EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security 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. In New York State, the Department of Health (DOH) administers the Medicaid program and coordinates the use of Medicaid by agencies that deliver services, such as the New York State Office for People With Developmental Disabilities (OPWDD). As part of this responsibility, OPWDD conducts audits and reviews of various providers of Medicaid reimbursable services. These audits and reviews are conducted to determine if the provider complied with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR)].

AUTHORITY, PURPOSE AND SCOPE

Audits and investigations of OPWDD's Medicaid-funded programs and services are conducted under the auspices of Public Health Law and Mental Hygiene Law. OPWDD's Office of Audit Services, Bureau of Compliance Management conducted this audit under the authority afforded OPWDD's Commissioner per Sections 16.11 and 43.02 of New York State Mental Hygiene Law and 14 NYCRR Section 635-4.6.

OPWDD reviewed Agency Name's (Agency's) documentation to support Home and Community Based Services (HCBS) waiver services provided during the audit period Month X, 20XX, through Month XX, 20XX. For the audit period, the Agency received $X,XXX,XXX.XX in Medicaid payments for waiver services.

SUMMARY OF FINDINGS

TEMPLATE NOTE – If applicable, insert a summary of internal control major findings

The Agency received payment for certain OPWDD HCBS waiver services which lacked proper documentation to support those services per regulatory requirements. Of the XXX beneficiary months in the random sample, XXX beneficiary months had claims for payment that were not in compliance with regulatory requirements.

Of the XXX beneficiary months for which the Agency improperly claimed Medicaid reimbursement, the following were the major categories of errors:

- for XXX beneficiary months (XXX claims), there is a missing or inadequate individualized service plan (ISP);
- for XXX beneficiary months (XXX claims), there is a missing or inadequate habilitation plan;
- for XXX beneficiary months (XXX claims), there was an improper billing (i.e., improper rate code, duration or units of service);
- for XXX beneficiary months (XXX claims), the record does not document that a service was provided;

- for XXX beneficiary months (XXX claims), there is missing or inadequate service documentation;
- for XX beneficiary months (XXX claims), services were provided by an ineligible provider;
- for XX beneficiary months (XXX claims), the provider could not provide documentation supporting a determination of a developmental disability for the individual receiving services; and,
- for XX beneficiary months (XXX claims), services were not provided by qualified staff.

Of the XXX claims in the random sample, XXX claims (or xx%) were not in compliance with regulatory requirements. The distribution of failed claims, by service, is as follows:

Waiver Service Type	Value of Claims in Sample	Value not in Compliance	Error Rates (Value)	# of Claims in Sample	# of Claims not in Compliance	Error Rates (Claims)
Insert Name of Service	$XXX,XXX.XX	$XX,XXX.XX	XX%	XXX	XXX	XX%
Insert Name of Service	XXX,XXX.XX	XX,XXX.XX	XX%	XXX	XXX	XX%
Insert Name of Service	XXX,XXX.XX	XX,XXX.XX	XX%	XXX	XXX	XX%
Total	**$X,XXX,XXX.XX**	**$XX,XXX.XX**	**XX%**	**XXX**	**XXX**	**XX%**

Based on the procedures performed, OPWDD has determined, on a preliminary basis, that the Agency was overpaid $XXX,XXX.XX in sample overpayments with an extrapolated adjusted point estimate of $XXX,XXX. The adjusted lower confidence limit of the amount overpaid is $XXX,XXX.

In addition, the Agency received $XXX,XXX.XX in overpayments for the small service sample (not subject to extrapolation). Therefore, the adjusted point estimate amount is $XXX,XXX and the adjusted lower confidence limit is $XXX,XXX, both of which include the small service overpayment of $XXX,XXX.XX.

OPWDD is 95% certain that the actual amount of the overpayment is greater than the adjusted lower confidence limit.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security 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.

New York State's Medicaid Program

In New York State, the Department of Health (DOH) is the single State agency responsible for operating the Medicaid program. The Office of the Medicaid Inspector General (OMIG) is an independent office within the Department of Health and OMIG is responsible for the investigation, detection and prevention of Medicaid fraud, waste and abuse, including sanctioning providers and recovering overpayments in the Medicaid program. The Office for People With Developmental Disabilities (OPWDD) is the agency responsible for developing and overseeing services provided to people with developmental disabilities.

