Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

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

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## EXECUTIVE SUMMARY

***New York claimed Federal Medicaid reimbursement for some waiver program services that did not comply with Federal and State requirements.***

### WHY WE DID THIS REVIEW

This audit is part of a series of reviews of New York State's Office for People With Developmental Disabilities (OPWDD) Medicaid waiver program. During a separate review of the program, we determined that the New York State Department of Health (State agency) claimed Federal Medicaid reimbursement for some home and community-based services (HCBS) provided by New York City providers that did not comply with Federal and State requirements.

The objective of this review was to determine whether the State agency claimed Federal Medicaid reimbursement for HCBS provided by OPWDD waiver program providers outside New York City that complied with certain Federal and State requirements. Throughout this report, we refer to these providers as "New York State providers."

### BACKGROUND

In New York State, OPWDD provides services to individuals—both Medicaid and non-Medicaid beneficiaries—with intellectual and developmental disabilities under a cooperative agreement with the State agency, which administers the State's Medicaid program. Under a memorandum of understanding with the State agency, 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 according to a written plan of care that is subject to periodic review and updated 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.

### HOW WE CONDUCTED THIS REVIEW

During calendar years 2006 through 2008, the State agency claimed Medicaid reimbursement totaling $10.51 billion ($5.38 billion Federal share) for certain OPWDD waiver program services provided by 2,275 New York State providers during 1,376,325 beneficiary-months. We reviewed a stratified random sample of 137 of these beneficiary-months. A beneficiary-month included all OPWDD waiver program services for a beneficiary for 1 month.

## WHAT WE FOUND

The State agency claimed Federal Medicaid reimbursement for some OPWDD waiver program services provided by New York State providers that did not comply with certain Federal and State requirements. Of the 137 beneficiary-months in our random sample, the State agency properly claimed Medicaid reimbursement for OPWDD waiver program services during 100 beneficiary-months. However, the State agency claimed $79,328 in Medicaid reimbursement for services that did not comply with certain Federal and State requirements for the remaining 37 beneficiary-months.

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

On the basis of our sample results, we estimated that the State agency improperly claimed $76,817,444 in Federal Medicaid reimbursement for OPWDD waiver program services during calendar years 2006 through 2008.

## WHAT WE RECOMMEND

We recommend that the State agency:

- refund $79,328 to the Federal Government;

- work with CMS to determine the additional amount of overpayments for claims in the sampling frame, estimated to be $76,738,116 ($76,817,444 less $79,328), in the remaining 1,376,188 beneficiary-months for which the State agency received Federal Medicaid reimbursement during calendar years 2006 through 2008; and

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

## STATE AGENCY COMMENTS AND OUR RESPONSE

In its written comments on our draft report, the State agency generally agreed with our findings and recommendations. Specifically, the State agency concurred with our first recommendation (financial disallowance) and third recommendation (strengthen policies and procedures). The State agency asserted that our use of the point estimate as the estimated recovery amount in our second recommendation (estimated amount of overpayments) was not appropriate; however, it agreed to discuss our results with CMS to determine an appropriate amount to refund the Federal Government.

We agree with the State agency's assertion that the estimated recovery amount should not be set at the point estimate. However, we are not recommending an estimated recovery amount in our second recommendation. Rather, we used the point estimate to derive an estimated amount of overpayment because, as the State agency also pointed out in its comments, the lower limit of our statistical estimation in this review was a negative dollar amount. The point estimate is our best estimate of the overpayments, but because of the uncertainty resulting from the sampling process, actual overpayments could be much higher or lower. We used the point estimate in our recommendation that the State agency work with CMS to determine the amount of overpayments.

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# INTRODUCTION

## WHY WE DID THIS REVIEW

This audit is part of a series of reviews of New York State's Office for People With Developmental Disabilities (OPWDD) Medicaid waiver program. During a separate review of the program, we determined that the New York State Department of Health (State agency) claimed Federal Medicaid reimbursement for some home and community-based services (HCBS) provided by New York City providers that did not comply with Federal and State requirements.[1]

## OBJECTIVE

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for HCBS provided by OPWDD waiver program providers outside New York City[2] that complied with certain Federal and State requirements.

## 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 Federal requirements.

### Home and Community-Based Services Waivers

Section 1915(c) of the Social Security Act (the Act) authorizes Medicaid 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 HCBS to be provided only after the State agency determines 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.[3] In addition,

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[1] *New York Claimed Some Unallowable Costs for Services by New York City Providers Under the State's Developmental Disabilities Waiver Program* (A-02-10-01027, issued August 14, 2012).

[2] Throughout this report, we refer to OPWDD waiver program providers outside New York City as "New York State providers."

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

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.

HCBS must be furnished under a written plan of care, which is subject to approval by the State Medicaid agency (42 CFR § 441.301(b)(1)(i)). The plan of care must include an assessment of the individual to determine the services needed to prevent institutionalization (section 4442.6 of CMS's *State Medicaid Manual*). 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.

