Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK CLAIMED SOME UNALLOWABLE COSTS FOR SERVICES BY NEW YORK CITY PROVIDERS UNDER THE STATE'S DEVELOPMENTAL DISABILITIES WAIVER PROGRAM

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General

August 2012
A-02-10-01027

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

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

Section 1915(c) of the Act authorizes Medicaid home and community-based services (HCBS) waiver programs. A State's HCBS waiver program must be approved by CMS and allows a State to claim Federal reimbursement for services not usually covered by Medicaid.

In New York State, the Office for People With Developmental Disabilities (OPWDD) provides services to individuals—both Medicaid and non-Medicaid beneficiaries—with intellectual and developmental disabilities under a cooperative agreement with the Department of Health (DOH), which administers the State's Medicaid program. Under a memorandum of understanding with DOH, OPWDD administers the OPWDD waiver program, an HCBS waiver program. The OPWDD waiver program is intended to enable adults and children with developmental disabilities to live in the community as an alternative to Intermediate Care Facilities for Individuals with Intellectual Disabilities. (The waiver program is formally known as the New York State Office of Mental Retardation and Developmental Disabilities waiver program. However, in July 2010, the Office of Mental Retardation and Developmental Disabilities was renamed the Office for People With Developmental Disabilities.)

Under the OPWDD waiver program, all services must be furnished pursuant to a written plan of care that is subject to periodic review and update every 6 months. In addition, OPWDD must maintain documentation of each plan of care. OPWDD waiver program service providers must maintain all information regarding claims submitted for payment.

During calendar years 2006 through 2008, DOH claimed reimbursement totaling $2.26 billion ($1.16 billion Federal share) for certain OPWDD waiver program services provided by New York City providers for 458,751 beneficiary-months. A beneficiary-month includes all HCBS for a beneficiary for 1 month.

OBJECTIVE

Our objective was to determine whether DOH claimed Medicaid reimbursement for HCBS provided by OPWDD waiver program providers in New York City that complied with certain Federal and State requirements.

SUMMARY OF FINDINGS

DOH claimed Federal Medicaid reimbursement for some OPWDD waiver program services provided by New York City providers that did not comply with certain Federal and State requirements. Of the 100 beneficiary-months in our random sample, DOH properly claimed Medicaid reimbursement for OPWDD waiver program services during 86 beneficiary-months. However, DOH claimed Medicaid reimbursement for services that did not comply with certain Federal and State requirements for the remaining 14 beneficiary-months.

Of the 14 beneficiary-months with services for which DOH improperly claimed Medicaid reimbursement, 2 contained more than 1 deficiency:

- For 6 beneficiary-months, DOH claimed reimbursement for service units billed that exceeded service units provided.

- For 4 beneficiary-months, DOH claimed reimbursement for OPWDD waiver program services that were not supported by adequate documentation.

- For 3 beneficiary-months, DOH claimed reimbursement for OPWDD waiver program services that were not provided.

- For 3 beneficiary-months, DOH claimed reimbursement for services that were not provided pursuant to a written plan of care.

The claims for unallowable services were made because DOH and OPWDD's policies and procedures for overseeing and administering the waiver program were not adequate to ensure that (1) providers claimed reimbursement only for services actually provided and maintained all the required documentation to support services billed and (2) OPWDD waiver program services were provided only to beneficiaries pursuant to written plans of care.

Based on our sample results, we estimate that DOH improperly claimed $7,772,807 in Federal Medicaid reimbursement for OPWDD waiver program services during calendar years 2006 through 2008.

RECOMMENDATIONS

We recommend that DOH:

- refund $7,772,807 to the Federal Government and

- work with OPWDD to strengthen policies and procedures to ensure that (1) providers claim reimbursement only for OPWDD waiver program services actually provided and maintain the required documentation to support services billed and (2) OPWDD waiver program services are provided pursuant to written plans of care.

DEPARTMENT OF HEALTH COMMENTS

In written comments on our draft report, DOH stated that it, along with OPWDD, concurred with our recommendations and described the actions it had taken or planned to take to address them.

DOH's comments are included in their entirety as Appendix D.

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INTRODUCTION

BACKGROUND

Medicaid Program

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

In New York State, the Department of Health (DOH) administers the Medicaid program. DOH uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

Home and Community-Based Services Waivers

Section 1915(c) of the Act authorizes Medicaid home and community-based services (HCBS) waiver programs. A State's HCBS waiver program must be approved by CMS and allows a State to claim Federal reimbursement for services not usually covered by Medicaid. HCBS are generally provided to Medicaid-eligible beneficiaries in the community rather than in an institutional setting.

