Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK CLAIMED SOME UNALLOWABLE COSTS FOR ASSISTIVE TECHNOLOGY SERVICES UNDER THE STATE'S DEVELOPMENTAL DISABILITIES WAIVER PROGRAM

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Deputy Inspector General

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Office of Inspector General

https://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

New York State claimed at least $1.8 million in Federal Medicaid reimbursement for assistive technology services that were unallowable over a 3-year period.

WHY WE DID THIS REVIEW

New York State's Office for People with Developmental Disabilities (OPWDD) waiver program provides Medicaid assistive technology services (e.g., wheelchair ramp installations) through contractors' solicited bids. A previous Office of Inspector General review of other OPWDD waiver program services identified unallowable Federal reimbursements. Thus, we audited assistive technology services in this review.

The objective of this review was to determine whether the New York State Department of Health (State agency) claimed Medicaid reimbursement for assistive technology services that complied with certain Federal and State requirements.

BACKGROUND

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

In New York State, the State agency administers the Medicaid program. Under a memorandum of understanding with the State agency, OPWDD administers the State's developmental disabilities HCBS waiver program, which covers a variety of services, including assistive technology services tailored to enable individuals to increase or maintain the ability to live independently and safely at home or in the community.

Payments for assistive technology services are arranged through contracts between OPWDD and a contractor, which may include a person enrolled in the waiver program, an advocate, a nonprofit agency, or a family care provider. According to OPWDD waiver program guidance, contractors obtain assistive technology services from vendors through solicited bids. OPWDD pays the contractors directly with State funds before submitting claims for the services to the State agency for Federal reimbursement.

HOW WE CONDUCTED THIS REVIEW

For the period 2006 through 2008, the State agency claimed approximately $15.5 million (Federal share) for 5,236 payments for assistive technology services. We reviewed a stratified random sample of 137 of these payments. A payment includes all claims paid for one beneficiary on a given date of service or contract closeout date.

WHAT WE FOUND

The State agency claimed Federal Medicaid reimbursement for some assistive technology services that did not comply with certain Federal and State requirements. Of the 137 payments in our random sample, the State agency properly claimed Medicaid reimbursement for 93 payments. However, for the remaining 44 payments, the State agency claimed Medicaid reimbursement for services that were unallowable or potentially unallowable. Specifically, 39 payments were for services that did not comply with certain Federal and State requirements, and for 5 payments, we could not determine whether the services complied with Federal and State requirements.

Of the 39 payments for which the State agency improperly claimed Federal reimbursement, 2 payments contained more than 1 deficiency:

- For 31 payments, the State agency claimed reimbursement for services that were not provided pursuant to a written plan of care.

- For four payments, the State agency claimed reimbursement for services not covered under the waiver program.

- For three payments, the State agency claimed reimbursement for which the costs of services were improperly allocated to the waiver program.

- For two payments, the State agency claimed reimbursement for services that were not provided.

- For one payment, the State agency claimed reimbursement for services that were not supported by adequate documentation.

For the remaining five payments, the State agency issued a payment voucher to the contractor; however, we could not verify the amount that the contractor paid to the vendor that performed the services.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $1,807,255 in Federal Medicaid reimbursement for assistive technology services that were unallowable. In addition, the State agency claimed $10,497 in Federal Medicaid reimbursement for a portion of five payments for assistive technology services that may not have complied with Federal and State requirements.

The claims for unallowable and potentially unallowable services were made because the State agency's and OPWDD's policies and procedures for overseeing and administering payments for assistive technology services did not adequately ensure that (1) services were provided only in accordance with written plans of care and (2) contractors properly claimed reimbursement for covered services and for services actually provided, maintained required documentation to support services billed, and properly allocated costs to the waiver program.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $1,807,255 to the Federal Government;

- work with CMS to resolve the portion of the five payments, totaling $10,497, for which the State agency may have claimed unallowable Federal Medicaid reimbursement and, if applicable, refund any unallowable amounts; and

- work with OPWDD to strengthen the agencies' policies and procedures for ensuring that (1) assistive technology services are provided only in accordance with written plans of care and (2) contractors properly claim reimbursement for covered services and for services actually provided, maintain required documentation to support services billed, and properly allocate costs to the waiver program.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our findings and recommendations and described the actions that it had taken or planned to take to address our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

New York State's Office for People with Developmental Disabilities (OPWDD) waiver program provides Medicaid assistive technology services (e.g., wheelchair ramp installations) through contractors' solicited bids. A previous Office of Inspector General review of other OPWDD waiver program services identified unallowable Federal reimbursements.[1] For example, we identified services that were not documented or provided pursuant to a written plan of care. Thus, we audited assistive technology services in this review.

OBJECTIVE

Our objective was to determine whether the New York State Department of Health (State agency) claimed Federal Medicaid reimbursement for assistive technology services that complied with certain Federal and State requirements.

BACKGROUND

The 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.

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.

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 State's developmental disabilities HCBS waiver program (the waiver program).[2] The waiver program has been in operation since State fiscal year 1992. On September 24, 2009, CMS approved the waiver program for a 5-year renewal period, through September 30, 2014.

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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).

[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, OMRDD was renamed the Office for People With Developmental Disabilities.

Assistive Technology Services

The waiver program covers a variety of services, including assistive technology services tailored to enable individuals to increase or maintain the ability to live independently and safely at home or in the community. Assistive technology services are provided in both State- and privately operated residences. Services are divided into two groups: environmental modifications and adaptive devices. Environmental modifications are modifications or adaptations to the person's home (e.g., installations of ramps and lifts) that address needs related to physical, behavioral, or sensory disabilities. Adaptive devices are aids, controls, appliances, or supplies of a communication or adaptive type (e.g., motorized wheelchairs and electronic speech devices) that assist the person in the performance of self-care, work, leisure activities, or physical exercise.

