rather than at the claim line level. Our methodology did not require a one-to-one alignment between EVV entries and claim lines; rather, we assessed whether each billed visit was supported by corresponding EVV documentation. For the 17 sampled claim lines without EVV support that we identified, the State agency agreed that documentation discrepancies existed, which resulted in some billed services that could not be verified in accordance with Federal and State EVV requirements. In addition, we note the State agency's explanation that missing service location data resulted from an EVV system logic defect. Although the underlying cause was technical in nature, the absence of required location information limited the State agency's ability to verify service delivery during the audit period.

We also acknowledge the State agency's explanation that issues related to GPS exceptions and EVV reason code use stemmed from the same system-level defect rather than from provider noncompliance. However, these issues resulted in incomplete EVV data during the audit period, including missing prompts for alternate location entry and inconsistent capture of required reason codes. Even when service delivery is not in question, the absence of required EVV elements limits the State agency's ability to fully verify and monitor EVV compliance. We maintain that implementing our recommendations will help ensure that required EVV data elements are consistently recorded going forward and that similar deficiencies are promptly identified and addressed.

Recommendations Regarding Electronic Visit Verification System Improvements With Which the State Agency Agreed

The State agency agreed with the two remaining EVV recommendations that providers verify that all PCS visits are entered into the EVV system, and that providers verify that the names of the attendants identified on EVV records match the names of the attendants who signed the corresponding timesheets.[32] The State agency also described corrective actions that it had taken or planned to take to address these recommendations.

[32] These are the third and seventh subrecommendations of our third recommendation.

RECOMMENDATIONS REGARDING BACKGROUND SCREENINGS AND ATTENDANT SUPPORT MANAGEMENT PLANS

State Agency Comments

The State agency partially agreed with our recommendation to improve its procedures to verify that providers maintain documentation that attendant background screenings are completed for all attendants.[33] The State agency said that although it requires background screenings to be completed prior to service delivery, the issues we identified reflected documentation "retention variances" rather than evidence of unallowable payments. The State agency added that we did not identify any caregivers with disqualifying criminal offenses, Adult Protective Services substantiations, exclusions, or other conditions that would have rendered them ineligible during the audit period. The State agency referred to State regulations and State agency policies and described additional oversight controls that, it said, provide reliable assurance that required background screenings were completed even when individual documents were not later retrievable. The State agency also described corrective actions that it planned to implement with respect to updated communication with provider agencies and FMS vendors.

The State agency said that Federal requirements do not establish specific background screening requirements for personal care attendants and that State policy determines payment based on attendant eligibility, not on long-term retention of background screening records. The State agency concluded that "[t]he instances identified reflect documentation variances rather than systemic control deficiencies."

The State agency also disagreed with the finding related to missing ASMPs and the associated disallowance, stating that we had a "fundamental misunderstanding" about the purpose and function of the ASMP within Colorado's CDASS model. The State agency said that "the ASMP serves as a planning tool, rather than a document that authorizes services or validates specific tasks performed." The State agency added that under Colorado's CMS-approved waiver, the task worksheet and CDASS allocation documents are the governing authorization instruments, and that these were in place for all four enrollees who were associated with the consumer-directed net claim lines we identified for this finding. The State agency also stated that the absence of an ASMP file, without evidence that services exceeded the approved task worksheet, does not demonstrate that services were unauthorized, unverified, or unallowable.

The State agency described additional program integrity controls that, it said, help to ensure services remain within authorized parameters. The State agency noted that two of the missing ASMPs predated 2010 and were "never required to be re-entered into the electronic system." The State agency said that the two remaining instances reflected "documentation storage variance inherent to consumer-directed programs." The State agency also stated that we identified no instance in which services exceeded authorized tasks and added that "[t]reating the absence of a non-authorizing planning document as grounds for a disallowance would be

[33] These are the two subrecommendations, respectively, of our fourth recommendation.

inconsistent with CMS's long-standing guidance for consumer-directed services, which allows greater documentation flexibility."

Office of Inspector General Response

We commend the State agency for its planned corrective actions to reinforce provider agency and FMS vendor documentation retention requirements for background screenings. However, we disagree with the State agency's position that claims remain allowable in cases when required background screening documentation is missing or incomplete, even when screenings conducted after the date of service did not identify disqualifying conditions. The absence of documentation demonstrating that required background screenings were completed before the date of service does not allow verification that services were rendered by eligible attendants, thereby posing a potential safety risk to Medicaid enrollees.

Additionally, we acknowledge that the State agency uses the ASMP as a care planning document prior to service delivery, and that the State agency uses additional documentation to govern the scope, type, and allowable tasks for enrollees (e.g., the task worksheet and CDASS allocation documents). We also acknowledge that two of the enrollee ASMPs from our sample predate 2010. However, we maintain that the Waiver requires that enrollees who receive consumer-directed PCS have an approved ASMP, and that consumer-directed PCS may not begin until the ASMP has been approved. Additionally, State regulations (10 CCR 2505-10 8.510.5.A) state: "[Consumer-directed PCS] shall not begin until the Case Manager approves the [ASMP] and provides a start date to the [FMS vendor]" and "[t]he FMS vendor will not reimburse attendants for services provided prior to the [consumer-directed PCS] start date" (10 CCR 2505-10 8.510.11.D).

Therefore, we maintain that in the absence of this background screening and ASMP documentation, the State agency cannot demonstrate compliance with these applicable Federal and State requirements, and the associated payments are appropriately considered unallowable.

RECOMMENDATIONS REGARDING SYSTEM EDITS TO VERIFY THAT UNITS PAID MATCH PLANS OF CARE AND THAT APPROVED RATES ARE USED

State Agency Comments

The State agency partially agreed with our recommendation to implement system edits to verify that units paid match the units approved on the enrollees' plans of care.[34] In this context, the State agency stated that it maintains multiple controls to ensure that billed services align with authorized units and approved reimbursement rates, including "MMIS fee schedule validation, service authorization controls within care planning systems, EVV verification of service delivery time, and analytics monitoring used to identify billing anomalies or provider outliers."

[34] This is the first subrecommendation of our fifth recommendation.

The State agency also stated that the issues that we identified resulted from the ways in which span-billing practices (footnote 30) interacted with claims processing controls. The State agency noted that some span-billed claims covered multiple months while the supporting documentation that we reviewed during our audit reflected only portions of that period, which created the appearance of excess units at the claim level. The State agency said that this issue reflected billing presentation limitations rather than a breakdown in authorization oversight, as all services remained subject to the approved prior authorization request (PAR), which governs allowable units under the Waiver.

The State agency agreed that strengthened prepayment safeguards are appropriate but stated that the findings do not demonstrate systemic billing outside PAR limits. The State agency added that it is developing and implementing system enhancements to better validate "billed units against verified service delivery data prior to payment," which, it believes, appropriately addresses the identified vulnerability "without requiring additional plan-of-care reconciliation edits." In addition, the State agency described related corrective actions that it planned to take.

The State agency disagreed with our recommendation to implement system edits to verify that rates paid are in accordance with the State's approved rates.[35] The State agency stated that Colorado's MMIS already contains automated controls that strictly enforce CMS-approved reimbursement rates, preventing providers from altering payment amounts. The State agency acknowledged that for the eight provider-directed PCS net claim lines that we identified, the Denver County rate was applied despite the enrollee's residence being listed in a different county. However, the State agency described these instances as "isolated administrative rate-selection errors" that occurred during a defined transition period in which the State temporarily allowed use of the Denver County rate while county-based rate logic was being implemented. The State agency said that seven of the eight instances occurred before this implementation date and the remaining case occurred during the transition window. The State agency concluded that "[t]hese eight instances therefore reflect a resolved transitional administrative variance—not systemic rate misapplication and not evidence of overpayment."

Office of Inspector General Response

We recognize the State agency's description of how span-billing practices can obscure the allocation of units across months when reviewed supporting documentation reflects only a portion of the claim period. However, the issues identified during our audit involved instances in which billed units exceeded the number of units supported by the documentation received for the relevant dates of service. We identified 14 net claim lines with excessive units, including 1 example of 3,876 units claimed over 8 dates (approximately 121 hours per day), while the associated timesheets documented 161 units (approximately 5 hours per day). Errors of this nature cannot be attributed solely to span billing presentation. Regardless of billing format, each paid claim must be supported by documentation that verifies both service delivery and compliance with the authorized limits established under the approved plan of care. Based on

[35] This is the second subrecommendation of our fifth recommendation.

our findings, we maintain that our recommendation remains valid, because implementation of system edits to verify that units paid match the units approved on enrollees' plans of care will help ensure that units paid match units authorized and will reduce the risk of overpayment.

We acknowledge the State agency's explanation that its MMIS includes automated rate-validation controls designed to ensure that payments align with the State's approved fee schedule. However, the eight provider-directed PCS net claim lines identified during our audit demonstrated that rates paid did not always align with the approved methodology in effect at the time of payment. Accordingly, we questioned only the difference between the Denver County enhanced rate and the applicable lower rate for the eight provider-directed PCS net claim lines that included PCS services rendered in each case to an enrollee whose residential address was located outside of Denver County and for whom the EVV check-in and check-out location data were outside of Denver County. Transitional policies and system flexibilities may explain the cause of these variances, but they do not eliminate the requirement that claims be paid at the correct rate. For this reason, we maintain that our recommendation remains appropriate, because implementation of system edits to ensure that paid rates match approved rates would strengthen the State agency's ability to prevent similar issues in the future.

RECOMMENDATION THAT TIMESHEETS FOR CONSUMER-DIRECTED PERSONAL CARE SERVICES DOCUMENT LEVEL OF DETAIL NECESSARY TO SUPPORT THAT SERVICES COMPLIED WITH ATTENDANT SUPPORT MANAGEMENT PLANS

State Agency Comments

In its comments on our sixth recommendation, the State agency stated that it disagreed with our associated finding that consumer-directed timesheets must document the specific PCS tasks performed and stated that this requirement is inconsistent with Colorado's CMS-approved CDASS model. The State agency said that the CDASS program relies on multiple oversight mechanisms to ensure that services are delivered appropriately and within authorized limits. According to the State agency, CMS expressly permits documentation flexibility for consumer-directed programs under its 1915(c) waiver authority, and no statute, regulation, or CMS guidance requires task-level entries on individual timesheets. In addition, the State agency stated that our finding "appears to apply provider agency-based service documentation standards to a consumer-directed model where CMS expressly allows flexibility." The State agency also said that "[t]he Task Worksheet, not the timesheet, serves as the governing document specifying allowable tasks," and that "[t]imesheets are used to record time and service duration."

The State agency further stated that Colorado's consumer-directed model intentionally separates prior authorization, task authorization, service-planning tools, EVV, and payroll documentation, and that these components "collectively disclose the extent of services provided without requiring redundant task-level entries." The State agency added that we did not identify unauthorized services, ineligible enrollees or attendants, excess units, or payments outside approved waiver authority, and that our finding reflects a difference in interpretation of

documentation format rather than evidence of improper service delivery. The State agency stated: "Since Colorado's consumer-directed documentation standards are approved by CMS and the OIG's interpretation is not supported by [F]ederal statute, regulation, or CMS-approved waiver authority on consumer-directed services, the set-aside amount is unfounded. These claims reflect permissible documentation differences, not unsupported or unallowable services." The State agency reiterated its request that we reconsider and eliminate the amount that our second recommendation set aside for CMS resolution, "consistent with approved waiver authority."

Office of Inspector General Response

We disagree with the State agency's comments on this finding and, by extension, on our sixth recommendation. Regardless of State-level program design, Federal Medicaid requirements still require providers to maintain documentation sufficient to fully disclose the extent of services provided and to support that billed services were rendered in accordance with the approved ASMP and Medicaid allowability standards. We emphasize that task-level documentation is necessary not because CMS requires tasks to be listed on timesheets, but because: (1) the ASMP defines the specific tasks, (2) the timesheet is the only record of what tasks were actually performed, and (3) without linking timesheet entries to the ASMP's specified tasks, the State agency cannot demonstrate that the services billed were allowable.