Section 1915(c)(1) of the Act and Federal regulations (42 CFR § 441.301(b)(1)(iii)) allow for HCBS waiver services to be provided only after a determination that in the absence of such services the recipients would require the Medicaid-covered level of care provided in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities.[1] In addition, Federal regulations (42 CFR § 441.302(c)) require the State Medicaid agency to provide for an initial evaluation of the recipient's need for the level of care that would be provided in an institution unless the individual received the HCBS. The regulations further require at least annual reevaluations of each recipient receiving HCBS.

Pursuant to 42 CFR § 441.301(b)(1)(i), HCBS must be furnished under a written plan of care subject to approval by the State Medicaid agency. Pursuant to section 4442.6 of CMS's *State Medicaid Manual*, an assessment of the individual to determine the services needed to prevent institutionalization is to be included in the plan of care. In addition, the plan of care specifies the medical and other services to be provided, their frequency, and the type of provider. No Federal financial participation is available for HCBS waiver program services furnished without a written plan of care.

[1] Changes in terminology are based on Rosa's Law (P.L. No. 111-256). For more information, see CMS Final Rule, 77 Fed. Reg. 29002, 29021 & 29028 (May 16, 2012).

New York's Office for People With Developmental Disabilities Waiver Program

In New York State, the Office for People With Developmental Disabilities (OPWDD) provides services to individuals—both Medicaid and non-Medicaid beneficiaries—with intellectual and developmental disabilities under a cooperative agreement with DOH. Under a memorandum of understanding with DOH, the agency administers the OPWDD[2] waiver program, an HCBS waiver program. OPWDD administers the program through Developmental Disabilities Services Offices (DDSO) throughout the State. DDSOs also provide direct services, and oversee and provide assistance to OPWDD-authorized not-for-profit agencies that serve OPWDD waiver program beneficiaries. Title 14 § 635-10 of the New York Compilation of Codes, Rules, & Regulations (NYCRR) establishes requirements for Medicaid reimbursement for OPWDD waiver program services.

The OPWDD waiver program is intended to enable adults and children with developmental disabilities to live in the community as an alternative to Intermediate Care Facilities for Individuals with Intellectual Disabilities.[3,4] Approximately half of OPWDD waiver program beneficiaries live in their own home or family home, where they receive services. Other beneficiaries have greater needs, including many who reside in a certified residence and use an intensive day service such as day habilitation. These beneficiaries commonly travel offsite for Medicaid services (e.g., clinical services) and use nonemergency medical transportation (NEMT).

DOH claims Medicaid reimbursement on a fee-for-service basis for HCBS provided to OPWDD waiver program beneficiaries by OPWDD waiver program providers. Under the memorandum of understanding with OPWDD, DOH is responsible for annually reviewing a sample of OPWDD waiver program beneficiaries' individualized service plans.

According to the State's OPWDD waiver agreement with CMS, to be eligible for the OPWDD waiver program, a beneficiary must be a Medicaid recipient, be diagnosed with intellectual or developmental disabilities, and be assessed to need Intermediate Care Facilities for Individuals with Intellectual Disabilities level of care. In addition, all services must be furnished pursuant to a written plan of care that is subject to periodic review and update every 6 months. OPWDD waiver program providers must maintain all information regarding claims for payment for a period of 6 years from the date of service.

[2] The waiver program is formally known as the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) waiver program. However, in July 2010, the OMRDD was renamed the Office for People With Developmental Disabilities. We refer to the waiver program throughout this report as "the OPWDD waiver program."

[3] See footnote 1.

[4] Services offered under the OPWDD waiver program include residential habilitation; day habilitation (assistance with improvement in self-help, socialization, and adaptive skills in a nonresidential setting); supported employment (support to perform in a paid work setting); prevocational services; respite services (short periods of rest or relief for a caregiver); adaptive technologies; assistive technology; plan of care support services; family education and training; consolidated supports and services; transitional supports; and fiscal/employer agent services.

During calendar years 2006 through 2008, DOH claimed reimbursement totaling $2.26 billion ($1.16 billion Federal share) for certain OPWDD waiver program services provided by New York City providers.[5]

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether DOH claimed Medicaid reimbursement for HCBS provided by OPWDD waiver program providers in New York City that complied with certain Federal and State requirements.