New York State's HCBS Waiver Program

Pursuant to Section 1915(c) of the Social Security Act, OPWDD has been authorized to implement a Home and Community Based Services (HCBS) waiver program. This program permits OPWDD to develop an array of home and community based services that assist individuals to live in the community and avoid more restrictive institutional-based settings. HCBS waiver services are uniquely tailored and individualized to meet each person's needs and may include residential services, day services, respite care, employment support, service coordination, and adaptive technologies, as well as a variety of self-directed services.

Audits and investigations of OPWDD's Medicaid-funded waiver programs and services are conducted under the auspices of Public Health Law and Mental Hygiene Law. OPWDD conducted this audit under the authority afforded OPWDD's Commissioner per Sections 16.11 and 43.02 of New York State Mental Hygiene Law and Title 14 NYCRR Section 635-4.6.

Agency Background

Agency Name (Agency) provided the following Medicaid-funded HCBS waiver services during OPWDD's audit period: List Waiver Services. (Please Capitalize the First Letter of each word of the Waiver Service – delete after completed)

The Agency's financial position and operating results for the last three years, for which financial statements were provided by the Agency's certified public accountants during OPWDD's fieldwork, are as follows:

	Year 20xx	Year 20xx	Year 20xx
Current Assets	$	$	$
Current Liabilities	$	$	$
Working Capital	$	$	$
Current Ratio	: 1	: 1	: 1

Net Assets	$	$	$

Total Income	$	$	$
Total Expenses	$	$	$
Operating Income	$	$	$

Other Additions	$	$	$
Other Subtractions	$	$	$
Change in Net Assets	$	$	$

PURPOSE, SCOPE, AND METHODOLOGY

Purpose

The purpose of this audit was to review a sample of the Agency's Medicaid-funded billings for HCBS waiver services, by beneficiary month (i.e., all claims for Medicaid-funded HCBS waiver services provided by the Agency to one individual for one month), and to verify that:

- the Agency complied with applicable regulatory requirements governing the New York State Medicaid Program;
- the Agency maintains an adequate internal control structure;
- Medicaid reimbursable services were rendered for the dates billed;
- appropriate rate or procedure codes were billed for services rendered; and,
- the Agency maintained appropriate documentation required by the regulations.

Scope

The audit period covered OPWDD Medicaid-funded HCBS waiver services provided by the Agency from Month X, 20XX, through Month XX, 20XX. The audit universe consisted of XX beneficiary months comprised of XXX,XXX claims totaling $XXX,XXX.XX. OPWDD reviewed supporting documentation for all claims associated with the XX beneficiary months in the random sample.

OPWDD separately reviewed a random sample of INSERT NAME OF SERVICE(s) claims that were not included in the population above as this/these service(s) totaled less than $10,000 (each) for the scope of the audit. The NAME OF SERVICE population included a total of XXX claims valued at $XXX,XXX.XX.

Internal controls were evaluated for the audit period and through the last day of fieldwork (Month XX, 20XX – Findings Meeting).

Methodology

OPWDD adheres to professional audit standards, which require that it plans and performs its audit to obtain sufficient, appropriate evidence that provides a reasonable basis for its findings and conclusions. To achieve its objectives, OPWDD:

- reviewed applicable federal and state laws, regulations, rules and policies;

- interviewed Agency officials to obtain an understanding of the policies, procedures and other documentation relative to OPWDD's audit scope. OPWDD evaluated the internal control structure for each program described by Agency officials to assess the degree to which controls, if properly applied and regularly monitored, provide reasonable assurance as to the appropriateness of the billing transaction;

- identified a population of claims from the Medicaid Information Service Center of New York (MISCNY) Medicaid Data Warehouse (MDW) for the scope of its audit;

- selected a statistically valid random sample of beneficiary months for review;

- reviewed documentation to support service provision for all services in the random sample of beneficiary months against criteria established in rules, regulations and administrative memoranda; and,

- estimated the overpayments in the population using the results from the beneficiary months reviewed.

LAWS, REGULATIONS, RULES AND POLICIES

The following are applicable Laws, Regulations, Rules and Policies of the Medicaid program referenced when conducting this audit:

- Departments of Health, Mental Hygiene and Social Services [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)].

- Medicaid Management Information Provider Manuals.