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

In New York State, the State agency administers the Medicaid program. Under a memorandum of understanding with the State agency, OPWDD administers the OPWDD[4] waiver program, an HCBS waiver program.[5]

OPWDD administers the OPWDD waiver program through Developmental Disabilities Services Offices (DDSOs) 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.[6] Approximately half of OPWDD waiver program beneficiaries live in their own homes or family homes, where they receive services. Other beneficiaries have greater needs, including many who reside in certified residences and use intensive day services, such as day habilitation. These beneficiaries commonly travel off-site for Medicaid services (e.g., clinical services) and use nonemergency medical transportation (NEMT).

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

[5] OPWDD provides services to individuals—both Medicaid and non-Medicaid beneficiaries—with intellectual and developmental disabilities under a cooperative agreement with the State agency.

[6] 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 (preparing an individual for employment); 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.

The State agency claims Medicaid reimbursement on a fee-for-service basis for OPWDD waiver program services provided to beneficiaries by OPWDD waiver program providers. Some waiver program services are provided through OPWDD's Options for People Through Services (OPTS) program. For OPTS program services, OPWDD is the provider of record and subcontracts with private providers to provide waiver program services.[7] Under the memorandum of understanding with OPWDD, the State agency is responsible for annually reviewing a sample of OPWDD waiver program beneficiaries' individualized service plans.

According to the State agency's OPWDD waiver agreement with CMS, to be eligible for the OPWDD waiver program, a beneficiary must be a Medicaid recipient, be diagnosed with an intellectual or developmental disability, and be assessed to need a level of care equivalent to that provided in an intermediate care facility for individuals with intellectual disabilities. In addition, all services must be furnished according to a written plan of care that is subject to periodic review and updated 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.

For details on Federal and State requirements related to OPWDD waiver program services, see Appendix A.

## HOW WE CONDUCTED THIS REVIEW

During calendar years 2006 through 2008, the State agency claimed Medicaid reimbursement totaling $10.51 billion ($5.38 billion Federal share) for certain OPWDD waiver program services provided by 2,275 New York State providers during 1,376,325 beneficiary-months.[8, 9] We reviewed a stratified random sample of 137 of these beneficiary-months. A beneficiary-month included all OPWDD waiver program services for a beneficiary for 1 month.

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 contains the details of our audit scope and methodology; Appendix C contains our statistical sampling methodology; Appendix D contains our sample results and estimates; and Appendix E contains a summary of deficiencies, if any, for each sampled beneficiary-month.

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[7] The OPTS program was officially retired in 2007. However, OPTS contracts that were in effect at the time of program retirement were allowed to continue.

[8] Our review covered all OPWDD waiver program services except assistive technology services because the State agency submitted these for Medicaid reimbursement under a statewide "county code." These claims were the subject of a separate review (*New York Claimed Some Unallowable Costs for Assistive Technology Services Under the State's Developmental Disabilities Waiver Program* (A-02-10-01039, November 20, 2013)).

[9] Our audit population did not include claims for OPWDD waiver program services submitted by 515 providers in New York City, which we reported on in a separate review (A-02-10-01027).

## FINDINGS

The State agency claimed Federal Medicaid reimbursement for some OPWDD waiver program services provided by New York State providers that did not comply with certain Federal and State requirements. Of the 137 beneficiary-months in our random sample, the State agency properly claimed Medicaid reimbursement for OPWDD waiver program services during 100 beneficiary-months. However, the State agency claimed $79,328 in Medicaid reimbursement for services that did not comply with certain Federal and State requirements for the remaining 37 beneficiary-months. Of these 37 beneficiary-months, 9 contained more than one deficiency.[10] Specifically:

- For 20 beneficiary-months, the State agency claimed reimbursement totaling $72,263 for OPWDD waiver program services that were not supported by adequate documentation.

- For 18 beneficiary-months, the State agency claimed reimbursement totaling $2,977 for service units billed that exceeded service units documented.

- For 4 beneficiary-months, the State agency claimed reimbursement totaling $3,786 for OPWDD waiver program services that were not provided according to a written plan of care.

- For 4 beneficiary-months, the State agency claimed reimbursement totaling $302 for OPWDD waiver program services that were not provided.

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

On the basis of our sample results, we estimated that the State agency improperly claimed $76,817,444 in Federal Medicaid reimbursement for OPWDD waiver program services during calendar years 2006 through 2008.

## UNALLOWABLE CLAIMS FOR WAIVER PROGRAM SERVICES

### Services Not Documented

Medicaid providers must document the extent of services provided to beneficiaries, and States may claim Medicaid reimbursement only for documented expenditures (section 1902(a)(27) of the Act, section 2500.2 of CMS's *State Medicaid Manual*). Medicaid providers are required to prepare and maintain documentation to support Medicaid claims, including records necessary to disclose the nature and extent of services furnished (18 NYCRR § 504.3(a)).

[10] For each disallowed service, we questioned only the dollar amount associated with that particular service. If we found multiple deficiencies for the same service, we questioned the dollar amount associated with that service only once.

OPWDD waiver program services providers may bill for a full unit of group day habilitation services when the provider documents at least two face-to-face services during a program day duration of 4 to 6 hours or a half unit of service when the provider documents at least one face-to-face service during a program day duration of at least 2 hours (14 NYCRR § 635-10.5(c)(6)). Providers must document the beneficiary's response to services provided (OMRDD Administrative Memorandum #2006-01, *Group Day Habilitation Service Documentation Requirements*).