Scope

Our review covered DOH's claim for Medicaid reimbursement for HCBS claims submitted by OPWDD waiver program providers in New York City during calendar years 2006 through 2008. During this period, DOH claimed $2.26 billion ($1.16 billion Federal share) for certain HCBS[6] provided under the OPWDD waiver program by 515 New York City providers during 458,751 beneficiary-months.[7]

We plan to issue separate reports on DOH's claims for Medicaid reimbursement for certain HCBS provided by OPWDD waiver program providers outside New York City (A-02-10-01044) and select OPWDD waiver program services (i.e., assistive technology) throughout the State (A-02-10-01039).

We did not assess DOH's or OPWDD's overall internal control structures. Rather, we limited our review of internal controls to those applicable to our objective, which did not require an understanding of all internal controls over the OPWDD waiver program. We reviewed New York City providers' and OPWDD's internal controls for documenting OPWDD waiver program services. We did not assess the appropriateness of OPWDD waiver program services payment rates. In addition, the scope of our audit did not require us to perform a medical review or an evaluation of the medical necessity of waiver program services claimed for reimbursement.

We performed our fieldwork at DOH's and OPWDD's offices in Albany, New York; the New York City DDSO's offices in New York, New York; and at 52 HCBS providers, 2 NEMT providers, and 14 clinics located throughout the New York City metropolitan area.

[5] New York State is divided into 58 social service districts. Each county is considered its own social services district, except the five counties (Bronx, Kings, New York, Queens, and Richmond) that make up New York City, which is considered a single district.

[6] Our review covered all OPWDD waiver program services except assistive technology services because DOH submitted these for Medicaid reimbursement under a statewide "county code."

[7] A beneficiary-month includes all HCBS for one beneficiary for 1 month. A beneficiary-month could include multiple services.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State Medicaid HCBS waiver laws, regulations, and guidance;

- met with CMS financial and program management officials to gain an understanding of the HCBS waiver approval, administration, and assessment processes;

- held discussions with DOH and OPWDD officials to gain an understanding of the OPWDD waiver program and to discuss the State's policies and procedures related to the administration of the OPWDD waiver program;

- met with officials from OPWDD waiver program provider agencies to obtain an understanding of their OPWDD waiver program policies and procedures;

- reconciled the OPWDD waiver program services claimed for Federal reimbursement by DOH on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, to the population of certain payments for OPWDD waiver program services to providers statewide obtained from the State's MMIS for the quarter January 1, 2008, through March 31, 2008;

- obtained from the MMIS a sampling frame of 458,751 beneficiary-months with OPWDD waiver program services provided by New York City providers[8] for which DOH claimed reimbursement totaling $2,258,322,087 ($1,155,217,004 Federal share) during the period January 1, 2006, through December 31, 2008;

- selected a stratified random sample of 100 beneficiary-months from the sampling frame of 458,751 beneficiary-months and, for each beneficiary-month

    - determined whether the beneficiary was diagnosed with a developmental disability and was assessed to need Intermediate Care Facilities for Individuals with Intellectual Disabilities level of care,

    - determined whether OPWDD waiver program services were provided pursuant to a written plan of care,

    - determined whether the staff members who provided the services met qualification and training requirements,

    - determined whether services were documented in accordance with Federal and State requirements,

[8] We used providers' correspondence addresses and county codes on the MMIS to identify those located in New York City.

- determined whether the number of units of OPWDD waiver program services billed for certain claims were actually provided; specifically, we

    - obtained from the MMIS a listing of all NEMT and clinic claims paid on behalf of the beneficiary during the sampled beneficiary-month,

    - reviewed any NEMT and/or clinic claims submitted during the corresponding beneficiary-month in which day habilitation services were paid on the same date of service,[9] and

    - obtained and reviewed documentation from NEMT providers and clinics regarding the corresponding beneficiaries' appointment time(s) and duration of services; and

- estimated the unallowable Federal Medicaid reimbursement paid in the total population of 458,751 beneficiary-months.

Appendix A contains the details of our sample design and methodology. Appendix B contains our sample results and estimates.