The absence of task-level information on timesheets prevented us from determining the specific tasks rendered for the PCS net claim lines in our sample. Although the State agency maintained that its model satisfies Federal oversight expectations, our audit could not verify compliance with the requirements that claims were supported by documentation showing the nature and extent of the services provided and that the services were allowable. For these reasons, we maintain that our sixth recommendation remains valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit period covered PCS provided and paid during State SFY 2024. We used claims data that the State agency gave us to perform our work.

We developed a sampling frame of 1,301,307 PCS net claim lines of $25 or more, from the Waiver, for which reimbursement totaled $299,230,641 ($152,860,012 Federal share) (footnote 8). From this sampling frame, we selected a stratified random sample of 160 PCS net claim lines, of which 50 PCS net claim lines were consumer-directed and 110 were provider-directed.

We reviewed documentation in the State agency's EVV Aggregator (footnote 7), from which we were able to review the details for each PCS visit (PCS net claim lines) to determine whether the visit was completed and verified electronically in accordance with Federal and State requirements.

In addition, we reviewed documentation that the State agency gave us for services rendered, attendant qualifications, and payment accuracy to determine whether each PCS visit in our sample complied with Federal and State requirements.

We assessed the control activities related to the State agency's administration of the EVV program, which included its oversight of the EVV system. Our assessment of these control activities included gaining an understanding of: (1) the responsibilities of the State agency, providers, and PCS attendants within the EVV program; (2) the process whereby an EVV record would be created; and (3) where in the EVV system the documentation of each EVV record is maintained. We also assessed the control activities related to the State agency's oversight of PCS rendered.

We conducted our audit work, which included visiting the State agency and two providers (footnote 9) in Denver, Colorado, from September 2024 to February 2026.

METHODOLOGY

We took the following steps to accomplish our objectives:

- Reviewed applicable Federal and State requirements, the CMS *State Medicaid Manual*, the State agency's HCBS waiver, and the State agency's EVV program policies and procedures, to include the State agency's EVV manual

- Held discussions with officials from the State agency and the EVV vendor to gain an understanding of the State's EVV program policies and procedures

- Conducted an on-site visit to the State agency in Denver, Colorado, and, during the visit, also met with two PCS providers to gain an understanding of the EVV program and how PCS visits are entered and processed in the EVV system

- Obtained from the State agency claims data for PCS provided and paid for during SFY 2024

- Reconciled the State agency's PCS claims data to the amounts that it reported to the Federal Government to claim Medicaid reimbursement for SFY 2024

- Developed a sampling frame of 1,301,307 PCS net claim lines with a total reimbursement of $299,230,641 ($152,860,012 Federal share)

- Selected a stratified random sample of 160 PCS net claim lines, obtained associated visit data from the State agency's data warehouse, and reviewed EVV system documentation and other supporting documentation for each sampled PCS net claim line to determine whether:

    - PCS net claim lines were entered and verified in the EVV system

    - PCS net claim lines included the six data points required by the Cures Act

    - The EVV system identified exceptions for any PCS net claim lines and whether those exceptions were addressed and corrected

    - The PCS rendered were allowable according to the enrollee's plan of care or ASMP and whether the units charged complied with requirements

    - Each enrollee's plan of care or ASMP was supported by an assessment or annual reassessment

    - Background check documentation was maintained for attendants rendering PCS to enrollees

    - The amount paid for the services was in accordance with the State's approved rates

- Used the sample results to estimate (Appendix D, Tables 2 and 3) the number of PCS net claim lines in the sampling frame that were not in compliance with Federal and State EVV requirements

- Used the sample results to estimate (Appendix D, Tables 4 through 6) the unallowable Federal Medicaid reimbursement in the sampling frame associated with the PCS errors we identified (for which we are recommending refund to the Federal Government)

- Used the sample results to estimate (Appendix D, Tables 7 through 9) the Federal Medicaid reimbursement in the sampling frame associated with the consumer-directed PCS net claim lines that lacked detailed timesheets, which we identified and set aside (footnote 12) for CMS resolution and potential recovery

- Discussed the results of our audit with State agency officials

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

APPENDIX B: PREVIOUSLY ISSUED OFFICE OF INSPECTOR GENERAL REPORTS[36]

Report Title	Report Number	Date Issued
New Jersey Did Not Ensure That Some Medicaid Personal Care Assistant Services Provided Under the Personal Preference Program Met Federal and State Requirements	A-02-22-01024	9/17/25
New Mexico Did Not Ensure Attendants Were Qualified To Provide Personal Care Services, Putting Medicaid Enrollees at Risk	A-06-22-02000	8/27/24
Kansas's Implemented Electronic Visit Verification System Could Be Improved	A-07-23-03255	8/20/24
Missouri Claimed Federal Medicaid Reimbursement for Tens of Millions in Consumer-Directed Personal Care Assistance Services That Did Not Comply With Federal and State Requirements	A-07-20-03243	2/23/23
New York Improved Its Monitoring of Its Personal Care Services Program But Still Made Improper Medicaid Payments of More Than $54 Million	A-02-19-01016	12/9/2020

[36] Our report on the State of Kansas (A-07-23-03255) is the only previously issued report that covered both EVV and PCS. All other previously issued reports listed covered only PCS.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 1,301,307 PCS net claim lines (footnote 8) of $25 or more, from the Waiver (footnote 5), for which reimbursement totaled $299,230,641 during SFY 2024.[37]

SAMPLE UNIT

The sample unit was one PCS net claim line.

SAMPLE DESIGN AND SAMPLE SIZE

Our sample design was a stratified random sample containing four strata, as shown in Table 1:

Table 1: Division of Strata for Sample Design

Stratum	PCS Type	Dollar Range	Number of Frame Units	Frame Dollar Value (Total)	Sample Size
1	Consumer-Directed	All from $25 to $2,920.40	646,964	$113,937,605	50
2	Provider-Directed	$25 to $699.99	587,817	71,806,965	45
3	Provider-Directed	$700 to $9,999.99	66,506	113,197,200	45
4	Provider-Directed	$10,000 and higher	20	288,871	20
		Totals	**1,301,307**	**$299,230,641**	**160**

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We sorted items in each stratum by both ICN and FDOS fields (footnote 8) in ascending order. We then consecutively numbered the items in each stratum in the sampling frame. After generating the random numbers for each of these strata, we selected the corresponding frame items for review.

[37] Within the PCS net claim lines associated with the Waiver, we reviewed two procedure codes. One of these codes includes the following types of provider-directed PCS: (1) PCS, (2) PCS relative, (3) PCS remote supports, and (4) in-home support services PCS. The other procedure code is specific to consumer-directed attendant support services and includes the following service types: (1) PCS; (2) homemaker; and (3) health maintenance.

ESTIMATION METHODOLOGY

We used the OIG, OAS, statistical software to estimate the number and percentage of PCS net claim lines in the sampling frame with EVV compliance issues. We calculated a point estimate and a two-sided 90-percent confidence interval using this software (Appendix D, Tables 2 and 3).

We also used the statistical software to estimate the total dollar value of the State agency's unallowable payments for PCS in our sampling frame at the lower limit of the two-sided 90-percent confidence interval (Appendix D, Tables 4 through 6). Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

Finally, we used the statistical software to estimate the total dollar value of the State agency's payments that we have set aside, for the consumer-directed PCS net claim lines that lacked detailed timesheets in our sampling frame. We calculated a point estimate and a two-sided 90-percent confidence interval using this software (Appendix D, Tables 7 through 9).

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results—Electronic Visit Verification Compliance

Stratum	Frame Size	Sample Size	Number of PCS Net Claim Lines With EVV Compliance Issues
1	646,964	50	34
2	587,817	45	16
3	66,506	45	23
4	20	20	18
Totals	**1,301,307**	**160**	**91**

Table 3: Estimated Number and Percentage of Personal Care Services Net Claim Lines in the Sampling Frame With Electronic Visit Verification Compliance Issues (*Limits Calculated at the 90-Percent Confidence Level*)

	Estimated Number of PCS Net Claim Lines With EVV Compliance Issues	Estimated Percentage of PCS Net Claim Lines With EVV Compliance Issues
Point estimate	682,947	52.48%
Lower limit	583,125	44.81%
Upper limit	782,769	60.15%

Table 4: Sample Results—Personal Care Services Errors (Total)

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of PCS Net Claim Lines With Errors (Unallowable)	Value of Unallowable PCS Net Claim Lines
1	646,964	$113,937,605	50	$8,718	7	$1,835
2	587,817	71,806,965	45	5,110	3	21
3	66,506	113,197,200	45	66,334	9	5,042
4	20	288,871	20	288,871	20	234,260
Totals	**1,301,307**	**$299,230,641**	**160**	**$369,033**	**39**	**$241,158**

Table 5: Sample Results—Personal Care Services Errors (Federal Share)

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of PCS Net Claim Lines With Errors (Unallowable)	Value of Unallowable PCS Net Claim Lines
1	646,964	$58,204,580	50	$4,468	7	$937
2	587,817	36,684,034	45	2,605	3	11
3	66,506	57,824,719	45	34,117	9	2,585
4	20	146,679	20	146,679	20	118,697
Totals	**1,301,307**	**$152,860,012**	**160**	**$187,869**	**39**	**$122,230**

Table 6: Estimated Value of Unallowable Personal Care Services in the Sampling Frame (*Limits Calculated at the 90-Percent Confidence Level*)

	Total	Federal Share
Point estimate	$31,704,496	$16,206,958
Lower limit	15,709,911	8,072,870
Upper limit	47,699,082	24,341,046

Table 7: Sample Results Set Aside—Consumer-Directed Personal Care Services That Lacked Detailed Timesheets (Total)

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of PCS Net Claim Lines Set Aside*	Value PCS Net Claim Lines Set Aside
1	646,964	$113,937,605	50	$8,718	43	$6,884
2	587,817	71,806,965	45	5,110	0	0
3	66,506	113,197,200	45	66,334	0	0
4	20	288,871	20	288,871	0	0
Totals	**1,301,307**	**$299,230,641**	**160**	**$369,033**	**43**	**$6,884**

* See footnote 12.

Table 8: Sample Results Set Aside—Consumer-Directed Personal Care Services That Lacked Detailed Timesheets (Federal Share)

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of PCS Net Claim Lines Set Aside*	Value PCS Net Claim Lines Set Aside
1	646,964	$58,204,580	50	$4,468	43	$3,531
2	587,817	36,684,034	45	2,605	0	0
3	66,506	57,824,719	45	34,117	0	0
4	20	146,679	20	146,679	0	0
Totals	**1,301,307**	**$152,860,012**	**160**	**$187,869**	**43**	**$3,531**

* See footnote 12.

Table 9: Estimated Value of Consumer-Directed Personal Care Services That Lacked Detailed Timesheets Set Aside in the Sampling Frame
(*Limits Calculated at the 90-Percent Confidence Level*)

	Total	Federal Share
Point estimate	$89,069,733	$45,688,080
Lower limit	72,804,307	37,366,416
Upper limit	105,335,159	54,009,743

APPENDIX E: FEDERAL AND STATE REQUIREMENTS FOR ELECTRONIC VISIT VERIFICATION AND PERSONAL CARE SERVICES

FEDERAL REQUIREMENTS

Medicaid Home and Community-Based Services Waiver

The Act § 1915(c)(1) authorizes waivers for HCBS and states:

> The Secretary may by waiver provide that a State plan approved under this title may include as 'medical assistance' under such plan payment for part or all of the cost of home or community-based services . . . which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility . . . the cost of which could be reimbursed under the State plan.