OPWDD waiver program services providers may bill for a full month of supervised residential habilitation when the provider documents face-to-face residential habilitation services in accordance with the beneficiary's plan of care and residential habilitation plan on each of the 22 days of the enrollment requirement (14 NYCRR § 635-10.5(b)(8)). (These services are generally provided in community residences.) Service documentation must include the beneficiary's response to services provided. The response must be documented in a monthly summary note, although a provider may choose to include the response more frequently (OMRDD Administrative Memorandum #2002-01, *Individual Residential Alternative Residential Habilitation Service Documentation Requirements*).

For residential habilitation services provided in a beneficiary's home (known as "at-home residential habilitation services") during our audit period, the service unit was 1 day (14 NYCRR § 635-10.5(b)(13)).[11] Providers were required to document the number of service hours delivered each session, the provision of at least one service in accordance with the beneficiary's plan of care and residential habilitation plan, and the staff person who delivered the service (OMRDD Administrative Memorandum #2004-01, *At-Home Residential Habilitation Service Documentation Requirements*).

For 20 beneficiary-months, the State agency claimed reimbursement for OPWDD waiver program services that were not supported by adequate documentation. Specifically:

- For 6 beneficiary-months, the group day habilitation or supervised residential habilitation provider did not document the beneficiary's response to services provided.

- For 5 beneficiary-months, the OPTS at-home residential habilitation provider's records did not document at least one service during each session.

- For 4 beneficiary-months, the group day habilitation or supervised residential habilitation provider's records did not describe the services provided or support the minimum number of required services.

- For 4 beneficiary-months, the at-home residential habilitation provider's records did not document the number of service hours delivered, describe the services provided, or support the minimum number of required services.

[11] The State agency revised its billing practices related to "at-home residential habilitation services" effective February 1, 2009—after the end of our audit period.

- For 1 beneficiary-month, the at-home residential habilitation provider's service notes did not document the staff person who delivered the service.

**Service Units Billed Exceeded Service Units Documented**

Medicaid providers must document the extent of services provided to beneficiaries, and States may claim Medicaid reimbursement only for documented expenditures (section 1902(a)(27) of the Act and section 2500.2 of CMS's *State Medicaid Manual*).

In its contracts with OPTS at-home residential habilitation services providers, OPWDD states that each 1-hour unit of service is divided into four 15-minute increments. The contracts also state that a minimum of one service must be documented for each session.

Group day habilitation services are reimbursed in full or half units of service. Specifically, providers may bill for a full unit when the provider documents at least two face-to-face services during a program day duration of 4 to 6 hours. Providers may bill a half unit of service when the provider delivers and documents at least one face-to-face service during a program day duration of at least 2 hours (14 NYCRR § 635-10.5(c)).

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 during a program day duration of at least 4 hours. Providers may bill a half unit when the provider delivers and documents at least one face-to-face service during a program day duration of at least 2 hours (14 NYCRR § 635-10.5(e)).

Individual day habilitation services are reimbursed in 1-hour units divided into four 15-minute increments. For each session, providers must document the service start and stop times and the provision of at least one service/staff action (14 NYCRR § 635-10.5(c)).

For 18 beneficiary-months, the State agency claimed reimbursement for service units billed that exceeded service units documented. Specifically:

- For 9 beneficiary-months, the at-home residential rehabilitation provider submitted a claim for which the number of units billed exceeded the number of service units documented. For example, 1 OPTS provider submitted a claim for 96 units but could provide documentation supporting only 32 units.

- For 7 beneficiary-months, the group day habilitation provider submitted a claim for a full unit of service; however, the provider documented only a half unit of service.

- For 1 beneficiary-month, the prevocational services provider submitted a claim for a full unit of service; however, the service duration overlapped with the beneficiary's group

day habilitation service duration, for which the provider also submitted a claim.[12] Therefore, the prevocational services warranted only a half unit of service.

- For 1 beneficiary-month, the individual day habilitation provider submitted a claim for 11 units of service; however, service documentation indicated that only 10 units of service were documented.

**Services Not Provided According to a Written Plan of Care**

Waiver services are to be provided only under a written plan of care subject to approval by the State Medicaid agency (section 1915(c)(1) of the Act). An assessment of the individual to determine the services needed to prevent institutionalization must be included in the plan of care. In addition, the plan of care must specify 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 (section 4442.6 of CMS's *State Medicaid Manual)*. According to the State's waiver agreement with CMS, an eligible OPWDD waiver program beneficiary must have a written plan of care.

For 4 beneficiary-months, the State agency claimed reimbursement for services that were not provided according to a written plan of care. Specifically, for 3 beneficiary-months, the State agency claimed reimbursement for services delivered that exceeded the frequency prescribed in the plan of care. For the remaining beneficiary-month, the State agency claimed reimbursement for services that were not listed in the beneficiary's plan of care.

**Services Not Provided**

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

For 4 beneficiary-months, the State agency claimed reimbursement for OPWDD waiver program services for which the provider's records indicated that either the beneficiary was absent or no service was provided on the date of service. Specifically, for three claims, the provider's records indicated that the beneficiary was absent from the group day habilitation services program; for the remaining claim, the provider's records indicated that the group day habilitation services were not provided.