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

FINDINGS AND RECOMMENDATIONS

DOH claimed Federal Medicaid reimbursement for some OPWDD waiver program services provided by New York City providers that did not comply with certain Federal and State requirements. Of the 100 beneficiary-months in our random sample, DOH properly claimed Medicaid reimbursement for OPWDD waiver program services during 86 beneficiary-months. However, DOH claimed Medicaid reimbursement for services that did not comply with certain Federal and State requirements for the remaining 14 beneficiary-months. Of the 14 beneficiary-months with services for which DOH improperly claimed Medicaid reimbursement, 2 contained more than 1 deficiency:

- For 6 beneficiary-months, DOH claimed reimbursement for service units billed that exceeded service units provided.

- For 4 beneficiary-months, DOH claimed reimbursement for OPWDD waiver program services that were not supported by adequate documentation.

[9] Of the 100 sampled beneficiary-months, 42 contained day habilitation services paid on the same date of service as an NEMT and/or clinic claim. Of these 42 beneficiary-months, 40 related to clinic services only (provided by 14 different providers) and 2 related to NEMT services and clinic claims.

- For 3 beneficiary-months, DOH claimed reimbursement for OPWDD waiver program services that were not provided.

- For 3 beneficiary-months, DOH claimed reimbursement for services that were not provided pursuant to a written plan of care.

Appendix C contains a summary of deficiencies, if any, identified for each sampled beneficiary-month.

The claims for unallowable services were made because DOH and OPWDD's policies and procedures for overseeing and administering the waiver program were not adequate to ensure that (1) providers claimed reimbursement only for services actually provided and maintained all the required documentation to support services billed and (2) OPWDD waiver program services were provided only to beneficiaries pursuant to written plans of care.

Based on our sample results, we estimate that DOH improperly claimed $7,772,807 in Federal Medicaid reimbursement for OPWDD waiver program services during calendar years 2006 through 2008.

UNALLOWABLE CLAIMS FOR WAIVER PROGRAM SERVICES

Service Units Billed Exceeded Service Units Provided

Under Office of Management and Budget (OMB) Circular A-87, Att. A, § C.1.c, (2 CFR § 225, App. A § C.1.c), costs claimed to Federal awards must be authorized or not prohibited under State or local laws or regulations. Pursuant to 14 NYCRR § 635-10.5(c) and (e), group day habilitation and prevocational services are reimbursed in full or half units of service. Specifically, providers may bill for a full unit when the provider delivers and documents at least two face-to-face services and a program day duration of at least 4 hours. Providers may bill a half unit of service when the provider delivers and documents at least one face-to-face service and a program day duration of at least 2 hours. In addition, time spent at any other separately reimbursed service that occurs during the day habilitation program day (e.g., clinic services), time spent traveling to/from the day habilitation service provider, and mealtime cannot be counted as part of the program day duration. Pursuant to 14 NYCRR §§ 635-10.5(h)(3)(ii), non-State-operated respite service providers may claim reimbursement in 15-minute increments, based on a 1-hour unit of service.

For 6 beneficiary-months, DOH claimed reimbursement for service units billed that exceeded service units provided. Specifically:

- For 4 beneficiary-months, the day habilitation provider submitted a claim that included time spent during a clinic visit and/or traveling to/from the clinic. As a result, the program day duration was calculated for a full unit of day habilitation services rather than a half unit.

- For 1 beneficiary-month, the prevocational services provider submitted a claim for a full unit of service; however, the provider's bus logs indicated that the beneficiary was at the prevocational provider for only 3.5 hours.

- For 1 beneficiary-month, the respite services provider submitted a claim for 16 units (4 hours); however, the provider's service document indicated that only 8 units (2 hours) were provided.

Services Not Documented

Section 1902(a)(27) of the Act mandates that States have agreements with Medicaid providers under which providers agree to keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the Medicaid State plan. Pursuant to OMB Circular A-87, *Cost Principles for State, Local, and Tribal Governments*, Att. A, § C.1.j (2 CFR § 225, App. A § C.1.j), costs must be adequately documented to be allowable under Federal awards. Pursuant to section 2500.2 of CMS's *State Medicaid Manual*, States are to report only expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is immediately available when the claim is filed.[10]

Pursuant to 18 NYCRR § 504.3(a), Medicaid providers must prepare and maintain documentation to support Medicaid claims, including records necessary to disclose the nature and extent of services furnished.

For 4 beneficiary-months, DOH claimed reimbursement for OPWDD waiver program services that were not supported by adequate documentation. For example, provider records did not describe services provided or support the minimum number of required services.