Electronic Visit Verification

Section 12006(a) of the Cures Act mandates that States implement EVV by January 1, 2020, for all Medicaid PCS that require an in-home visit by an attendant (footnote 4). This statute also provides that States that have not implemented EVV by that date are subject to incremental FMAP reductions of up to 1 percent, unless the State has both made a good-faith effort to comply and encountered unavoidable delays. Colorado requested and was approved for a 1-year good-faith-effort extension for PCS, which extended the deadline for it to implement EVV for PCS to January 1, 2021 (footnote 1).

Section 12006(a)(5)(A) of the Cures Act defines EVV with respect to PCS as a system under which visits conducted as part of such services are electronically verified with respect to:

(1) the type of service performed,
(2) the individual receiving the service,
(3) the date of the service,
(4) the location of service delivery,
(5) the individual providing the service, and
(6) the time the service began and ended.

Personal Care Services

The Act authorizes PCS, which it defines as "services furnished to an individual . . . that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services

and who is not a member of the individual's family, and (C) furnished in a home or other location" (the Act § 1905(a)(24)). Examples of PCS include, but are not limited to, eating, dressing, grooming, and bathing.

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

Implementing Federal regulations state that PCS may be provided only to individuals who are not inpatients at a hospital or residents of a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institution for mental disease (42 CFR § 440.167(a)).

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

Federal regulations state that a Medicaid enrollee's PCSP must reflect the services and supports that are important for the enrollee to meet the needs identified through an assessment of functional need and must reflect what is important to the enrollee with regard to preferences for the delivery of such services and supports (42 CFR § 441.301(c)(2)).

Federal regulations state that a PCSP must prevent the provision of unnecessary or inappropriate services and supports (42 CFR § 441.301(c)(2)(xii)).

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

STATE REQUIREMENTS

The Waiver requires all attendants who provide PCS to submit to a CBI screening prior to employment. For consumer-directed attendants who have a high-risk crime identified on their CBI screening that would initially prohibit employment, the Waiver allows an exception process through which the enrollee may provide a written acknowledgement to the State agency that the enrollee understands the reason for the attendant's initial ineligibility but still chooses to hire that attendant. In addition, the Waiver requires all provider-directed attendants to submit to a CAPS screening (footnote 18). The Waiver also requires all consumer-directed attendants

to be checked against the OIG exclusion list (Waiver Application, Appendix C: *Participant Services*, section C-2, "General Service Specifications").

The Waiver says that consumer-directed PCS may not begin until the ASMP is approved by the case manager (Waiver Application, Appendix E: *Participant Direction of Services*, section E-1, "Overview (1 of 13)").

State regulations state that providers using the EVV system must collect, for each visit, information to identify the Direct Care Worker (i.e., the attendant) providing the service (10 CCR 2505-10 8.001.3.A.1.b.ii). Additionally, State regulations state that providers that fail to comply with this rule after January 1, 2021, may be subject to compliance monitoring, request for written response, overpayment recovery, denial of claims, suspension, termination, or nonrenewal of their Colorado Medicaid Provider Agreement (10 CCR 2505-10 8.001.3.E.1.c).

State regulations state: "[Consumer-directed PCS] shall not begin until the Case Manager approves the [ASMP] and provides a start date to the [FMS vendor]" (10 CCR 2505-10 8.510.5.A) (footnote 17). Furthermore, "The FMS vendor will not reimburse attendants for services provided prior to the [consumer-directed PCS] start date" (10 CCR 2505-10 8.510.11.D).

State regulation requires providers to compare all PCS attendant names against the OIG exclusion list prior to employment, effective March 16, 2024 (10 CCR 2505-10 8.7409.E).

APPENDIX F: SUMMARY OF ELECTRONIC VISIT VERIFICATION COMPLIANCE ISSUES AND PERSONAL CARE SERVICES ERRORS FOR EACH NET CLAIM LINE

Table 10: Compliance Issues and Errors Identified for Each Personal Care Services Net Claim Line[38, 39]

Sample Number	Stratum	EVV Compliance Issues				PCS Errors				PCS Set-Aside Errors
		Manual Entries	Visits Not Entered Into EVV System	Location of Service Not Documented	GPS Exceptions Not Reviewed	Background Screening Was Not Documented	Units Claimed Were Excessive	Rates Paid Were Excessive	ASMP Was Not Documented	
1	1	X								X
2	1	X								X
3	1									X
4	1	X		X						X
5	1	X		X		X				*
6	1	X								X
7	1									X
8	1								X	*
9	1	X								X
10	1									X
11	1	X								X
12	1	X		X						X
13	1	X								X
14	1	X		X					X	*
15	1	X								X
16	1	X								X

[38] Sample numbers 1 through 50 were consumer-directed PCS and sample numbers 51 through 160 were provider-directed PCS.

[39] Sampled PCS net claim lines shown with an asterisk in the right-hand column had this error; however, we did not include these net claim lines in our estimate of the Federal share of Medicaid reimbursement that we have set aside because they were already included in our estimate of unallowable reimbursement.

Sample Number	Stratum	EVV Compliance Issues				PCS Errors				PCS Set-Aside Errors
		Manual Entries	Visits Not Entered Into EVV System	Location of Service Not Documented	GPS Exceptions Not Reviewed	Background Screening Was Not Documented	Units Claimed Were Excessive	Rates Paid Were Excessive	ASMP Was Not Documented	
17	1									X
18	1									X
19	1	X								X
20	1				X					X
21	1	X				X				*
22	1									X
23	1									X
24	1									X
25	1	X								X
26	1									X
27	1	X								X
28	1	X								X
29	1	X				X				*
30	1									X
31	1	X		X						X
32	1	X		X						X
33	1									X
34	1	X								X
35	1	X								X
36	1	X							X	*
37	1	X								X
38	1	X							X	*
39	1									X
40	1	X								X
41	1									X

Sample Number	Stratum	EVV Compliance Issues				PCS Errors				PCS Set-Aside Errors
		Manual Entries	Visits Not Entered Into EVV System	Location of Service Not Documented	GPS Exceptions Not Reviewed	Background Screening Was Not Documented	Units Claimed Were Excessive	Rates Paid Were Excessive	ASMP Was Not Documented	
42	1				X					X
43	1				X					X
44	1	X								X
45	1									X
46	1	X								X
47	1				X					X
48	1									X
49	1	X								X
50	1	X								X
51	2				X					
52	2									
53	2									
54	2	X								
55	2									
56	2				X					
57	2				X					
58	2									
59	2							X		
60	2									
61	2									
62	2	X								
63	2									
64	2									
65	2									
66	2									

Sample Number	Stratum	EVV Compliance Issues				PCS Errors				PCS Set-Aside Errors
		Manual Entries	Visits Not Entered Into EVV System	Location of Service Not Documented	GPS Exceptions Not Reviewed	Background Screening Was Not Documented	Units Claimed Were Excessive	Rates Paid Were Excessive	ASMP Was Not Documented	
67	2									
68	2							X		
69	2				X					
70	2									
71	2									
72	2									
73	2									
74	2									
75	2	X		X						
76	2	X								
77	2				X					
78	2	X								
79	2							X		
80	2									
81	2	X		X						
82	2				X					
83	2				X					
84	2									
85	2	X								
86	2	X								
87	2									
88	2									
89	2	X								
90	2									
91	2									

Sample Number	Stratum	EVV Compliance Issues				PCS Errors				PCS Set-Aside Errors
		Manual Entries	Visits Not Entered Into EVV System	Location of Service Not Documented	GPS Exceptions Not Reviewed	Background Screening Was Not Documented	Units Claimed Were Excessive	Rates Paid Were Excessive	ASMP Was Not Documented	
92	2									
93	2									
94	2									
95	2									
96	3				X			X		
97	3									
98	3					X				
99	3									
100	3					X				
101	3	X								
102	3									
103	3									
104	3	X								
105	3					X				
106	3				X					
107	3							X		
108	3	X								
109	3									
110	3									
111	3									
112	3	X								
113	3	X								
114	3	X								
115	3			X						
116	3	X								

Sample Number	Stratum	EVV Compliance Issues				PCS Errors				PCS Set-Aside Errors
		Manual Entries	Visits Not Entered Into EVV System	Location of Service Not Documented	GPS Exceptions Not Reviewed	Background Screening Was Not Documented	Units Claimed Were Excessive	Rates Paid Were Excessive	ASMP Was Not Documented	
117	3									
118	3				X					
119	3									
120	3									
121	3	X								
122	3									
123	3									
124	3	X		X		X				
125	3					X				
126	3		X							
127	3									
128	3	X			X					
129	3	X		X		X				
130	3									
131	3									
132	3	X								
133	3	X								
134	3	X	X	X						
135	3									
136	3	X		X						
137	3	X	X			X				
138	3									
139	3	X		X						
140	3	X								
141	4		X	X		X				

Sample Number	Stratum	EVV Compliance Issues				PCS Errors				PCS Set-Aside Errors
		Manual Entries	Visits Not Entered Into EVV System	Location of Service Not Documented	GPS Exceptions Not Reviewed	Background Screening Was Not Documented	Units Claimed Were Excessive	Rates Paid Were Excessive	ASMP Was Not Documented	
142	4						X			
143	4		X			X				
144	4	X	X				X			
145	4		X			X				
146	4		X			X				
147	4	X					X			
148	4		X			X				
149	4			X			X			
150	4				X	X				
151	4	X	X			X	X			
152	4		X			X	X	X		
153	4	X					X			
154	4		X				X			
155	4	X	X				X			
156	4		X			X	X			
157	4					X	X			
158	4		X			X	X			
159	4		X			X	X	X		
160	4		X			X	X	X		
Totals	**160**	**62**	**17**	**16**	**16**	**23**	**14**	**8**	**4**	**43**

COLORADO
Department of Health Care Policy & Financing

303 East 17th Avenue, Suite 1100
Denver, CO 80203

April 3, 2026

Mr. James Korn
Regional Inspector General for
Audit Services
Office of Audit Services, Region VII
1201 Walnut Street
Suite 1309
Kansas City, MO 64106

Re: Report Number 07-24-03260

Dear Mr. Korn:

Enclosed is the Department of Health Care Policy and Financing response to the Department of Health and Human Services, Office of Inspector General (OIG), draft report *Colorado Could Improve Its Electronic Visit Verification System and Claimed Federal Medicaid Reimbursement for Millions of Dollars in Personal Care Services That Did Not Comply With Federal and State Requirements.*

If you have any questions or need additional information, please contact Melissa Green at melissa.green@state.co.us.

Sincerely,

/Melissa Green/

Melissa Green
External Audits Coordinator

Colorado Department of Health Care Policy and Financing Response to the Department of Health and Human Services Office of Inspector General (OIG) Audit Draft Report Titled ***Colorado Could Improve Its Electronic Visit Verification System and Claimed Federal Medicaid Reimbursement for Millions of Dollars in Personal Care Services That Did Not Comply with Federal and State Requirements (A-07-24-03260)***

OIG Recommendations and Department Responses

1. *We recommend that the State agency refund $8,072,870 (Federal share) in estimated overpayments to the Federal Government.*

HCPF Response: Disagree

As a preliminary matter, the Department requests clarification from OIG regarding its use of the word "disallow" in the draft report. The draft report contains several references to OIG disallowing certain claim lines. For example, on page 16, the draft report states "…we disallowed only the units of service…" in two separate paragraphs. On page 17, the draft report states "…we disallowed only the difference between…" And on page 18, the draft report states "…we disallowed all units of service…" What does "disallowed" mean in this context, what actions has OIG taken with respect to those claim lines, and how does this affect CMS's ultimate decision-making authority over what actions should be taken as a result of OIG's recommendations?