## CAUSES OF UNALLOWABLE CLAIMS

The claims for unallowable services were made because the State agency's and OPWDD's policies and procedures for overseeing and administering the waiver program were not adequate to ensure that (1) providers maintained all the required documentation to support services billed

[12] Specifically, the service provider's documentation indicated that the beneficiary received prevocational services from 9 a.m. to 3 p.m. and group day habilitation services from 8:54 a.m. to 11:15 a.m., an overlap of approximately 2 hours.

and claimed reimbursement only for services actually provided and (2) OPWDD waiver program services were provided according to written plans of care.

## ESTIMATED OVERPAYMENTS

On the basis of our sample results, we estimated that the State agency improperly claimed $76,817,444 in Federal Medicaid reimbursement for OPWDD waiver program services during calendar years 2006 through 2008.

## RECOMMENDATIONS

We recommend that the State agency:

- refund $79,328 to the Federal Government;

- work with CMS to determine the additional amount of overpayments for claims in the sampling frame, estimated to be $76,738,116 ($76,817,444 less $79,328), in the remaining 1,376,188 beneficiary-months for which the State agency received Federal Medicaid reimbursement during calendar years 2006 through 2008; and

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

## STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on our draft report, the State agency generally agreed with our findings and recommendations. Specifically, the State agency concurred with our first recommendation (financial disallowance) and third recommendation (strengthen policies and procedures). The State agency asserted that our use of the point estimate as the estimated recovery amount in our second recommendation (estimated amount of overpayments) was not appropriate; however, it agreed to discuss our results with CMS to determine an appropriate amount to refund the Federal Government.

We agree with the State agency's assertion that the estimated recovery amount should not be set at the point estimate. However, we are not recommending an estimated recovery amount in our second recommendation.[13] Rather, we used the point estimate to derive an estimated amount of overpayment because, as the State agency also pointed out in its comments, the lower limit of our statistical estimation in this review was a negative dollar amount. The point estimate is our best estimate of the overpayments, but because of the uncertainty resulting from the sampling process, actual overpayments could be much higher or lower. We used the point estimate in our

[13] The recommended recovery in our first recommendation relates directly to the value of sample claims determined to be in error and is not an estimate.

recommendation that the State agency work with CMS to determine the amount of overpayments.

The State agency's comments appear in their entirety as Appendix F.

## APPENDIX A: FEDERAL AND STATE REQUIREMENTS RELATED TO WAIVER PROGRAM SERVICES

### FEDERAL REQUIREMENTS

Section 1902(a)(27) of the Act mandates that States have agreements with Medicaid providers under which providers agree to keep records necessary to fully disclose the extent of the services provided to individuals receiving assistance under the Medicaid State plan.

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 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.[14]

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. No Federal financial participation is available for OPWDD waiver program services furnished without a written plan of care.

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.

Pursuant to the State's waiver agreement with CMS, an eligible OPWDD waiver program beneficiary must have a written plan of care.

### STATE REQUIREMENTS

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.

Pursuant to 14 NYCRR § 635-10.5(b), the unit of service for at-home residential habilitation services is 1 day.[15]

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[14] 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.

[15] In guidance to at-home residential habilitation service providers, OPWDD stated that the required service documentation must include verification of service provision by the at-home residential habilitation staff person delivering the service, the provision of at least one service in accordance with the beneficiary's plan of care, and the number of service hours delivered (OMRDD Administrative Memorandum #2004-01, *At-Home Residential Habilitation Service Documentation Requirements*).

Pursuant to 14 NYCRR § 635-10.5(b), providers may bill for a full month of supervised residential habilitation when the provider delivers and documents face-to-face residential habilitation services in accordance with the beneficiary's individualized service plan and residential habilitation plan on each of the 22 days of the enrollment requirement.[16]

Pursuant to 14 NYCRR § 635-10.5(c), group day habilitation services are reimbursed in full or half units of service. Specifically, providers may bill for a full unit of service when the provider delivers and documents at least two face-to-face services during a program day duration of 4 to 6 hours. Providers may bill a half unit of service when the provider delivers and documents at least one face-to-face service during a program day duration of at least 2 hours.

Pursuant to 14 NYCRR § 635-10.5(e), 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 during a program day duration of at least 4 hours. Providers may bill a half unit when the provider delivers and documents at least one face-to-face service during a program day duration of at least 2 hours.

Pursuant to 14 NYCRR § 635-10.5(c), the unit of service for an individual day habilitation service is 1 hour and is reimbursed in 15-minute increments. For each continuous service delivery period, the provider must document the service start time and the service stop time and the provision of at least one service/staff action.

[16] In guidance to group day habilitation and residential habilitation providers, OPWDD stated that required service documentation must include the beneficiary's response to services provided. Specifically, the beneficiary's response must be documented in a monthly summary note, although a provider may choose to include the response more frequently (OMRDD Administrative Memorandum #2006-01, *Group Day Habilitation Service Documentation Requirements* and OMRDD Administrative Memorandum #2002-01, *Individual Residential Alternative Residential Habilitation Service Documentation Requirements*).