- Specifically, Title 18 NYCRR Section 540.6, 14 NYCRR Section 635-4.6, and OPWDD Administrative Memoranda (List Memoranda, such as #2002-01, #2010-05).

- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

  "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department." *18 NYCRR Section 504.3*

  "Fee-for-service providers. (1) All providers … must prepare and maintain contemporaneous records demonstrating their right to receive payment . . . All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor … must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department … for audit and review." *18 NYCRR Section 517.3(b)*

  "All bills for medical care, services and supplies shall contain: (1) patient name, case number and date of service; (2) itemization of the volume and specific types of care, services and supplies provided (including for a physician, his final diagnosis, and for drugs, the prescription filled); (3) the unit price and total cost of the care, services and supplies provided; . . . and (8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing; . . . that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment; . . . and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided...." *18 NYCRR Section 540.7(a)(1)-(3) and (8)*

“An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.” *18 NYCRR Section 518.1(c)*

“Vendor payments for medical care and other items of medical assistance shall not be made unless such care or other items of assistance have been furnished on the basis of the appropriate authorization prescribed by the rules of the board and regulations of the department.” *18 NYCRR Section 540.1*

“The department may require repayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim.” *18 NYCRR Section 518.3(a)*

“The department may require repayment for inappropriate, improper, unnecessary or excessive care, services or supplies from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished….” *18 NYCRR Section 518.3(b)*

“Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client’s medical record.” *18 NYCRR Section 518.3(b)*

ANALYSIS OF INTERNAL CONTROLS

OPWDD adheres to professional audit standards which require that it obtains an understanding of internal controls and reports deficiencies that are significant within the context of the audit objectives and based upon the audit work performed.

OPWDD utilized the internal control framework issued by the Committee of Sponsoring Organizations (COSO) of the United States Treadway Commission. The COSO framework includes 5 elements (see below) related to an organization's internal control structure. COSO describes a "synergy and linkage among these components, forming an integrated system that reacts dynamically to changing conditions."

1. Risk Assessment – An assessment of risk, and an evaluation of control to mitigate those risks, are essential to any organization to maximize its opportunities for success, management of risks and minimize the impact of negative events should they occur.

2. Control Activities - Control activities are the policies and procedures that help ensure management directives are carried out and organizational risks are minimized. Policies and procedures are essential for achieving control objectives in any organizational endeavor.

3. Information and Communication – The Agency needs to identify pertinent and adequate information, and capture and communicate that information, in a form and timeframe that enables people to carry out their responsibilities. Accordingly, information systems should be able to produce reports using that information, making it possible to run and control the Agency in the most effective and efficient manner.

4. Monitoring – An internal control structure cannot work properly without adequate monitoring. Monitoring is needed to evaluate an internal control system's performance over time and in a continuum.

5. Control Environment – The control environment is the sum of management's support for all other components of internal control, providing discipline and structure. Control environment factors include the integrity, ethical values and competence of the entity's people; management's philosophy and operating style; the way management assigns authority and responsibility and organizes and develops its people; and the attention and direction provided by the board of directors.

OPWDD focused primarily on the internal control structure for HCBS waiver billings. OPWDD interviewed Agency officials to obtain an understanding of the policies, procedures and other documentation relative to OPWDD's audit scope; and then, assessed each (unique) control structure by type of waiver service. Our review also addressed broader, enterprise-type controls that impact the control structure for waiver billings.

The following deficiencies were noted:

INSERT DEFICIENCIES:

INSERT RECOMMENDATIONS BASED ON THOSE DEFICIENCIES:

AUDIT FINDINGS DETAIL

The XXX beneficiary months in the random sample represented a total of XXX,XXX claims for Medicaid-funded HCBS waiver services with a value of $XXX,XXX.XX. OPWDD identified a total of XXX,XXX claims with errors in XXX beneficiary months. The value of identified errors is $XXX,XXX.XX (see Attachments D and E).

The following identifies the main categories of errors identified during the audit; the associated criteria from regulations/administrative guidance; the number of exceptions found related to the regulations/administrative guidance; and, identification of the associated beneficiary months by sample number.

1. **INSERT MAJOR CATEGORY OF ERROR (i.e., from 8 major categories of errors)**

   a. Insert sub-category of error – service specific (from protocol and/or detailed findings sheet)

   CRITERIA
   Cite applicable regulation/ADM – Look for regulatory reference listed with protocol criteria and/or detailed findings tool.