The Department maintains multiple controls designed to ensure Personal Care Services (PCS) claims are supported by authorized services and valid EVV documentation. These controls include EVV verification of service delivery, service authorization through approved care plans and task worksheets, MMIS claim validation edits, and ongoing analytics monitoring to identify anomalies in EVV usage or billing patterns.

The estimated $8,072,870 Federal share is based on extrapolation from a statistically selected sample of 160 net claim lines, of which OIG determined 39 were partially unallowable. However, as detailed below, the extrapolated overpayment amount is based on a sample that was not statistically representative of the claim population and disproportionately captured a small subset of provider agencies and members with atypical billing patterns. At no point did the Office of Inspector General (OIG) identify (1) services not delivered, (2) payments to ineligible caregivers, or (3) services outside approved waiver authority.

Several findings cited as payment errors reflect isolated instances of some providers failing to produce documentation of background checks and Attendant Support Management Plans (ASMPs), or previously identified system limitations rather than evidence of improper service delivery, ineligible caregivers, or unauthorized services. During the audit period, Colorado

processed more than 1.3 million PCS claim lines, the vast majority of which were paid consistent with program requirements and approved service authorizations. Statewide EVV analytics demonstrate that on average approximately 98% of PCS claim lines during the audit period had corresponding EVV records consistent with required federal data elements. In addition, approximately 77% of visits were captured without modification, demonstrating strong real-time utilization of EVV technology. When viewed within the context of the total PCS claim population, the isolated findings identified in the audit sample represent a very small fraction of overall program activity and do not reflect systemic payment or compliance failures.

Accordingly, the Department respectfully concludes the record does not establish a sufficient factual or regulatory basis to support refund of the identified amount. Because the Department disagrees with the underlying financial determination and maintains that the projected overpayment is not supported by reliable statistical methodology or evidence of improper payment, no repayment or additional corrective action is warranted beyond ongoing or planned enhancements noted in this response.

OIG's recent Kansas EVV audit (2024) reviewed a similar scope, objectives, and methodology, and identified comparable documentation and system-related findings. In Colorado, the issues identified are primarily technical or documentation-related. Many were corrected through system updates, operational improvements before, during or shortly after the audit period, or reflect documentation practices permissible under Federal and State regulations.

The Department maintains that these issues do not indicate systemic noncompliance or unsupported services. Existing oversight controls, including EVV analytics monitoring, provider documentation requirements, and case management oversight, are designed to ensure services are authorized and delivered appropriately. The Department has also implemented and continues to implement program enhancements and monitoring to further strengthen these controls.

Unreliable Statistical Methods

OIG's sampling results contain statistical irregularities that suggest some degree of selection bias and that the sample was not representative of the 1.3 million claim line population. Based on the distribution of sampled claim lines, the Department has concerns that the sample may not reflect a fully representative or proportionate selection of claim lines, which may limit the reliability of extrapolating the results to the broader population. The Department requests additional documentation regarding OIG's sampling methodology, including sampling design, stratification, and weighting approach, to further assess whether the methodology meets standards for statistically valid estimation.

First, six of OIG's 39 "partially unallowable" claim lines came from a single member out of a 1.3 million claim line population, and a total of 14 members had multiple claim lines included in the sample. This outcome indicates that a small subset of members disproportionately drove observed error rates, which may influence extrapolation.

In addition, of the 14 claims that were found to have excessive units, 13 came from only 3 provider agencies. While these provider agencies were more than 17% of the T1019 audit sample lines, they account for only 5.4% of overall T1019 PCS expenditures. These overrepresented provider agencies had error rates far exceeding those of their peers. For example, the largest

T1019 provider agency who had an error rate of 0% in the sample only had 6 lines included despite being nearly 5 times larger than a provider agency with 9 lines sampled that had a 100% error rate.

Additionally, if the sample involves clusters of correlated units at a non-representative rate (such as oversampled providers or members), there would be a negative impact on the effective sample size of the sample at some unknown rate, but one that is proportional to the correlation in error rate amongst those clustered units. This would have some impact on reducing the effective sample size, which doesn't seem to have been adjusted for in the variance estimates within this audit and is concerning due to the already low sample size relative to the entire claims universe in this audit. In terms of suspected magnitude of this impact, within any one provider, error rate is likely highly correlated between their individual claims, especially with the very high error rate of certain providers. This would equate to a high within-cluster relation, and therefore much lower effective sample size than the already low sample size from this audit.

This disproportionate clustering of claim lines among a limited number of provider agencies and members demonstrates that the sample does not reflect typical statewide program behavior. Extrapolating these concentrated anomalies across the entire claim population inflates the projected error rate for the broader population.

Improper Mixing of Administrative and Monetary Findings

The OIG's methodology improperly conflates missing documentation of background checks or ASMPs with monetary findings, resulting in a fundamentally flawed error rate calculation. These documentation gaps, in isolation, do not demonstrate that services were not rendered, were not medically necessary, or were otherwise noncompliant with waiver requirements.

Federal Medicaid oversight standards require that the determination of improper payments be supported by sufficient evidence demonstrating that payments did not meet applicable program requirements. Under 42 CFR §431.107(b), providers must maintain records sufficient to disclose the extent of services furnished, and federal improper payment guidance defines improper payments as those that should not have been made or were made in an incorrect amount (OMB Circular A-123, Appendix C; Improper Payments Information Act, as amended).

The reliance on missing documentation of background checks or ASMPs findings, in isolation, as a proxy for payment error is inconsistent with these standards and introduces significant methodological bias. Missing documentation of background checks and ASMPs represent administrative noncompliance and should be addressed through corrective action, not financial disallowance, particularly where there is no evidence that services were not delivered, were unauthorized, or were billed incorrectly. Furthermore, OIG's findings indicate a fundamental misunderstanding of the role of ASMPs, as described in more detail below.

Extrapolation is only appropriate when the underlying sample identifies confirmed improper payments that are representative of the broader population. Extending extrapolation to these isolated documentation findings, absent verification of actual payment error, artificially inflates the projected error rate and overstates program risk.

Given these concerns, the Department requests that administrative documentation findings be removed from the financial error rate calculation and that any extrapolated disallowance be recalculated based solely on validated improper payments. For further detail on how the OIG's findings related to ASMPs do not support OIG's recommendation of a disallowance, please refer to the Department's response to part (2) of OIG's fourth recommendation below.

Background Documentation and Administrative Findings
Certain sampled claim lines were deemed partially unallowable due to incomplete or unavailable background screening documentation. However, OIG did not identify any caregiver with a substantiated Adult Protective Services (APS) finding or federal program exclusion.

Under Colorado policy, providers and Financial Management Service (FMS) vendors are required to complete background screenings prior to service delivery and maintain documentation sufficient to substantiate compliance in accordance with applicable record retention requirements. These requirements are actively enforced through provider oversight, case management review, and FMS vendor hiring processes. Under federal Medicaid allowability standards as applied in this audit, the absence of documentation of background checks, in isolation and without affirmative evidence that services were provided by an ineligible caregiver or were otherwise unallowable, does not establish that the services were improper. While documentation must be maintained, federal allowability standards should not require the long-term retention of every individual screening document as a condition of payment absent evidence of ineligible service delivery. The Department maintains and exercises separate program integrity and provider oversight authorities to address deficiencies, including the ability to pursue corrective action or overpayment determinations where appropriate under state and federal policy.

While federal cost principles require that costs be supported by adequate documentation (2 CFR §200.403(g) and §200.302(b)(3)), disallowances must be based on evidence that costs are not allowable, allocable, or reasonable under federal requirements. In the Medicaid context, this should only include circumstances where services were not provided, were not medically necessary, or were delivered by ineligible providers. None of these conditions were identified in the sampled claims.

The absence of background check documentation retained several years, and in some instances over a decade, after service delivery does not establish that required screenings were not completed, nor does it demonstrate that services were rendered by unqualified providers. To the extent background check deficiencies exist, they represent administrative or recordkeeping compliance issues rather than evidence of unallowable services.

Further, federal record retention requirements (2 CFR §200.334) establish timeframes for maintaining documentation but do not establish that the absence of documentation of background checks, in isolation, is sufficient to demonstrate that services were not provided or that providers were ineligible. Absent evidence of noncompliance at the time services were delivered, documentation deficiencies alone should not result in claim disallowance.

Rather, compliance is based on whether required screenings were completed and whether the caregiver met eligibility requirements at the time of service delivery. Where documentation of background checks is unavailable, the Department relies on other available evidence, including retrospective screenings, FMS hiring verification (e.g., Good-to-Go determinations), and oversight processes, to confirm caregiver eligibility.

In the absence of evidence that a caregiver was ineligible to provide services at the time of service delivery, OIG has not established sufficient legal basis to deem the associated claims in this sample unallowable, nor has the OIG established that those sampled claims should form the basis for extrapolations.

Where OIG identified discrete provider agency-level billing variances, such as excessive units or isolated rate-selection errors, those instances were limited to a small number of provider agencies and do not reflect systemic payment control deficiencies. The Department has already implemented, or initiated, corrective actions to strengthen claim-edit logic and targeted provider oversight.

Further, the identified errors were concentrated among specific provider agencies rather than distributed across the sampled population. As such, the findings do not satisfy the statistical requirements necessary for valid extrapolation. Federal audit standards require that projections be based on representative samples that meet assumptions of randomness and independence (Generally Accepted Government Auditing Standards and OIG statistical sampling guidance). The concentration of errors within a limited subset of providers undermines the reliability of extrapolating these findings to the broader population.

Finally, the absence of any substantiated APS findings or federal exclusions indicates there was no demonstrated program integrity risk or beneficiary harm associated with the sampled claims. Accordingly, the findings reflect documentation and administrative compliance issues rather than evidence of unallowable services and do not provide a sufficient legal or statistical basis for claim disallowance or extrapolated repayment.

Comparison to Prior OIG Audit Findings

OIG's 2024 Kansas audit identified similar findings, including missing EVV data, manual entries, incomplete background documentation, inaccurate time reporting, and lack of task-level detail. In that audit, OIG issued technical recommendations focused on strengthening oversight rather than pursuing financial recovery.

During discussions between the Department and OIG, OIG indicated that fiscal recovery was not pursued in the Kansas audit due to the managed care delivery system, which purportedly limits the ability to directly attribute and quantify payment amounts associated with specific documentation findings. In contrast, the OIG stated that Colorado's fee-for-service structure allows for direct linkage between claims and payment amounts, enabling estimation of potential financial impacts associated with documentation deficiencies.

While the OIG's position is that this difference in payment methodology affects the ability to quantify potential overpayments, it is arbitrary and capricious to recommend financial penalties for fee-for-service states but not managed care states where the underlying findings across both

audits are similar in nature and primarily reflect specific documentation variances and system configuration issues. The Department's review indicates these findings do not reflect systemic billing for services not rendered, but rather inconsistencies in documentation, EVV utilization, and system configuration.

Additionally, the identified findings were not evenly distributed across the sample population but instead were concentrated among specific providers and documentation practices. This clustering limits the statistical reliability of extrapolating a statewide error rate, as the sample does not reflect a uniform or randomly distributed pattern of noncompliance. As a result, even assuming without conceding that individual findings may be valid at the claim level, extrapolation to a broader population should be interpreted with caution.

The Department also notes that many of the identified issues reflect administrative and documentation deficiencies rather than confirmed instances of unsupported services. As such, the inclusion of these findings in calculations of financial impact may overstate the extent of actual improper payments, because missing documentation of background checks or ASMPs does not, in isolation, equate to services not rendered or rendered improperly.

The Department has already implemented and continues to strengthen corrective actions to address these issues, including enhanced EVV data validation controls, expanded analytics monitoring, targeted provider training and technical assistance, and improved oversight of documentation requirements. These actions are designed to ensure alignment between documentation, service delivery, and billing practices, and to prevent recurrence.