## APPENDIX B: AUDIT SCOPE AND METHODOLOGY

### SCOPE

During calendar years 2006 through 2008, the State agency claimed Medicaid reimbursement totaling $10.51 billion ($5.38 billion Federal share) for certain OPWDD waiver program services provided by 2,275 New York State providers during 1,376,325 beneficiary-months. We reviewed a stratified random sample of 137 of these beneficiary-months. A beneficiary-month included all OPWDD waiver program services for a beneficiary for 1 month. Our review excluded all assistive technology services[17] and claims for services submitted by 515 providers in New York City, which we reviewed during a separate review.

We did not assess the State agency's, OPWDD's, or New York State providers' overall internal control structures. Rather, we limited our review of internal controls to those applicable to our objective. Specifically, we reviewed New York State providers' and OPWDD's internal controls for providing and 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 the State agency's and OPWDD's offices in Albany, New York, and at 10 DDSOs, 73 HCBS providers, and 6 clinics located throughout the State.

### 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 State agency 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 the State agency on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, to the total of certain payments for OPWDD waiver

[17] The State agency submitted these services for Medicaid reimbursement under a statewide "county code." We reported on these services in a separate review (A-02-10-01039).

program services made to providers statewide obtained from the State's Medicaid Management Information System (MMIS) for the quarter January 1, 2008, through March 31, 2008;

- extracted from the MMIS a data file containing claims information for 1,407,556 beneficiary-months with OPWDD waiver program services provided by New York State providers for which the State agency claimed reimbursement totaling $10,511,607,600 ($5,377,377,686 Federal share) during the period January 1, 2006, through December 31, 2008;

- removed from the data file all claims information for beneficiary-months of service with total Medicaid payments of less than or equal to $100 (Federal share);

- determined that our sampling frame consisted of 1,376,325 beneficiary-months that included claims totaling $10,507,879,907 ($5,375,472,408 Federal share) during the period January 1, 2006, through December 31, 2008;[18]

- selected a stratified random sample of 137 beneficiary-months from the sampling frame of 1,376,325 beneficiary-months and, for each beneficiary-month:

    - determined whether the beneficiary was diagnosed with a developmental disability and was assessed to need a level of care equivalent to that provided in an intermediate care facility for individuals with intellectual disabilities,

    - determined whether OPWDD waiver program services were provided according 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,

    - determined whether the number of units of OPWDD waiver program services billed for certain claims were actually provided by:

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

        - reviewing any NEMT or clinic claims submitted during the corresponding beneficiary-month in which day habilitation, prevocational, respite, and

[18] We used providers' correspondence addresses and county codes in the MMIS to identify those located outside New York City. All State-operated providers (including those located in New York City) were included in the sampling frame because State-operated providers bill under a single county code. The sampling frame did not include HCBS claims submitted by one provider that was under criminal investigation by the Medicaid Fraud Control Unit.

at-home residential habilitation services were paid on the same date of service;[19] and

- obtaining and reviewing documentation from NEMT providers and clinics regarding the corresponding beneficiaries' appointment times and duration of services;

- estimated the unallowable Federal Medicaid reimbursement paid for claims in the sampling frame of 1,376,325 beneficiary-months; and

- discussed the results of our review 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.

[19] Of the 137 sampled beneficiary-months, 50 contained day habilitation, prevocational, respite, and at-home residential habilitation services paid on the same date of service as an NEMT or clinic claim. Of these 50 beneficiary-months, 49 related to clinic services only (provided by 36 different providers) and 1 related to NEMT services and clinic claims.

## APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

### POPULATION

The population consisted of beneficiary-months of service with total payments greater than $100 (Federal share) for which the State agency claimed Medicaid reimbursement for claims submitted by providers in New York State under New York's OPWDD waiver program during calendar years 2006 through 2008.

### SAMPLING FRAME

The sampling frame was an Access file containing 1,376,325 beneficiary-months of service (with payments greater than $100) totaling $10,507,879,907 ($5,375,472,408 Federal Share). The data for beneficiary-months of service under the waiver program were extracted from the New York MMIS.

### SAMPLE UNIT

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

### SAMPLE DESIGN

We used a stratified random sample to review Medicaid payments made by the State agency to New York State 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 $20,000 (Federal share)—1,376,288 beneficiary-months totaling $10,506,455,617 ($5,374,651,225 Federal share).

- Stratum 2: beneficiary-months with total payments greater than $20,000 (Federal share)—37 beneficiary-months totaling $1,424,290 ($821,183 Federal share).

### SAMPLE SIZE

We selected a sample of 137 beneficiary-months of service, as follows:

- 100 beneficiary-months from stratum 1 and

- 37 beneficiary-months from stratum 2.

## SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OAS), statistical software.

## METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each of the two strata. After generating 100 random numbers for stratum 1, we selected the corresponding frame items. We selected for review all 37 sample units in stratum 2.

## ESTIMATION METHODOLOGY

We used the OAS statistical software to appraise the sample results. We estimated the overpayment associated with claims for unallowable OPWDD waiver program services at the point estimate.