   CONDITION

   e.g., For 4 beneficiary months (10 failed claims), the habilitation plan was missing the name of the habilitation service provider.

   CAUSE

   This finding applies to beneficiary month # X; failed claim # X OR if the finding applies to beneficiary months, it should read: This finding applies to beneficiary month #s X, X, and X; failed claim #s X, X, and X (FAILED CLAIM NUMBERS MUST BE WRITTEN IN THE FORMAT OF 1, 2, 3, 4, 5; **NOT 1-5)**.

   The dollar disallowance associated with this finding was not used in the extrapolation. However, this does not apply if an extrapolated finding was also identified for the sampled claim. **DELETE IF NOT APPROPRIATE.**

   b. Insert sub-category of error – service specific (from protocol and/or detailed findings sheet)

   CRITERIA
   Cite applicable regulation/ADM – Look for regulatory reference listed with protocol criteria and/or detailed findings tool.

   CONDITION

   e.g., For 4 beneficiary months (10 failed claims), the habilitation plan was missing the name of the habilitation service provider.

   CAUSE

   This finding applies to beneficiary month # X; failed claim # X OR if the finding applies to beneficiary months, it should read: This finding applies to beneficiary month #s X, X, and X; failed claim #s X, X, and X (FAILED CLAIM NUMBERS MUST BE WRITTEN IN THE FORMAT OF 1, 2, 3, 4, 5; **NOT 1-5)**.

The dollar disallowance associated with this finding was not used in the extrapolation. However, this does not apply if an extrapolated finding was also identified for the sampled claim. **DELETE IF NOT APPROPRIATE.**

2. INSERT MAJOR CATEGORY OF ERROR

a. Insert sub-category of error – service specific (from protocol and/or detailed findings sheet

CRITERIA
Cite applicable regulation/ADM – Look for regulatory reference listed with protocol criteria and/or detailed findings tool.

CONDITION

e.g., For 4 beneficiary months (10 failed claims), the habilitation plan was missing the name of the habilitation service provider.

CAUSE

This finding applies to beneficiary month # X; failed claim # X OR if the finding applies to beneficiary months, it should read: This finding applies to beneficiary month #s X, X, and X; failed claim #s X, X, and X.

The dollar disallowance associated with this finding was not used in the extrapolation. However, this does not apply if an extrapolated finding was also identified for the sampled claim. **DELETE IF NOT APPROPRIATE.**

Recommendation #XX: INSERT RECOMMENDATION.

AUDIT FINDINGS DETAIL - SMALL SERVICE

OPWDD reviewed XX claims from the small service population(s) (XX claims for Name of Service and XX claims for Name of Service). A total of XX claims valued at $XXX,XXX.XX were found to be in error for the following reasons:

1. **INSERT MAJOR CATEGORY OF ERROR (i.e. from 8 major categories of errors)**

   a. Insert sub-category of error – service specific (from protocol and/or detailed findings sheet)

   CRITERIA
   Cite applicable regulation/ADM – Look for regulatory reference listed with protocol criteria and/or detailed findings tool.

   CONDITION

   e.g., For 4 beneficiary months (10 failed claims), the habilitation plan was missing the name of the habilitation service provider.

   CAUSE

   This finding applies to beneficiary month # X; failed claim # X OR if the finding applies to beneficiary months, it should read: This finding applies to beneficiary month #s X, X, and X; failed claim #s X, X, and X (FAILED CLAIM NUMBERS MUST BE WRITTEN IN THE FORMAT OF 1, 2, 3, 4, 5; **NOT 1-5)**.

AUDIT FINDINGS DETAIL - ADDITIONAL COMPLIANCE TESTING

In addition to the random sample of beneficiary months, OPWDD separately reviewed a small sample of NAME OF SERVICE claims as they did not appear in the random sample. To ensure adequate review of all services provided by the Agency, OPWDD selected XX claims for compliance testing only (i.e., no errors will be subject to recovery for these claims as they were included in the universe population). OPWDD noted the areas for improvement as XX out of XX claims had errors (please note XX claims had more than one type of error).