While the Department recognizes OIG's authority to identify and quantify potential payment impacts within a fee-for-service environment, it maintains that the root causes of these findings are most appropriately addressed through targeted program improvements and strengthened controls to ensure ongoing compliance and program integrity.

Conclusion

In summary, OIG's sampling methodology raises significant concerns regarding statistical validity for financial extrapolation and is inconsistent with federal standards for projecting disallowances. The sample used to estimate statewide noncompliance was not demonstrated to be random or representative of the universe of claims. As a result, the extrapolated disallowance amount is not reliable for purposes of determining federal financial liability.

The findings identified in the sample primarily relate to documentation practices and system configuration elements within Colorado's CMS-approved 1915(c) waiver and established self-directed service model. These program design elements, including documentation flexibility and the separation of service planning, authorization, and verification functions, were reviewed and approved by CMS as part of the waiver approval process. Claims were supported by valid service authorizations, EVV-confirmed service delivery, and claims system controls, and therefore meet federal requirements for allowable expenditures and federal financial participation.

While certain documentation elements were identified as incomplete or inconsistent, these do not, in themselves and absent affirmative evidence of noncompliance, demonstrate that services

were not rendered or that payments were unallowable under federal audit standards. Independent verification through EVV data, aligned service plans, and authorization records substantiate that services were delivered as billed. Accordingly, the identified issues are more appropriately characterized as documentation or administrative findings rather than unsupported or unallowable payments.

The extrapolation is further weakened by the limited sample size relative to a universe exceeding 1.3 million claim lines during the audit period. The observed findings within this small sample cannot be reliably projected statewide without meeting established statistical standards, including appropriate sampling design. Absent these elements, the projection overstates potential error and does not provide a defensible basis for disallowance.

OIG's prior audit work in other states has treated similar EVV-related findings, particularly those involving documentation and system configuration, as technical compliance issues addressed through corrective action rather than financial recovery. This reflects a distinction between documentation deficiencies and actual payment errors resulting in unallowable federal expenditures. The issues identified in Colorado are consistent with the former.

Colorado has implemented and continues to enhance corrective actions and oversight mechanisms, including EVV analytics monitoring, provider education and outreach, and system improvements. These actions are designed to strengthen documentation consistency and program integrity and do not constitute an acknowledgment of unallowable payments but rather reflect continuous program improvement.

Taken together, the methodological limitations of the sample, the presence of independent verification of service delivery, and the CMS-approved design and operation of the program demonstrate that the identified findings do not support a determination of unallowable expenditures. Accordingly, the extrapolated disallowance is not warranted.

2. *We recommend that the State agency work with CMS to determine the allowability of the estimated $45,688,080 (Federal share) that we have set aside, and refund to the Federal Government any amount that is determined to be unallowable.*

HCPF Response: Disagree

The Department respectfully disagrees with the finding and the associated estimated federal share set-aside of $45,688,080.

As a preliminary matter, the Department requests that the OIG clarify what is meant by the phrase "…that we have set aside." What has the OIG done to "set aside" these funds, and how does that affect CMS's ultimate decision-making authority based on OIG's recommendations?

The finding is based on OIG's interpretation that consumer-directed timesheets must include task-level documentation to support payment allowability.

OIG cites the following authorities:

- Social Security Act §1902(a)(27)(A), "requiring providers to keep records "necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan"
- CMS State Medicaid Manual §2497.1, stating that expenditures require "adequate supporting documentation to be allowable for Federal reimbursement."
- 10 CCR 2505-10 8.510.8.D and E., which states "Consumer-directed PCS attendants must be able to perform the tasks listed on the enrollee's ASMP for which they are being reimbursed, and that the attendant timesheets submitted for approval must be accurate and reflect time worked"
- 10 CCR 2505-10 8.510.6.A.16 and 17, which "require consumer-directed PCS enrollees (or their authorized representatives) to review all attendant timesheets for time worked and completeness. These regulations also state that timesheets should reflect the actual time spent providing services"

While these authorities establish general recordkeeping standards and require documentation sufficient to demonstrate that services were authorized and delivered. OIG's response confirms that no authority explicitly requires task-by-task documentation on consumer-directed timesheets, and that Colorado's Consumer-Directed Attendant Support Services (CDASS) model does not require such documentation. Further, in discussions with OIG in January 2026, OIG acknowledged that Colorado's CDASS model does not require task-level documentation on timesheets. Therefore, OIG did not identify any federal statute, regulation, CMS guidance, or approved waiver provision that explicitly requires task-level documentation on consumer-directed timesheets as a condition of payment.

Federal financial participation (FFP) is available for expenditures that are authorized, properly documented, and supported in accordance with applicable federal requirements, including 42 CFR § 440.180 and § 441.300 et seq. governing Home and Community-Based Services waivers, as well as the cost principles at 2 CFR § 200.403. These authorities require that costs be necessary, reasonable, and adequately documented to demonstrate that services were authorized and delivered, but do not prescribe task-level documentation on timesheets within consumer-directed service models. The Department's documentation framework provides sufficient detail to demonstrate that services were authorized, delivered, and appropriately claimed, consistent with federal documentation and allowability standards.

Colorado's CDASS program operates under CMS-approved 1915(c) Home and Community-Based Services waivers, which expressly allow flexibility in documentation and verification methodologies for consumer-directed service models. Within this model, the member (or Authorized Representative) directs services, supervises the attendant, and verifies service delivery through timesheet approval.

Consistent with CMS-approved waiver authority, Colorado utilizes an integrated documentation and oversight framework to ensure services are authorized, delivered, and allowable. This framework includes:

- Prior Authorization Requests (PARs) establishing approved services and units
- Person-Centered Support Plans developed with the member to ensure a member's unique needs are met through the authorization of HCBS services.
- Task Worksheets defining authorized tasks and associated time
- Attendant Support Management Plans (ASMPs) for service planning
- Electronic Visit Verification (EVV) for service time validation
- Payroll documentation (timesheets) confirming hours worked

Within this structure, the Task Worksheet—not the timesheet—is the governing document specifying allowable tasks. Timesheets are used to document service occurrence, duration, and verification by the member. The ASMP acts as the Member's planning tool for how attendant care will be organized and managed within the scope of the authorized services. This approach is consistent with consumer-directed service design and CMS-approved waiver flexibility.

Additionally, CMS-approved 1915(c) waivers require states to meet specific assurances, including that services are provided in accordance with the service plan and that claims are supported by adequate documentation. Colorado's documentation and oversight structure, including service plans, authorization controls, EVV, and member verification, satisfies these assurances. Importantly, OIG did not identify:

- Unauthorized services
- Ineligible members or attendants
- Units exceeding authorized limits
- Payments outside approved waiver authority

Absent evidence of unauthorized services or improper payments, the finding reflects a difference in interpretation regarding documentation format rather than a failure to meet federal allowability requirements.

Colorado's participant-directed model also includes several oversight controls to ensure services are delivered appropriately. These include case manager oversight of service plans and task worksheets, FMS vendor verification of attendant eligibility and payroll processing, EVV verification of service time, and allocation monitoring to ensure spending remains within authorized service budgets.

Additionally, the Department notes that OIG has not identified a statutory or regulatory basis to support applying statewide extrapolated financial set-aside in this context. In comparable circumstances in Kansas, OIG did not pursue financial recovery, which OIG stated was due to Kansas's managed care delivery system. Absent a clear statutory or regulatory distinction, applying a financial set-aside in Colorado for substantively similar findings would be arbitrary and capricious, and would result in inconsistent application of federal oversight standards across states with materially similar service models.

Federal allowability standards focus on whether services were authorized and delivered, rather than prescribing specific documentation formats within approved program models. OIG has not

identified any federal requirement establishing task-level timesheet documentation as a condition of payment.

Because Colorado's documentation approach is consistent with CMS-approved waiver authority and satisfies federal requirements for allowability, including that costs are necessary, reasonable, and supported by sufficient documentation, the estimated set-aside is not supported. The claims at issue reflect permissible documentation differences within a consumer-directed model, not unallowable expenditures.

Accordingly, the Department respectfully requests that OIG reconsider and eliminate the set-aside.

We recommend that the State agency improve its EVV system by:

a. (1) establishing system edits and/or formal policy requirements governing attendants' use of manual entries and by implementing limit thresholds for how often manual entries can be used;

HCPF Response: Disagree

The Department acknowledges that continued monitoring and refinement of guidance strengthens oversight. However, the Department respectfully disagrees with any implication that manually entered EVV records inherently indicate noncompliance or that services were not provided.

Manual entries are federally permissible under the 21st Century Cures Act, CMS guidance, and Colorado regulations. While manual entries may not be captured in real time, they represent verified service delivery when supported by required documentation and EVV data elements. Federal EVV requirements focus on the capture of six required data elements, not the method by which they are recorded.

The Department also maintains monitoring processes to ensure manual entries are used appropriately. EVV analytics reports are used to monitor manual-entry rates across providers and service delivery models. Provider outreach or technical assistance is conducted when elevated usage patterns are identified, and patterns of concern may be escalated for additional review through program integrity monitoring processes.

Federal Authority:

Section 12006(a) of the 21st Century Cures Act (Pub. L. 114-255) mandates that States implement a Medicaid EVV system for in-home PCS and home health care services requiring an in-home visit. To meet this requirement, EVV systems must verify six data elements: (1) service type; (2) the individual receiving the service; (3) date of service; (4) location of service delivery; (5) the individual providing the service; and (6) the time the service begins and ends. While the law requires EVV, it does not prescribe a single uniform system; States have discretion in how they implement EVV, provided they meet the statutory data-element and start-date requirements.

CMS's "Documenting EVV in Applications for 1915(c) Waivers and Other Programs" (May 2022, Page 3) clarifies that, "EVV solutions may verify service delivery through a number of methods… Circumstances may arise such that services cannot be verified electronically… In such situations, the attendant or provider agency may need to manually submit service information in order to populate a claim." This confirms that manual entries are a CMS-recognized and compliant EVV method.

State Requirements:

10 CCR 2505-10 § 8.001.1.G reads, "Electronic Visit Verification (EVV) means the use of technology, including mobile device technology, telephony, or Manual Visit Entry, to verify the required data elements related to the delivery of a service mandated to be provided using EVV by the "21st Century Cures Act," P.L. No. 114-255, or this rule."

Taken together, federal statute, CMS guidance, and Colorado Medicaid regulations all affirm that manual EVV entries are an authorized, expected, and compliant component of EVV data collection. Their presence does not indicate missing EVV, unverifiable services, or improper payment and therefore cannot be treated as evidence of noncompliance. The Department maintains that manual entries, used appropriately and monitored through established CMS-aligned oversight processes and controls, represent a legitimate and fully allowable EVV verification method. Any assertion to the contrary is inconsistent with federal EVV requirements and CMS's documented policy framework.

Oversight and Monitoring

In line with CMS direction, HCPF actively monitors how many modified and manually entered visits are submitted per provider agency through internal analytics and determines what an appropriate proportion of modifications is in Colorado. The state's rates are consistent with expected utilization patterns. Provider agencies are subject to ongoing education, compliance oversight, and targeted outreach when elevated manual-entry patterns are identified to ensure that manual entries are used appropriately and do not increase compliance risks.

The Department maintains ongoing oversight of manual entry utilization and has established measurable performance benchmarks. Department data from multiple years has shown that approximately 19-25% of visits for all EVV-required services are manually entered, corresponding to 75-81% of visits being captured in real-time. This range differs from the 38% (62 of 160 claim lines) manual entry rate identified in the OIG sample, suggesting that the sample may not reflect typical statewide utilization patterns. The audit findings do not reflect systemic lack of monitoring but rather discrete provider agency-level instances within a broader framework. These differences further support the need for additional evaluation of the sampling methodology prior to extrapolation.