## APPENDIX D: SAMPLE RESULTS AND ESTIMATES

### Sample Details and Results

| Strata | 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 | 1,376,288 | $5,374,651,225 | 100 | $353,683 | 15 | $5,576 |
| 2 | 37 | $821,183 | 37 | $821,183 | 22 | $73,752 |
| **Total** | **1,376,325** | **$5,375,472,408** | **137** | **$1,174,866** | **37** | **$79,328** |

### Estimated Value of Unallowable Services
***(Limits Calculated for the 90-Percent Confidence Interval)***

| | |
|---|---|
| **Point Estimate** | $ 76,817,444 |
| **Lower Limit** | ($12,542,223) |
| **Upper Limit** | $166,177,111 |

## APPENDIX E: SUMMARY OF DEFICIENCIES FOR EACH SAMPLED BENEFICIARY-MONTH

**Table: Office of Inspector General Review Determinations on the 137 Sampled Beneficiary-Months**

**Legend**

| | |
|---|---|
| **1** | Services Not Documented |
| **2** | Service Units Billed Exceeded Service Units Documented |
| **3** | Services Not Provided in Accordance With Plan of Care |
| **4** | Services Not Provided |

| Sample Beneficiary-Month | Stratum | Deficiency 1 | Deficiency 2 | Deficiency 3 | Deficiency 4 | No. of Deficiencies |
|---|---|---|---|---|---|---|
| 1 | 1 | | | | | |
| 2 | 1 | | | | | |
| 3 | 1 | | | | | |
| 4 | 1 | | | | | |
| 5 | 1 | | | | | |
| 6 | 1 | | | | | |
| 7 | 1 | | | | | |
| 8 | 1 | | | | | |
| 9 | 1 | | | | | |
| 10 | 1 | | | | | |
| 11 | 1 | | | | | |
| 12 | 1 | | | | | |
| 13 | 1 | | | | | |
| 14 | 1 | | | | | |
| 15 | 1 | | | | | |
| 16 | 1 | | | | | |
| 17 | 1 | | | | | |
| 18 | 1 | | | | | |
| 19 | 1 | | | | | |
| 20 | 2 | | | | | |
| 21 | 1 | | | | | |
| 22 | 1 | | X | | | 1 |
| 23 | 1 | | | | | |

| Sample Beneficiary-Month | Stratum | Deficiency 1 | Deficiency 2 | Deficiency 3 | Deficiency 4 | No. of Deficiencies |
|---|---|---|---|---|---|---|
| 24 | 1 | X | | | | 1 |
| 25 | 1 | | | | | |
| 26 | 1 | | | | | |
| 27 | 1 | | | | | |
| 28 | 2 | | | | | |
| 29 | 1 | | | | | |
| 30 | 1 | | | | | |
| 31 | 2 | X | | | | 1 |
| 32 | 2 | | | | | |
| 33 | 1 | | | | | |
| 34 | 2 | X | | | | 1 |
| 35 | 2 | | | | | |
| 36 | 2 | | X | | | 1 |
| 37 | 2 | | X | | | 1 |
| 38 | 1 | | | | | |
| 39 | 1 | X | | | | 1 |
| 40 | 1 | | | | | |
| 41 | 1 | | X | | | 1 |
| 42 | 1 | | | | | |
| 43 | 1 | | | | | |
| 44 | 2 | | | | | |
| 45 | 2 | X | X | | | 2 |
| 46 | 2 | | | | | |
| 47 | 2 | | X | | | 1 |
| 48 | 1 | | | | X | 1 |
| 49 | 2 | X | | | | 1 |
| 50 | 2 | X | | | | 1 |
| 51 | 1 | | | | | |
| 52 | 1 | | | X | | 1 |
| 53 | 1 | | | | | |
| 54 | 2 | X | | | | 1 |
| 55 | 2 | | | | | |
| 56 | 2 | X | X | | | 2 |

| Sample Beneficiary-Month | Stratum | Deficiency 1 | Deficiency 2 | Deficiency 3 | Deficiency 4 | No. of Deficiencies |
|---|---|---|---|---|---|---|
| 57 | 1 | | | | | |
| 58 | 2 | X | | | | 1 |
| 59 | 2 | | | | | |
| 60 | 1 | | | | | |
| 61 | 2 | | | | | |
| 62 | 1 | | | | | |
| 63 | 1 | | | | | |
| 64 | 1 | | | | | |
| 65 | 2 | X | | | | 1 |
| 66 | 1 | | | | | |
| 67 | 1 | | X | | | 1 |
| 68 | 2 | | X | | X | 2 |
| 69 | 2 | | | | | |
| 70 | 1 | | | | | |
| 71 | 1 | | X | | | 1 |
| 72 | 2 | | | X | X | 2 |
| 73 | 1 | | | | | |
| 74 | 1 | | | | | |
| 75 | 1 | | | | | |
| 76 | 1 | X | | | | 1 |
| 77 | 1 | | | | | |
| 78 | 1 | | | | | |
| 79 | 1 | | | | | |
| 80 | 1 | | | | X | 1 |
| 81 | 1 | | | | | |
| 82 | 1 | | | | | |
| 83 | 1 | | | | | |
| 84 | 1 | | | | | |
| 85 | 2 | | X | | | 1 |
| 86 | 1 | | | | | |
| 87 | 1 | | | | | |
| 88 | 1 | | | | | |
| 89 | 1 | | | | | |