Services Not Provided

Under section 1903(a) (1) of the Act, and pursuant to section 2497.1 of CMS's *State Medicaid Manual*, Federal financial participation is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers.

For 3 beneficiary-months, DOH claimed reimbursement for OPWDD waiver program services for which provider's records indicated that the provider's employee or beneficiary was absent on the date of service. Specifically, for two claims, the beneficiary was absent from the prevocational services program and, for one claim, the employee documented to have provided the service was absent from work on the date of an at-home residential habilitation service.

[10] Supporting documentation includes as a minimum the following: date of service; name of recipient; Medicaid identification number; name of provider agency and person providing the service; nature, extent, or units of service; and the place of service.

Services Not Provided Pursuant to a Written Plan of Care

Pursuant to section 1915(c)(1) of the Act, waiver services are to be provided only under a written plan of care subject to approval by the State Medicaid agency. Pursuant to the State's waiver agreement with CMS, an eligible OPWDD waiver program beneficiary must have a written plan of care. Pursuant to section 4442.6 of CMS's *State Medicaid Manual*, an assessment of the individual to determine the services needed to prevent institutionalization is to be included in the plan of care. In addition, the plan of care specifies the medical and other services to be provided, their frequency, and the type of provider. No Federal financial participation is available for OPWDD waiver program services furnished without a written plan of care.

For 3 beneficiary-months, DOH claimed reimbursement for services that were not provided pursuant to a written plan of care. Specifically, for 2 beneficiary-months, DOH claimed reimbursement for services that were not listed on the corresponding beneficiary's plan of care. For the remaining beneficiary-month, DOH claimed reimbursement for services provided to a beneficiary for whom neither OPWDD nor the provider could provide the plan of care.

CAUSES OF UNALLOWABLE CLAIMS

The claims for unallowable services were made because DOH and OPWDD's policies and procedures for overseeing and administering the waiver program were not adequate to ensure that (1) providers claimed reimbursement only for services actually provided and maintained all the required documentation to support services billed and (2) OPWDD waiver program services were provided only to beneficiaries and only pursuant to written plans of care.

RECOMMENDATIONS

We recommend that DOH:

- refund $7,772,807 to the Federal Government and

- work with OPWDD to strengthen policies and procedures to ensure that (1) providers claim reimbursement only for OPWDD waiver program services actually provided and maintain the required documentation to support services billed and (2) OPWDD waiver program services are provided pursuant to written plans of care.

DEPARTMENT OF HEALTH COMMENTS

In written comments on our draft report, DOH stated that it, along with OPWDD, concurred with our recommendations and described the actions it had taken or planned to take to address them.

DOH's comments are included in their entirety as Appendix D.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of beneficiary-months of service with total payments greater than $100 (Federal share) for which the New York State Department of Health (DOH) claimed Medicaid reimbursement for claims submitted by New York City providers under New York's Office for People With Developmental Disabilities home and community-based services (HCBS) waiver program (the waiver program) during calendar years 2006 through 2008.

SAMPLING FRAME

The sampling frame was an Access file containing 458,751 beneficiary-months of service (with payments greater than $100) totaling $2,258,322,087 ($1,155,217,004 Federal share). The data for beneficiary-months of service under the waiver program were extracted from the New York Medicaid Management Information System.

SAMPLE UNIT

The sample unit was a beneficiary-month during calendar years 2006 through 2008 for which DOH claimed Medicaid reimbursement for services provided by New York City providers under the waiver program. A beneficiary-month is defined as all HCBS for one beneficiary for 1 month.

SAMPLE DESIGN

We used a stratified random sample to review Medicaid payments made by DOH to New York City providers on behalf of beneficiaries enrolled in the waiver program. To accomplish this, we separated the sampling frame into two strata as follows:

- Stratum 1: beneficiary-months with total payments greater than $100 and less than or equal to $3,000 (Federal share)—317,282 beneficiary-months totaling $781,075,154 ($399,137,554 Federal share).

- Stratum 2: beneficiary-months with total payments greater than $3,000 (Federal share)—141,469 beneficiary-months totaling $1,477,246,933 ($756,079,450 Federal share).

SAMPLE SIZE

We selected a sample of 100 beneficiary-months of service, as follows:

- 50 beneficiary-months from Stratum 1 and

- 50 beneficiary-months from Stratum 2.