Threshold Considerations

While the Department continues to evaluate programmatic strategies to improve unmodified visit capture rates, rigid statewide caps or automatic denial thresholds could unintentionally restrict flexibility inherent in CMS-approved agency and consumer-directed service models and may create service-access disruptions.

Manual entries, when used appropriately and supported by required documentation, do not constitute missing EVV, unverifiable services, or improper payment. Accordingly, the Department would prefer to continue to employ and enhance alternative oversight techniques that do not include system edits or hard thresholds.

Fraud Prevention and Manual Entries

While manual entries may present increased fraud risk if left unmonitored, OIG did not identify any instance in the audit sample in which a manual entry was associated with unsupported services, ineligible caregivers, or improper payment. Therefore, these findings do not demonstrate that manual entries were the direct result of fraud, waste, or abuse.

Federal EVV policy is outcomes-based and requires verification of six data elements, not a prohibition on specific entry methods. Risk-based oversight requires monitoring and control mechanisms, not elimination of CMS-recognized verification methods. As with any documentation method, fraud risk is mitigated through layered oversight, not categorical prohibition. Colorado's layered oversight structure, including analytics monitoring, variance reporting, and Fraud Waste, and Abuse (FWA) Division escalation, addresses potential risk without restricting federally permissible EVV methodologies.

Corrective Actions Already in Place Prior to OIG Audit:

- The Department maintains ongoing analytics monitoring of manual entry rates by provider agency and by service delivery model, which is also used to identify provider agencies with elevated or atypical manual entry utilization.
- Provider agencies exceeding established variance thresholds are subject to targeted outreach, technical assistance, and education regarding appropriate use of manual entries.
- Statewide monitoring indicates that more than 97% of submitted PCS claims meet EVV requirements for payment, while the remaining ~3% are denied due to missing EVV data.
- Persistent patterns of concern may be escalated to the Department's FWA Division for further review.

b. (2) implementing system edits to verify that all PCS visits have corresponding EVV records;

HCPF Response: Partially Agree

The Department partially agrees with this finding. The audit identified 17 PCS claim lines in which one or more dates lacked corresponding EVV entries. These instances reflect provider agency-level documentation and billing discrepancies, and the Department is taking steps to strengthen oversight and validation processes.

This recommendation aligns with ongoing system enhancements that were initiated prior to the OIG audit and is designed to improve prepayment claim validation by ensuring that billed units do not exceed EVV-verified visit duration. Enhancements include refinement of automated claim-edit logic to identify discrepancies between EVV visit data and billed units for applicable services and strengthening automated EVV-to-claim alignment controls.

In addition, the Department has implemented coordinated oversight between the EVV team and the FWA Division to conduct targeted provider agency outreach when discrepancies are identified. This includes:

- Monitoring reports identifying misalignment between EVV records and billed units.
- Direct provider agency education and technical assistance.
- Escalation to the Department's FWA Division review when patterns of concern are detected.

These efforts demonstrate that the Department has an established framework for identifying and addressing EVV-to-claim discrepancies beyond the isolated instances cited in the sample.

It is important, however, to distinguish these discrete discrepancies from the broader question of span-billing that allows provider agencies to submit a single claim line covering a range of dates, while EVV continues to verify service delivery at the visit level, as the two issues are separate. A single span-billed claim line may cover multiple dates of service and multiple EVV-verified visits. The absence of a one-to-one visit-to-claim-line match does not indicate missing EVV. Because EVV records services at the visit level and Medicaid Management Information System (MMIS) processes payment at the claim-line level, the number of EVV visits may not, and is not required to, match the number of claim lines. A span-billed claim line represents a date range for billing purposes, not an assertion that services occurred on every date within that range. Accordingly, EVV and MMIS function as complementary but distinct systems in contrast to the misrepresentation of this in OIG's report.

This billing structure is federally permissible and supported by CMS Medicare Claims Processing Manual (Pub. 100-04), Chapter 25, which recognizes occurrence-span codes for multi-date service ranges, allowing consolidated billing. Additionally, Colorado HCBS Billing Manuals explicitly permit span billing for consecutive-date services.

Clarification Regarding Span-Billed Claim Example

The report cites an example in which a PCS claim line included 29 dates of service, while only 6 corresponding EVV entries were identified. This example reflects the structural characteristics of span billing rather than OIG's statement of an absence of EVV verification.

Under span billing, a single claim line may aggregate multiple service dates within an authorized period. The number of dates reflected on the claim line does not represent individual payment events or daily authorization requirements. Payment is based on billed units within the authorized service period—not on the number of dates listed within the span.

EVV captures service delivery at the visit level, verifying required data elements for each delivered visit. The relevant compliance control is alignment between total billed units and EVV-verified service time, not a one-to-one correspondence between each date within a span and an individual EVV record.

To the extent the audit example reflects a discrepancy between billed units and EVV-verified service time, that issue is addressed by the system enhancement noted above. However, the

absence of a one-to-one date match within a span-billed claim line itself does not indicate missing EVV or unsupported service delivery.

In summary, the Department concurs that the 17 sampled claim lines reflected documentation discrepancies and is addressing them accordingly. At the same time, the Department emphasizes that span billing is a permissible and compliant billing methodology.

Corrective Action:

- Implementation of enhanced claim-edit logic to identify and prevent discrepancies between billed units and verified EVV visits.
- Continued coordination between EVV and the Department's FWA Division for provider agency outreach and monitoring.
- Ongoing analytics reporting to identify provider agencies with elevated variance patterns.

Estimated Completion Date:

- Targeted outreach to provider agencies currently underway
- Initial implementation of revised claim-edit logic, target date Q4 2026

c. (3) requiring providers to verify that all PCS visits are entered in the EVV system;

HCPF Response: Agree

The Department agrees that provider agencies are responsible for ensuring that all PCS visits are properly documented within the EVV system in accordance with federal and state requirements.

Colorado's EVV policy already requires that provider agencies document service delivery through EVV prior to claim submission. Provider agencies are contractually and regulatorily obligated to maintain documentation sufficient to substantiate services billed to Medicaid. The expectation that all delivered PCS visits be recorded in EVV is not new and is embedded within existing policy and oversight processes.

The Department conducts post-payment reviews, analytics monitoring, and provider agency-specific remediation when discrepancies between billed services and EVV documentation are identified. Patterns of concern are escalated as appropriate.

To further reinforce this expectation, the Department will:

- Clarify provider agency guidance that EVV documentation must reflect all delivered PCS visits prior to billing;
- Incorporate EVV completeness expectations into future provider agency communications and training materials;
- Continue analytics monitoring to identify provider agencies with patterns of missing EVV documentation; and

- Coordinate with the Department's FWA Division for targeted outreach when patterns of concern arise.

These measures build upon existing oversight structures and strengthen provider agency accountability while maintaining alignment with CMS-approved billing methodologies.

Corrective Action:

- Update provider agency communication reinforcing EVV completeness expectations;
- Continue monitoring and targeted outreach for identified discrepancies.

Estimated Completion Date:

- Updated provider agency communication by April 30, 2026;
- Ongoing monitoring thereafter.

d. (4) implementing system edits that capture the location of services provided, and establishing requirements for providers and attendants to document and verify the actual location where PCS is provided;

HCPF Response: Partially Agree

The Department partially agrees with this finding. We concur that 16 PCS claim lines contained missing location fields, and we acknowledge these as discrete data-capture errors attributable to system logic defects rather than provider agency noncompliance or unverified service delivery.

Colorado's review determined that these isolated instances were caused by system logic defects. Under Colorado's EVV design, the location requirement may be met either through GPS coordinates or through an Alternate Location field paired with Reason Codes 15 or 16. In these cases, provider agencies delivered services as required, but a vendor system issue prevented the correct prompting and capture of location data. Specifically, the Department discovered that latitude/longitude values were not being consistently captured for Mobile Visit Verification (MVV) call types and that Exception 41, which is designed to alert provider agencies when location data is missing, was not firing as intended.

This issue was isolated to specific call types and was not indicative of provider agency behavior or systemic noncompliance. In accordance with federal outcomes-based system improvement requirements at 42 CFR §433.112(b)(15), Colorado documented the problem, escalated it to the vendor on April 9, 2025, and received corrections that fixed the Exception 41 logic. The vendor deployed the full corrective update on July 31, 2025, including restoration of proper Exception 41 logic and strengthened GPS capture requirements within the EVV system.

The Department's identification of the defect—combined with timely reporting, and vendor remediation—demonstrates that internal monitoring controls functioned as intended. These circumstances reflect a technical system issue already captured within Colorado's EVV continuous-improvement framework, not an ongoing compliance concern and not a failure in oversight.

Because the underlying cause has been identified, tracked, and incorporated into formal system-enhancement work already in progress, the Department does not agree that these 16 instances warrant additional corrective action or imply broader EVV noncompliance.

e. (5) implementing system edits that require providers to review and then correct GPS exceptions;

HCPF Response: Partially Agree

The Department partially agrees with this recommendation. We acknowledge that 16 PCS claim lines displayed GPS exceptions without corresponding alternate location entries, however, they were attributable to a vendor logic defect rather than provider agency noncompliance.

Colorado's EVV workflow relies on Exception 41 to signal that the location field must be completed using Reason Code 15 or 16. During the audit period, Exception 41 did not consistently fire, meaning provider agencies may not have been prompted to enter alternate locations. This was a system prompting failure, not a provider agency documentation issue. All other required EVV data elements, including member, caregiver, date, and time in/out, were captured and OIG did not identify evidence that services were not delivered.

Colorado's internal EVV monitoring controls identified the underlying cause of these issues: a vendor logic defect that prevented consistent requirement of alternate location for certain reason codes and enabled "null" as a permissible alternate location. Because the alternate location requirement was not being applied for certain reason codes, provider agencies weren't notified that an alternate location entry was needed. All other required EVV data elements—including member, caregiver, date, and time in/out—were correctly captured.

The Department escalated the issue to the EVV vendor on May 15, 2025. The vendor completed and deployed the full corrective logic update on July 31, 2025. The update restored proper Exception 41 functionality and strengthened system edits to ensure provider agencies are prompted to review and address GPS exceptions when alternate location documentation is required. Since July 31, 2025, auditing and monitoring confirm that the issue has been fully resolved for State Solution users and is being finalized for Provider Choice System users. Because the issue had been almost completely remediated before OIG finalized its fieldwork, it does not indicate an ongoing system gap or a need for state-level corrective action beyond what has already been completed.

OIG did not present any evidence that services were not delivered. All other required EVV data elements (member, caregiver, date, time) were captured. The absence of alternate-location fields was a technical system issue, not a service-delivery or documentation failure, and reflects a resolved system configuration issue rather than systemic noncompliance.

f. (6) requiring providers to monitor the use of EVV reason codes and confirm their appropriate application; and

HCPF Response: Partially Agree

The Department partially agrees with this recommendation. Colorado's EVV policies require the use of standardized reason codes when corrections or manual entries are made within the EVV system. These reason codes provide structured documentation explaining the nature of an exception, including manual entries and alternate location scenarios.

The Department clarifies that reason code selection was embedded within the EVV workflow during the audit period, and provider agencies were required to select applicable codes when modifying visit data. The identified concerns were not the result of provider agencies failing to apply reason codes but rather stemmed from system logic defects that affected prompting requirements in limited circumstances, including the Exception 41 issue previously described.

Colorado's internal EVV monitoring controls include analytics reporting designed to identify irregular patterns in EVV data, including elevated rates of manual entries or specific reason code usage. These monitoring processes functioned as intended by identifying anomalies, documenting the underlying cause, and initiating vendor remediation where appropriate. The instances cited in the audit do not reflect systemic misuse of reason codes or a breakdown in provider agency oversight.