CONTRIBUTORS TO THE REPORT

Mr. FIRST LAST NAME, Audit Director
Mr. FIRST LAST NAME, Deputy Director
List Other Contributors
NAME, Audit Supervisor
NAME, Auditor-In-Charge
NAME, Audit Staff
NAME, Quality Assurance

OFFICE OF AUDIT SERVICES
BUREAU OF COMPLIANCE MANAGEMENT
44 HOLLAND AVE 3rd FLOOR
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518-473-2100

AGENCY RIGHTS

Pursuant to State regulations, the Agency may submit additional documentation and written arguments in objection to this determination and proposed action. If any response will be submitted to OPWDD, the Agency's submission must be sent to the following address within 30 days of receipt of this Draft Audit Report. Receipt of this notice is presumed to be five days after the date of this Draft Audit Report.

ADMIN ASSISTANT
Office for People With Developmental Disabilities
Office of Audit Services, XX Floor
44 Holland Avenue
Albany, New York 12229

The Agency's objections must include a written statement detailing the specific items in this Draft Audit Report to which the Agency objects, and include any additional material or documentation that the Agency wishes to be considered in support of the objections. After a review of the Agency's objections and documentation to this Draft Audit Report, the OMIG will notify the Agency of our final determination. Issues raised at an administrative hearing will be limited to those contained in your objections. Your failure to submit, in a timely manner, documentation or written arguments in objection to this Draft Audit Report, may, at the sole discretion of the OMIG's audit staff, result in the issuance of this Draft Audit Report as the Final Agency Action.

This audit may be settled through repayment of the adjusted lower confidence limit of $XXX,XXX. Settling at the lower confidence limit will eliminate the need for an administrative action where the OMIG would seek and defend the adjusted point estimate of $XXX,XXX. The Final Audit Report will advise you of the repayment options and instructions.

Do not submit claim voids in response to this Draft Audit Report.

SAMPLING METHODOLOGY

Sampling based audits commence with a request from OPWDD auditors to OPWDD's Data Analysis, Support and Planning Unit for a listing of Agency claims and respective beneficiary months for the audit scope.

All Medicaid electronic claims payment records are maintained by the Department of Health's fiscal agency, General Dynamics Information Technology (GDIT), in the Medicaid Management Information System (MMIS) and are accessible to OPWDD in what is known as the "data warehouse" or "Datamart." The data warehouse or Datamart contains records of all Medicaid claims submitted by an agency. Depending on the type of claim or service OPWDD identifies for audit, a request or "query" is made of the system and a database is generated of claims submitted by a specific provider.

The Data Analysis, Support and Planning Unit extracts a universe of claims from the data warehouse based on specifications established by OPWDD's Office of Audit Services (Audit Services). The Data Analysis, Support and Planning Unit then summarizes claim detail by beneficiary month.

OPWDD contracts with the consulting firm, Karl Heiner Statistical Consulting (KHSC) to independently generate random samples; perform extrapolations of errors to the populations and provide expert technical advice. Dr. Heiner has a doctorate in Applied Statistics and has over 27 years of experience in conducting statistical reviews of Medicaid providers.

OPWDD provides the population of beneficiary months to the statistician who analyzes the population and develops an appropriate stratification from which to draw random samples. Random samples are drawn by the statistician using the 'RandomSample' function in *Mathematica*. This function requires strata sizes and strata sample sizes in order to generate random indices which are then applied to the population sampling frame. *Mathematica* reads the computer's clock and the time is utilized to select the "seed" used by the 'RandomSample' function as the starting point for generating random numbers. The seed is documented for future re-performance if required.

Mathematica then conducts a series of statistical tests on the resulting sample to test for apparent randomness. If the sample does not pass the randomness tests, the process starts over. If the sample passes the randomness tests the random sample of beneficiary months is provided to OPWDD. OPWDD then matches the randomly selected beneficiary months to the listing of claims and provides the resulting sample claims to the auditors for review.

Audit staff review documentation supporting the sample claims and identify and record findings of disallowed claims, if any. The disallowed amounts in the sample are then extrapolated over the population from which the sample was drawn to arrive at an estimate of the mean dollars in error which is reported in the Draft Audit Report. OPWDD may also calculate the lower confidence limit for a given confidence level and report this information in the Draft Audit Report.