| Sample Beneficiary-Month | Stratum | Deficiency 1 | Deficiency 2 | Deficiency 3 | Deficiency 4 | No. of Deficiencies |
|---|---|---|---|---|---|---|
| 90 | 1 | | | | | |
| 91 | 2 | | | | | |
| 92 | 1 | | | | | |
| 93 | 2 | X | X | | | 2 |
| 94 | 2 | X | | | | 1 |
| 95 | 2 | X | | | | 1 |
| 96 | 2 | X | X | | | 2 |
| 97 | 1 | | | | | |
| 98 | 1 | X | | X | | 2 |
| 99 | 1 | | | | | |
| 100 | 1 | | | | | |
| 101 | 1 | | | | | |
| 102 | 1 | | | | | |
| 103 | 1 | | | | | |
| 104 | 1 | | | | | |
| 105 | 1 | | | | | |
| 106 | 1 | | X | | | 1 |
| 107 | 1 | | | | | |
| 108 | 1 | | | | | |
| 109 | 1 | X | | X | | 2 |
| 110 | 1 | | | | | |
| 111 | 1 | | | | | |
| 112 | 1 | | | | | |
| 113 | 1 | | | | | |
| 114 | 1 | | | | | |
| 115 | 1 | | | | | |
| 116 | 1 | | | | | |
| 117 | 2 | | | | | |
| 118 | 2 | | | | | |
| 119 | 1 | | | | | |
| 120 | 1 | | | | | |
| 121 | 1 | | X | | | 1 |
| 122 | 1 | | | | | |

| Sample Beneficiary-Month | Stratum | Deficiency 1 | Deficiency 2 | Deficiency 3 | Deficiency 4 | No. of Deficiencies |
|---|---|---|---|---|---|---|
| 123 | 1 | | | | | |
| 124 | 1 | | | | | |
| 125 | 2 | | X | | | 1 |
| 126 | 2 | X | X | | | 2 |
| 127 | 2 | | X | | | 1 |
| 128 | 1 | | | | | |
| 129 | 1 | | | | | |
| 130 | 2 | | | | | |
| 131 | 1 | X | | | | 1 |
| 132 | 2 | | | | | |
| 133 | 1 | | | | | |
| 134 | 1 | | | | | |
| 135 | 1 | | | | | |
| 136 | 1 | | | | | |
| 137 | 1 | | | | | |

| Category Totals | | 20 | 18 | 4 | 4 | 46[20] |
|---|---|---|---|---|---|---|

**37 Beneficiary-Months With Deficiencies**

[20] Nine beneficiary-months contained more than one deficiency.

# APPENDIX F: STATE AGENCY COMMENTS

NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

October 28, 2014

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-02-10-01044

Dear Mr. Edert:

Enclosed are the Department of Health's comments on the U.S. Department of Health and Human Services, Office of Inspector General draft audit report number A-02-10-01044 entitled, "New York Claimed Some Unallowable Costs for Services by New York State Providers Under the State's Developmental Disabilities Waiver Program."

Thank you for the opportunity to comment.

Sincerely,

*Michael J. Nazarko*

Michael J. Nazarko
Deputy Commissioner
for Administration

Enclosure

cc: Jason A. Helgerson
James C. Cox
Robert W. Locicero
Robert Loftus
Joan Kewley
James Cataldo
Diane Christensen
Lori Conway
Ronald Farrell
Brian Kiernan
Elizabeth Misa
Ralph Bielefeldt
Mary Peck
Vincent Sleasman
OHIP Audit BML

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# New York State Department of Health
# Comments on the
# Department of Health and Human Services
# Office of Inspector General
# Draft Audit Report A-02-10-01044 entitled
# "New York Claimed Some Unallowable Costs for Services by New York State Providers Under the State's Developmental Disabilities Waiver Program"

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The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-10-01044 entitled, "New York Claimed Some Unallowable Costs for Services by New York State Providers Under the State's Developmental Disabilities Waiver Program."

**Background:**

New York State is a national leader in its oversight of the Medicaid Program. Through the efforts of the Department and the Office of the Medicaid Inspector General (OMIG), over the last five years, New York State alone accounted for 54.9 percent of the national total of fraud, waste, and abuse recoveries. These results reflect a trend of increased productivity and enforcement. Over the last three calendar years, the administration's Medicaid enforcement efforts have recovered over $1.73 billion, a 34 percent increase over the prior three-year period.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 840,000 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to $7,929 in 2013, consistent with levels from a decade ago.

**Recommendation #1:**

Refund $79,328 to the Federal Government.

**Response #1:**

The Department concurs with the recommendation to refund the Federal share of $79,328 to the Federal Government.

**Recommendation #2:**

Work with the Centers for Medicare and Medicaid Services (CMS) to determine the additional amount of overpayments in the sampling frame, estimated to be $76,738,116 ($76,817,444 less $79,328), in the remaining 1,376,188 beneficiary-months for which the State agency received Federal Medicaid reimbursement during calendar years 2006 through 2008.

**Response #2:**

While the State agrees with the result of the review of the sample beneficiary months (refund $79,328), the State does not agree with the estimated amount of overpayment of $76,738,116. Because this figure is significantly overstated and is so misleading to the reader of the report, the State respectfully requests that it be removed from the final audit report.