Manual entries and associated reason codes remain federally permissible under the 21st Century Cures Act and CMS guidance when supported by appropriate documentation. All other required EVV data elements (i.e., member, caregiver, date, and time in/out) were captured in the cited cases, and OIG did not identify evidence that services were not delivered.

Since reason code use was already required within Colorado's EVV framework, and because the identified issues were attributable to discrete system-level defects rather than provider agency noncompliance, the Department does not agree that these instances indicate broader EVV compliance concerns.

Corrective Action:

- Reinforce appropriate EVV reason code application through updated provider agency communications and training materials.
- Continue analytics monitoring to identify provider agencies with elevated or irregular reason code usage patterns and conduct targeted outreach when appropriate.

Estimated Completion Date:

- Updated provider agency communication by July 31, 2026.
- Ongoing analytics monitoring thereafter

g. (7) requiring providers to verify that the names of the attendants identified on EVV records match the names of the attendants who signed the corresponding timesheets.

HCPF Response: Agree

The Department acknowledges two isolated instances in which the caregiver listed on a provider agency's timesheet did not match the caregiver record in the corresponding EVV entry. These were limited documentation inconsistencies, not indications of unqualified caregivers. All services were delivered to eligible members and caregivers involved have been notified and are undergoing remediation.

Both instances were attributable to two caregivers within a single agency and were not observed across the broader provider agency population. The limited and concentrated nature of these discrepancies indicates that they do not reflect a systemic pattern.

Under 10 CCR 2505-10 § 8.001.3.C.3, provider agencies must maintain all documentation necessary to substantiate EVV data elements, including those involving manual entries, visit modifications, and exceptions. When supporting documentation cannot be stored within the EVV system, it must be maintained externally and made available upon request in accordance with § 8.130.2. These regulatory provisions establish clear documentation retention requirements and support provider agency accountability within the EVV framework.

Since the EVV and MMIS systems verified that services were delivered to eligible members by properly enrolled provider agencies, a mismatch between a timesheet and an EVV record is a documentation alignment issue—not a service-delivery issue. An administrative mismatch of this type should not convert an otherwise valid claim into a disallowable payment.

These findings are appropriately addressed through provider agency-level remediation and reinforcement of documentation alignment expectations.

Corrective Action:

- Provider agency-specific remediation;
- Reinforced expectations for alignment between EVV records and service documentation;
- Additional provider agency guidance and targeted monitoring to ensure data accuracy and audit readiness.
- Continued analytics monitoring to identify and address any future discrepancies.

Estimated Completion Date:

- Updated provider agency and FMS vendor communication by July 31, 2026.
- Ongoing monitoring thereafter.

3. *We recommend that the State agency improve its procedures to verify that:*
    a. *(1) providers maintain documentation that attendant background screenings are completed for all attendants, and*

HCPF Response: Partially Agree

The Department partially agrees with this recommendation. Colorado agrees that required background checks should be documented, however, the central issue is whether later

unavailability of background check records converts otherwise allowable services into unallowable payments. Colorado requires provider agencies and FMS vendors to complete caregiver background screenings prior to service delivery and to maintain documentation in accordance with applicable record-retention requirements. The Department respectfully disagrees with OIG's conclusion that missing or incomplete background-check documentation renders the associated claims unallowable.

OIG did not identify any caregiver with a disqualifying criminal offense, substantiated APS finding, program exclusion, or other condition that would prohibit service delivery. All located screening records—both historical and retrospective—confirmed no disqualifying conditions. The findings reflect background check record retention variances rather than evidence of unqualified caregivers or improper payment.

OIG identified a similar issue in the 2024 Kansas EVV audit. In that case, OIG treated the issue as a documentation variance and did not recommend fiscal recovery. Colorado's oversight framework similarly includes multiple controls designed to ensure caregiver eligibility and service authorization, including background screening requirements, case management oversight, and FMS vendor hiring verification processes.

Relevant Policies:

The Colorado Department of Public Health and Environment (CDPHE) reviews provider agency personnel files during site surveys to confirm that background screenings were completed prior to service delivery and in accordance with HCPF policy. This oversight function serves as the State's primary compliance control to ensure background screening requirements are met.

As of March 16, 2024, rule updates clarified requirements under, 10 CCR 2505-10 §8.7409.A.2.f and §8.7409.E. Provider agencies must now complete and document:

- Colorado Adult Protective Services (CAPS) checks
- Colorado Bureau of Investigation (CBI) criminal background checks (CBC)
- Reference checks
- OIG exclusion list verification prior to hire
- Department of Regulatory Agency (DORA) checks for licensed professionals, as applicable

In CDASS, the FMS vendors are responsible for background screening on all attendants for which receives a hiring packet from the CDASS employer (Medicaid member or their Authorized Representative). CDASS employers and prospective attendants are notified before and during the hiring process that the attendant is not permitted to work until the background screening has been completed and other hiring paperwork processed. This attendant hiring process is clear, communicated throughout the CDASS enrollment process, and is best practice in self-direction. FMS vendors are required to conduct checks of the following:

- Colorado Bureau of Investigation (CBI) criminal background check (CBC)
- OIG exclusion list

- Board of Nursing (BON) license database checks known as Department of Regulatory Agency (DORA) checks,
- E-Verify

Missing Background Check Records

Under federal Medicaid allowability standards as applied in this audit, disallowances should not be recommended based on isolated instances of some providers failing to retain individual background-check documents in the absence of evidence of ineligible service delivery. Disallowances should only be recommended when a caregiver or attendant is disqualified or prohibited from providing services. No such circumstances were present here.

A missing background check identified years after the date of service, in the absence of evidence of caregiver ineligibility, does not by itself establish that a required screening was not completed or that a claim should be unallowable under federal audit standards. While a small number of caregivers had incomplete or unavailable screening documentation, OIG did not identify any caregiver with a disqualifying criminal record, APS substantiation, or program exclusion.

Caregiver Eligibility Supporting Documentation

While not all original background-check documents were retrievable due to vendor transitions and the age of some records, the Department obtained and reviewed all documents that could be located. These results are highly probative:

- All located CBI results reviewed showed no disqualifying offenses; where arrest records were present, none met Colorado's disqualification criteria.
- All located OIG exclusion checks showed no program exclusions.
- All located CAPS checks showed no substantiated APS findings.

This supports the reasonableness of concluding that the remaining screenings were likewise completed and compliant. In addition, because disqualifying events such as arrests, APS substantiations, or exclusions persist on record when checks are re-run, Colorado's retrospective screenings provide reliable confirmation that no disqualifying events existed before or during the period of service.

The G2G process provides independent, pre-service confirmation of eligibility

As part of follow-up communication with CDASS vendors, the Department obtained G2G (Good-to-Go) confirmations demonstrating that attendants in the sample were cleared to begin providing services. Under the CDASS model, FMS vendors issue a G2G notice only after verifying that all required hiring requirements, which include that background screenings have been completed and meet program standards.

Together, the G2G confirmations, and where available, the associated screening documents provide independent, pre-service evidence that required background checks were completed, even where individual documents could not later be located.

Colorado does not require background-check documentation retention as a condition of payment

Colorado policy conditions payment on caregiver eligibility, not on long-term physical retention of every background screening document. Payment would be improper if services were rendered by an ineligible or disqualified individual, but OIG did not identify such circumstances, and the Department's review confirms all identified caregivers were qualified to provide services at the time of care delivery.

Further, there is no single federal requirement that outlines specific background check requirements for personal care providers or attendants. 42 CFR § 455.434 does include information on background checks that may apply to personal care attendants and providers, but it only requires State Medicaid Agencies to have a provider screening and enrollment process that may include criminal background checks and fingerprinting for providers or individuals with ownership interests when classified as "high risk" based on potential for fraud, waste, or abuse. In lieu of federal requirements for attendant background screening, the state is authorized to set state-specific standards.

While Colorado requires background checks as part of provider agency and FMS vendor's onboarding processes, payment is not contingent on having a background check record on file. Therefore, a missing background-check document in Colorado is a documentation variance, not an unallowable claim, and cannot be extrapolated as a payment error.

There is no basis for recoupment or extrapolation

Recoupment or extrapolation requires evidence of improper payment. An improper payment would require evidence that services were delivered by an ineligible caregiver or that services were provided outside authorized program parameters. The OIG did not identify any caregivers who were disqualified, ineligible, or otherwise prohibited from providing services during the audit period.

Available screening records, G2G confirmations, and retrospective checks further confirm that caregivers met applicable eligibility requirements at the time services were delivered.

Accordingly, the findings reflect variances in the documentation of background checks rather than improper payments and therefore do not provide a valid basis for recoupment or extrapolated recovery.

The issues identified in the sample reflect background check record retention variances, not improper payments, unqualified caregivers, or failures to complete required screenings. Colorado's review confirms that sampled services were delivered by eligible caregivers who met all screening requirements in effect at the time of hire.

Multiple oversight mechanisms — including CDPHE surveys, provider agency screening obligations, and the FMS vendor's mandatory G2G process — provide reliable, pre-service assurance that caregivers are screened and eligible before services begin. Where individual documents were unavailable, the Department obtained strong substitute evidence (located

screenings, G2G confirmations, and retrospective checks) demonstrating that disqualifying conditions did not exist.

Because there is no evidence of disqualification, ineligible service delivery, or improper payment, the Department does not agree that recoupment or extrapolation is warranted. The instances identified reflect documentation variances rather than systemic control deficiencies.

Corrective Action:

- Reinforce provider agency and FMS vendor documentation-retention requirements related to background screenings;
- Conduct provider agency-level remediation when documentation deficiencies are identified.

Estimated Completion Date:

- Updated provider agency and FMS vendor communication by July 31, 2026;
- Ongoing monitoring thereafter.

b. (2) providers complete and maintain ASMPs for all enrollees receiving consumer-directed PCS.

HCPF Response: Disagree

The Department respectfully disagrees with OIG findings and the associated potential disallowance. Colorado requires that all enrollees receiving PCS through CDASS have an approved Attendant Support Management Plan (ASMP) that outlines authorized services and budget parameters. However, the OIG has a fundamental misunderstanding about the purpose of this form, what it should include, and how often it is updated. ASMPs are developed through the case management process and must be in place prior to service delivery. Under Colorado's CMS-approved CDASS model, the ASMP serves as a planning tool, rather than a document that authorizes services or validates specific tasks performed. It is designed to help members outline how they intend to manage their support at the onset of CDASS participation and does not require annual updates unless the member chooses to modify their approach.

For service authorization and verification, Colorado relies on the member's approved Task Worksheet, which was in place for all cited claims. The Task Worksheet and the CDASS Allocation documents govern the scope, type, and allowable tasks and are the authoritative sources for payment validation under the 1915(c) HCBS waiver. Therefore, the absence of an ASMP file, in isolation and without evidence of unauthorized or unverified services, does not establish that services were unauthorized or unverified.

The Department maintains and exercises separate program integrity and provider oversight authorities to enforce documentation requirements, including expectations related to ASMP completion and retention, and may pursue corrective action or overpayment determinations where appropriate under State and federal policy.

In addition to the Task Worksheet, several controls ensure services remain within authorized parameters. Case managers are responsible for reviewing and approving service needs and allocations, and FMS vendors verify payroll and spending against the member's approved allocation. EVV visit data and claims processing controls further support verification that services were delivered within authorized service limits.

The OIG did not identify any instance in which a service exceeded the member's authorized Task Worksheet. Therefore, even where an ASMP file was not retrievable, there is no evidence that services were misaligned with authorized tasks or improperly delivered.