SOURCE OF THE RANDOM NUMBERS

We used the Office of Audit Services' statistical software, RAT-STATS 2007, to generate the random numbers for our stratified random sample.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each of the two strata. After generating 50 random numbers for each stratum, we selected the corresponding frame items. We then created a list of 100 sampled items.

ESTIMATION METHODOLOGY

We used RAT-STATS to calculate our estimates. We used the lower limit of the 90-percent confidence interval to estimate the overpayment associated with claims for unallowable waiver program services.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Stratum	Beneficiary-Months in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Beneficiary-Months with Unallowable Services	Value of Unallowable Services (Federal Share)
1	317,282	$399,137,554	50	$65,118	7	$4,602
2	141,469	$756,079,450	50	$245,109	7	$557
Total	**458,751**	**$1,155,217,004**	**100**	**$310,227**	**14**	**$5,159**

Estimated Value of Unallowable Services
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	$30,778,326
Lower Limit	$7,772,807
Upper Limit	$53,783,844

APPENDIX C: SUMMARY OF DEFICIENCIES FOR EACH SAMPLED BENEFICIARY-MONTH

Legend

1	Service Units Billed Exceeded Service Units Provided
2	Services Not Documented
3	Services Not Provided
4	Services Not Provided Pursuant to a Written Plan of Care

Office of Inspector General Review Determinations on the 100 Sampled Beneficiary-Months

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
1					
2					
3					
4					
5	X				1
6					
7					
8					
9					
10					
11					
12					
13					
14				X	1
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27		X			1
28					
29					
30					
31					

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
32					
33					
34					
35					
36					
37					
38					
39					
40		X			1
41					
42					
43					
44					
45					
46					
47					
48					
49					
50					
51					
52					
53					
54					
55					
56					
57	X			X	2
58					
59					
60					
61					
62					
63					
64					
65					
66					
67					
68					
69					
70					
71					
72	X				1
73					

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
74		X	X		2
75			X		1
76					
77					
78					
79					
80					
81					
82					
83					
84					
85	X				1
86	X				1
87					
88			X		1
89					
90					
91					
92	X				1
93		X			1
94				X	1
95					
96					
97					
98					
99					
100					
Category Totals	6	4	3	3	16*
14 Beneficiary-Months With Deficiencies					

* Two claims contained more than one deficiency.

APPENDIX D: DEPARTMENT OF HEALTH COMMENTS

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

June 29, 2012

James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: A-02-10-01027

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the Department of Health and Human Services, Office of Inspector General's draft audit report A-02-10-01027 on "New York Claimed Some Unallowable Costs for Services by New York Providers Under the State's Developmental Disabilities Waiver Program."

Thank you for the opportunity to comment.

Sincerely,

Michael J. Nazarko
Deputy Commissioner for Administration

Enclosure

cc: Courtney Burke
Jason Helgerson
James C. Cox
Diane Christensen
Stephen Abbott
Stephen LaCasse
Vincent Sleasman
Irene Myron
John Brooks
Ronald Farrell
Barry Benner

New York State Department of Health
Comments on Department of Health and Human Services Office of Inspector General Draft Audit Report A-02-10-01027 titled "New York Claimed Some Unallowable Costs for Services by New York City Providers Under the State's Developmental Disabilities Waiver Program"

The following are the New York State Department of Health's (Department) comments in response to Department of Health and Human Services, Office of Inspector General (OIG) draft audit report A-02-10-01027 titled "New York Claimed Some Unallowable Costs for Services by New York City Providers Under the State's Developmental Disabilities Waiver Program."

Recommendation #1:

The Department should refund $7,772,807 to the Federal Government.

Response #1:

The Department and the Office for People With Developmental Disabilities (OPWDD) concur with the recommendation for the Department to refund $7,772,807 to the Federal Government.

Recommendation #2:

The Department should work with OPWDD to strengthen procedures to ensure that (1) providers claim reimbursement only for OPWDD waiver program services actually provided and maintain the required documentation to support services billed, and (2) OPWDD waiver program services are provided pursuant to written plans of care.

Response #2:

The Department and OPWDD agree with the recommendation and each will continue to collaborate on implementing a revised quality improvement strategy that fully addresses OIG's findings. Additionally, the Department's redesigned individual service plan (ISP) review includes an annual review of a statistically valid random sample of ISPs for the purpose of confirming that only the services listed in the ISP are reflected in claim detail reports.