The auditors used statistical software to appraise the sample results to arrive at the estimated overpayment for all Medicaid payments in the sample frame during calendar years 2006 through 2008. The software produced three estimates of overpayment: Lower Limit (smallest amount), Point Estimate (middle amount) and Upper Limit (highest amount). For the draft report, the auditors used the Point Estimate amount of $76,738,116. The use of the Point Estimate amount is inappropriate, one reason being the auditors consistently use the Lower Limit to determine overpayments. The following fully explains why using the Point Estimate is inappropriate.

Appendix C of the draft report provides detailed information regarding the statistical sampling methodology, and Appendix D of the draft report states the audit results for the sample items. [1] It also states estimates of the value of unallowable services, which is arrived at by using statistical software to appraise the sample results. The software provides a confidence interval (three estimates) that can be used for the estimated disallowance. The following from Appendix D of the report states the range of a 90% confidence interval:

| | |
|---|---|
| (Limits calculated for 90 percent confidence interval) | Point Estimate $76,817,444<br>Lower Limit ($12,542,223)<br>Upper Limit $166,177,111 |

Note: This means that HHS OIG is 90% confident that the true errors in the population are between $166 million and negative $12 million.

The issue of determining overpayment from statistical samples in CMS audits is discussed in a variety of OIG and CMS documents. According to the OIG Medicare Program Integrity Manual, a reasonable recovery is the lower limit of a one-sided 90 percent confidence interval:

> In most situations the lower limit of a one-sided 90 percent confidence interval shall be used as the amount of overpayment to be demanded for recovery from the provider or supplier. The details of the calculation of this lower limit involve subtracting some multiple of the estimated standard error from the point estimate, thus yielding a lower figure. This procedure, which, through confidence interval estimation, incorporates

[1]

| Strata | Beneficiary-Months in Frame | Value of Frame | Sample Size | Value of Sample | No. of Beneficiary-Months With Unallowable Services | Value of Unallowable Services |
|---|---|---|---|---|---|---|
| 1 | 1,376,288 | $5,374,651,225 | 100 | $353,683 | 15 | $5,576 |
| 2 | 37 | $821,183 | 37 | $821,183 | 22 | $73,752 |
| Total | 1,376,325 | $5,375,472,408 | 137 | $1,174,866 | 37 | $79,328 |

> the uncertainty inherent in the sample design, is a conservative method that works to the financial advantage of the provider or supplier. That is, it yields a demand amount for recovery that is very likely less than the true amount of overpayment, and it allows a reasonable recovery without requiring the tight precision that might be needed to support a demand for the point estimate. However, the PSC or ZPIC BI unit or the contractor MR unit is not precluded from demanding the point estimate where high precision has been achieved.
>
> Medicare Program Integrity Manual, section 8.4.5 - Calculating the Estimated Overpayment.

Recovery should be equated to the lower limit of a two sided 90% confidence interval, unless the estimate has high precision, e.g. interval half width divided by the point estimate of four or five percent or less. However, in this audit, the interval half width divided by the point estimate is not in the neighborhood of four or five percent, it is one hundred and sixteen percent. Therefore, using OIG guidelines, recovery in this audit should not be equated to the point estimate.

For this reason, the Departmental Appeals Board has rejected CMS's use of a point estimate, *see, e.g., FY 1981 Medicaid Quality Control Disallowances,* DAB No. 1332 (1992). Instead, "the Board has repeatedly concluded that a result . . . that is based on the lower limit of a two-sided 90% confidence interval . . . [is] an appropriate basis for disallowing [Medicaid] funds." *Puerto Rico Dept. of Health,* DAB No. 2385 (2011), *citing Pennsylvania Dept. of Public Welfare,* DAB No. 1508 (1995); *Oklahoma Dept. of Human Servs.*, DAB No. 1436 (1993); *New York State Dept. of Social Services*, DAB No. 1358 (1992); *Pennsylvania Dept. of Public Welfare*, DAB No. 1278 (1991); *California Dept. of Social Services*, DAB No. 816 (1986).

It is clear that the estimated recovery amount should not be set at the Point Estimate confidence limit.

Using the Point Estimate in this audit is also inequitable. OIG auditors consistently use the lower limit to estimate overpayments in audits of other providers (as well as in other NYS audits), and to use a different standard for the State in this audit violates the principle that auditees should be treated in a consistent manner.

Finally, it is inexplicable that the estimated disallowance should increase because the error rate in the sample decreased. At the exit conference in March 2012, the auditors stated that the amount to be refunded, based on the review of the sample beneficiary months, was $89,859 and the estimated overpayment was $5.9 million, based on the Lower Limit. The State submitted additional documentation, which was accepted by the auditors and which reduced the amount to be refunded to $79,328. In return for these efforts, the State is now facing a higher estimated disallowance. The fact that the Lower Limit amount is now negative (as a result of the documentation provided by the State and accepted by the auditors) does not necessitate the use of the Point Estimate.

The Department would be happy to discuss our concerns and the audit results with CMS to determine an appropriate amount of overpayment.

**Recommendation #3:**

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

**Response #3:**

The Department and the OPWDD concur and will work together with CMS to strengthen policies and procedures.

.