Of the four instances with missing ASMPs, two predate 2010, and their enrollments predate the use of current authorization tools. Members who were enrolled in CDASS prior to that transition often had ASMPs maintained in historical paper files held by legacy Case Management Agencies (CMAs). These pre-2010 ASMPs were never required to be re-entered into the electronic system, which explains their absence in the central repository.

The remaining instances reflect documentation storage variance inherent to consumer-directed programs, where CMAs maintain records and upload timelines may vary. These are not indicators of improper services, lack of authorization, or overpayment.

Treating the absence of a non-authorizing planning document as grounds for a disallowance would be inconsistent with CMS's long-standing guidance for consumer-directed services, which allows greater documentation flexibility. Those assurances are satisfied through the Task Worksheet, which was present for all 4 members.

While ASMPs are required planning documents under state policy, they are not payment-authorizing instruments under the CMS-approved waiver. Further, because the ASMP is not the governing authorization document, Task Worksheets were in place for all members, and most ASMPs have since been located, with others tied to pre-2010 file transitions. These findings represent isolated documentation variances, not unallowable claims. Since OIG identified no evidence of unauthorized or inappropriate service delivery, it is improper to deem these claims unallowable or using them to support extrapolated recovery.

Even if a claim were improper due to the absence of an ASMP, OIG identified a similar issue in the 2024 Kansas EVV audit involving missing care-planning documentation in IHSS—their consumer-directed model. In Kansas, OIG correctly recognized this as a documentation flexibility inherent to consumer-directed services and did not require financial repayment. Colorado requests consistent treatment to ensure equitable and uniform application of federal oversight standards. Consistent with the Kansas precedent, this item should be at most classified as a non-fiscal technical finding with no disallowance.

4. *We recommend that the State agency implement system edits to verify that*

   a) units paid match the units approved on the enrollees' plans of care and

HCPF Response: Partially Agree

The Department partially agrees with this recommendation. The Department maintains multiple controls designed to ensure claims align with authorized services and approved reimbursement rates. These include MMIS fee schedule validation, service authorization controls within care planning systems, EVV verification of service delivery time, and analytics monitoring used to identify billing anomalies or provider outliers. We agree that enhanced safeguards are appropriate however, the Department does not agree that the findings demonstrate a systemic failure of authorization controls.

For HCBS waiver services, the controlling authorization mechanism is the approved prior authorization request (PAR), which establishes the total number of units authorized during the applicable authorization period. The plan of care operationalizes service delivery within that authorization, but members are not beholden to use all services on their plan of care, so claims paid for these services may not exactly align with the plan of care. Similarly, members may choose to not use all of the authorized units on their PAR.

The claims identified by OIG reflect limitations in how span billing practices interacted with existing claims-processing controls. In certain instances, span billed claims reflected services furnished across multiple months, while documentation reviewed during the audit corresponded to only a portion of the service period included in the claim. This structure reduced clarity regarding the allocation of units across months and contributed to excessive units appearing at the claim level. The issue therefore relates to billing presentation and pre-payment validation rather than to the underlying authorization framework.

The Department agrees that services billed must correspond to services rendered and documented, and that strengthened pre-payment safeguards are appropriate. However, the findings do not establish systemic payment outside authorized PAR limits or waiver parameters. The identified risk arose from billing flexibility and claims-level transparency, not from a breakdown in the authorization framework itself.

To address this risk, the Department is developing and implementing system enhancements designed to strengthen validation of billed units against verified service delivery data prior to payment. These actions appropriately mitigate the identified vulnerability without requiring additional plan-of-care reconciliation edits.

Corrective Action:

The Department is undertaking the following corrective actions:

- Development of EVV-Based Validation Edit: The Department is developing and implementing a system edit that will convert billed units to minutes and reconcile those minutes against EVV data prior to payment.
- Pre-Payment Claims Control Enhancement: Upon implementation, the edit will prevent payment of units that exceed EVV-supported service delivery time.
- Billing Practice Guidance: The Department will issue clarification reinforcing that services billed must align with services rendered and documented, including expectations regarding span billing practices.

- Post-Implementation Monitoring: The Department will conduct targeted monitoring following implementation to evaluate the effectiveness of the enhanced control and ensure alignment between billed units and verified service delivery.

Estimated Completion Date:

- The Department anticipates completing development and implementation of the system enhancement within Q4 2026, subject to system testing and release scheduling.
- Interim monitoring and provider outreach are already in place to address identified issues while the system enhancement is implemented.

b) [the state implements a system edit] to verify that rates paid are in accordance with the State's approved rates

HCPF Response: Disagree

The Department respectfully disagrees with this recommendation. Colorado's MMIS contains automated system controls that ensure claims are paid strictly in accordance with the State's approved fee schedule rates. Provider agencies cannot override established reimbursement rates. Payment amounts are system-calculated and aligned with CMS-approved methodologies and rates. Because rate validation controls are already embedded within MMIS, the Department does not agree that this component of the recommendation reflects a system deficiency.

The Department acknowledges that eight claim lines applied the Denver County rate when the member's residence was listed in a different county. These were isolated administrative rate-selection errors that occurred during a period when Denver geographic rate logic was in transition and system edits had not yet been fully implemented.

Under Operational Memo 23-041 (effective July 1, 2023), provider agencies were temporarily permitted to bill using the Denver County rate during the shift to county-based rate alignment as long as they entered the service location ZIP code on the claim. This transition policy remained in effect throughout the OIG audit period. During this time, the system was being updated to support county-specific rate enforcement, and rate validation was intentionally flexible to avoid service or payment disruption.

To address these inconsistencies, the Department implemented the required use of the HX modifier to clearly identify services provided in Denver County under Operational Memo 24-020 (effective May 1, 2024). This modification ensures accurate rate application, eliminates ambiguity, and prevents recurrence. System edits reinforcing this requirement have since been deployed.

Seven of the eight claim lines identified by OIG occurred prior to May 1, 2024, during the defined transition period. The remaining claim line occurred concurrently with the implementation window. Because the underlying rate-alignment issue was fully resolved as of May 1, 2024, and has not recurred, extrapolating pre-transition variances into post-implementation periods would be methodologically unsound. Any analysis would necessarily be limited to the defined pre-implementation timeframe.

These eight instances therefore reflect a resolved transitional administrative variance—not systemic rate misapplication and not evidence of overpayment.

5. *We recommend that the State agency develop and implement requirements that attendants who render consumer-directed PCS document on their timesheets the level of detail necessary to support that the rendered services complied with the enrollees' ASMPs.*

HCPF Response: Disagree

The Department respectfully disagrees with the finding that consumer-directed timesheets must document the specific PCS tasks performed. Colorado's participant-directed model includes several oversight mechanisms designed to ensure services are delivered appropriately. These include case manager oversight of service plans and task worksheets, FMS vendor verification of attendant eligibility and payroll processing, EVV verification of service start and end times, and allocation monitoring to ensure services remain within authorized budgets. Colorado's CDASS model operates under CMS-approved 1915(c) Home and Community-Based Services (HCBS) waivers, which explicitly allow flexibility in documentation and verification for consumer-directed services. The OIG finding appears to apply provider agency-based service documentation standards to a consumer-directed model where CMS expressly allows flexibility. Nothing in statute, regulation, CMS guidance, or Colorado's approved waiver authority establishes task-by-task documentation on individual timesheets as a condition of payment under federal Medicaid allowability standards. In fact, including task-level detail on the timesheet would significantly alter the CMS-approved design of the CDASS program, which intentionally separates verification of time worked (timesheet) from authorization of tasks (Task Worksheet).

The Department maintains and exercises separate program integrity and provider oversight authorities to enforce documentation requirements and address deficiencies at the provider level, including the ability to pursue corrective action or overpayment determinations where appropriate under State and federal policy.

The authorities cited by OIG—including Social Security Act §1902(a)(27)(A) and general recordkeeping provisions—establish documentation standards but do not require task-by-task entries on timesheets. Additionally, in prior clarification, OIG acknowledged that Colorado's CDASS model does not require documentation of specific tasks performed during each visit.

Under 1915(c) waiver authority and CMS guidance, consumer-directed programs are allowed flexibility in documentation format, provided that oversight mechanisms ensure participant health, welfare, and financial accountability. The Task Worksheet, not the timesheet, serves as the governing document specifying allowable tasks. Timesheets are used to record time and service duration. Timesheets are designed to document time worked and to support payroll processing, consistent with the CMS-approved consumer-directed service model. They are not intended to duplicate the Task Worksheet or function as a secondary plan-of-care document. Therefore, the lack of task descriptions on individual timesheets is consistent with federal allowances for consumer-directed service models and, in the absence of evidence of unauthorized or unallowable services, does not establish that claims were unallowable under federal Medicaid allowability standards.

The CDASS model intentionally separates:

- A prior authorization request (PAR), which establishes the services and total number of units authorized during the authorization period
- Person-Centered Support Plans are developed by a case manager, with the member, to ensure a member's unique needs are met through the authorization of HCBS services.
- A Task Worksheet establishing authorized tasks and associated time;
- An Attendant Support Management Plan (ASMP) for service planning;
- Electronic Visit Verification (EVV); and
- Payroll documentation (timesheet)

This CMS-approved structure confirms that tasks are identified on the Task Worksheet and are not required on each timesheet. The Task Worksheet serves as the governing document identifying approved service categories (Personal Care, Homemaker, and Health Maintenance Activities). The ASMP acts as the Member's planning tool for how attendant care will be organized and managed within the scope of the authorized services.

These components collectively disclose the extent of services provided without requiring redundant task-level entries. OIG did not identify unauthorized services, ineligible members or attendants, units exceeding authorized allocations, or payments outside approved waiver authority. The finding reflects a difference in interpretation regarding documentation format—not evidence of improper service delivery.

Since Colorado's consumer-directed documentation standards are approved by CMS and the OIG's interpretation is not supported by federal statute, regulation, or CMS-approved waiver authority on consumer-directed services, the set-aside amount is unfounded. These claims reflect permissible documentation differences, not unsupported or unallowable services. The Department respectfully requests that OIG reconsider and eliminates the set-aside, consistent with approved waiver authority.

Response Summary and Request

The Department appreciates OIG's review and the opportunity to provide clarification on the findings presented in their report. Taken together, the issues identified throughout this response demonstrate that the analytical and methodological framework applied in the report does not provide a sufficient basis to support the findings or associated financial conclusions. As described above, the extrapolated financial findings rely on a sample that was not demonstrated to be representative of the statewide claim population and that disproportionately reflects a limited subset of providers and members, thereby undermining the validity of applying these results to the broader population.

In addition, the report repeatedly treats missing documentation of background checks or ASMPs, or administrative variances, as evidence of improper payment, despite the absence of evidence that services were not delivered, were unauthorized, or were provided by ineligible caregivers. Under applicable federal Medicaid allowability standards, including FFP standards, the determination of an improper or unallowable payment requires sufficient evidence that program requirements were not met. Missing documentation of background checks or ASMPs, in

isolation, should not establish that claims are unallowable absent evidence that services were not delivered, were unauthorized, or were provided by ineligible caregivers. Several findings are further based on interpretations of documentation requirements that are not supported by federal statute, regulation, or Colorado's CMS-approved waiver structure. The Department also notes that applying extrapolated financial recovery in this context, while substantively similar findings in other states have been addressed through technical recommendations, results in an arbitrarily inconsistent application of federal oversight standards.

Accordingly, the Department respectfully requests that OIG revise and modify the findings, conclusions, and associated financial recommendations in the final report to align with applicable federal requirements and the evidentiary record. This includes reclassifying documentation-based findings as administrative or technical in nature, discontinuing the use of statistical extrapolation where the underlying assumptions of representativeness are not met, and removing or adjusting any associated recommendations for financial disallowances or set-aside amounts that are not supported by reliable evidence or a valid legal basis.

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