The auditors consider all responses from an agency for each finding associated with each sample. If a finding(s) is eliminated based on an Agency's response, audit staff record the remaining findings associated with that sample. Any sample with one or more findings remaining is disallowed on audit. Extrapolations are recalculated as necessary. As a result of this, agencies should respond to each category of disallowance identified for each sample in an audit.

In cases where there is more than one category of disallowance, a single sample will only be disallowed once in each audit. Samples are disallowed and extrapolated based on a hierarchy of priorities. Full disallowances are given first priority in extrapolating; findings which result in a partial disallowance are given second priority in extrapolating; and findings which are not extrapolated are given third priority in the extrapolation process.

ATTACHMENT A - SAMPLE DESIGN

OPWDD analyzed the population to determine the service types the Agency provided during its scope. If a particular service totaled less than $10,000 for the audit period (small service), those claims were removed from the population because, from a statistical standpoint, these services may not be represented in a randomized sample. The Agency did not have any services that met this criterion. **OR** Name of Service met this criterion and the following claims were removed from the beneficiary month population for separate sampling.

Waiver Service Type	Sum of Claims	# of Claims	Value of Claims in Random Sample	# of Claims in Random Sample
Name of Service	$XXX,XXX.XX	XX	$XXX,XXX.XX	XX
Total	**$XXX,XXX.XX**	**XX**	**$XXX,XXX.XX**	**XX**

From the remaining population OPWDD aggregated claims data into "beneficiary months". A beneficiary month is defined as all Medicaid-funded HCBS waiver services provided by the Agency for one beneficiary for one month.

- Per the Medicaid Data Warehouse, the population included XXX beneficiary months, and was comprised of XXX,XXX claims with a value of $XXX,XXX.XX.
- The above population excludes beneficiary months/claims under the following conditions:
  - Beneficiary months with Medicaid payments totaling less than $100;
  - Any Beneficiary months that were subject to a review of the Individualized Service Plan (ISP) by the Department of Health (DOH); and
  - Any claims that were previously self-disclosed to the Office of the Medicaid Inspector General (OMIG).

After obtaining its data, OPWDD then:

- had its statistician generate a stratified random sample of XXX beneficiary months from the Medicaid Data Warehouse for detailed testing;
- reviewed the documentation provided by the Agency in support of each claim in the random sample(s) of beneficiary months to ensure compliance with the applicable requirements; and,
- had its statistician extrapolate claims in error over the population to arrive at the mean dollars in error using a 90% confidence interval.

The Agency received Medicaid payments for the following HCBS waiver services during the audit scope:

Waiver Service Type	Sum of Claims	# of Claims	Value of Claims in Random Sample	# of Claims in Random Sample
Name of Service	$XXX,XXX.XX	XXX	$XXX,XXX.XX	XXX

Total	**$XXX,XXX.XX**	**XXX**	**$XXX,XXX.XX**	**XXX**

ATTACHMENT B - STATISTICAL PROJECTIONS

ATTACHMENT B: STATISTICAL PROJECTIONS (Continued)

ATTACHMENT C - RESPONDING TO OPWDD RECOMMENDATIONS

Please prepare a written response which clearly indicates whether the Agency agrees or disagrees with the findings and recommendations in the report. The Agency's response will be included in the Final Audit Report. Portions of the Agency response containing protected health information (PHI) should be identified as such (by the Agency) and will not be included in the Final Audit Report. In addition to your response, please complete and sign the management representation letter provided to you at the beginning of our engagement, which is part of OPWDD's standard process.

Your response along with the management representation letter must be sent to the following within 30 days of receipt of this correspondence to be considered in the development of the Final Audit Report. Your failure to respond or your response is without sufficient detail (i.e., not in the form and format prescribed) may result in the issuance of this Draft Audit Report as our Final Audit Report.

ADMIN ASSISTANT
Office for People With Developmental Disabilities
Office of Audit Services
44 Holland Avenue, XX Floor
Albany, New York 12229

In your response, please restate each recommendation and:

- Where you agree, please write "Agree" and provide:
    - What corrective actions your Agency will take;
    - Who (by title) will be responsible for implementing those measures; and,
    - When the implementation of corrective actions will be complete.

- If you disagree with any findings or recommendations, please write "Disagree" following the restatement of the particular finding or recommendation. This will be deemed an objection to that finding or recommendation.