OPWDD pays contractors[3] to arrange for assistive technology services through individual vendors (e.g., construction companies, architects, and retailers). According to OPWDD waiver program guidance, contractors obtain assistive technology services from vendors through solicited bids. OPWDD pays the contractors directly with State funds before submitting claims for the services to the State agency for Federal reimbursement.

HOW WE CONDUCTED THIS REVIEW

For the period 2006 through 2008, the State agency claimed Federal reimbursement of approximately $15.5 million for 5,236 payments that it made to contractors for assistive technology services. We reviewed a stratified random sample of 137 of these payments. A payment is defined as all claims paid for one beneficiary on a given date of service or contract closeout date.

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

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

The State agency claimed Federal Medicaid reimbursement for some assistive technology services that did not comply with certain Federal and State requirements. Of the 137 payments in our random sample, the State agency properly claimed Medicaid reimbursement for 93 payments. However, for the remaining 44 payments, the State agency claimed Medicaid reimbursement for services that were unallowable or potentially unallowable. Specifically, 39 payments were for services that did not comply with certain Federal and State requirements, and for 5 payments, we could not determine whether the services complied with Federal and State requirements.

[3] A contractor may be a beneficiary, an advocate, a nonprofit agency, or a family care provider.

Of the 39 payments for which the State agency improperly claimed Federal reimbursement, 2 payments contained more than 1 deficiency:

- For 31 payments, the State agency claimed reimbursement for services that were not provided pursuant to a written plan of care.

- For four payments, the State agency claimed reimbursement for services not covered under the waiver program.

- For three payments, the State agency claimed reimbursement for which the costs of services were improperly allocated to the waiver program.

- For two payments, the State agency claimed reimbursement for services that were not provided.

- For one payment, the State agency claimed reimbursement for services that were not supported by adequate documentation.

For the remaining five payments, the State agency issued a payment voucher to the contractor; however, we could not verify the amount that the contractor paid to the vendor that performed the services.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $1,807,255 in Federal Medicaid reimbursement for assistive technology services that were unallowable. In addition, the State agency claimed $10,497 in Federal Medicaid reimbursement for a portion of five payments for assistive technology services that may not have complied with Federal and State requirements.

The claims for unallowable and potentially unallowable services were made because the State agency's and OPWDD's policies and procedures for overseeing and administering payments for assistive technology services did not adequately ensure that (1) services were provided only in accordance with written plans of care and (2) contractors properly claimed reimbursement for covered services and for services actually provided, maintained required documentation to support services billed, and properly allocated costs to the waiver program.

Appendix D contains a summary of deficiencies, if any, identified for each sampled payment.

SERVICES NOT PROVIDED IN ACCORDANCE WITH A WRITTEN PLAN OF CARE

Waiver program services must be provided only under a written plan of care subject to approval by the State Medicaid agency (section 1915(c)(1) of the Act and the State's waiver agreement with CMS). The plan of care must specify the services to be provided, their frequency, and the type of provider (section 4442.6 of the CMS *State Medicaid Manual*). No Federal Medicaid reimbursement is available for waiver program services furnished without a written plan of care.

For 31 of the 137 sampled payments, the State agency claimed reimbursement for assistive technology services (including vehicle, kitchen, and bathroom modifications and fire alarm and sprinkler system installations) that were not provided pursuant to a written plan of care. Specifically, for 30 payments, the State agency claimed reimbursement for services that were not listed on the beneficiary's plan of care prior to being furnished. For the remaining payment, OPWDD could not provide the plan of care that covered the sampled service period.

SERVICES NOT COVERED

Federal Medicaid reimbursement is available only for allowable expenditures made on behalf of eligible recipients for covered services (section 2497.1 of the CMS *State Medicaid Manual*). Within Federal requirements, waiver services include services as defined by the State agency and approved by CMS (42 CFR § 440.180(a)(1)). In defining environmental modifications as a waiver service, OPWDD guidance to its regional offices states that payments for additions to residential homes are prohibited. [4] The guidance also states that items required by local building codes are not eligible for reimbursement.

For 4 of the 137 sampled payments, the State agency claimed reimbursement for assistive technology services that were not covered under the waiver program. Specifically, for two payments, the State agency claimed reimbursement for architect fees for creating plans for the conversion of a garage into a bedroom, and for one payment, the State agency claimed reimbursement for the conversion of a garage into a bedroom. For the remaining payment, the State agency claimed reimbursement for the installation of a porch railing required by local building code.[5]

COSTS FOR SERVICES IMPROPERLY ALLOCATED TO WAIVER PROGRAM

In order to be allowable, a cost incurred under a Federal award must be reasonable, adequately supported, and allocable (2 CFR § 225, Appendix A, § C.1). A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received (2 CFR § 225, Appendix A, § C.3.a).

For 3 of the 137 sampled payments, the State agency claimed reimbursement for assistive technology services for which the cost of services was improperly allocated to the waiver program. Specifically, for two payments, the State agency claimed reimbursement under the waiver program for the entire cost of renovations to a residence that benefited both waiver- and non-waiver-enrolled beneficiaries. For the remaining payment, the claim amount exceeded the contractor's actual cost for the item purchased.

[4] NYS OMRDD Advisory Memorandum - Assistive Technology (Environmental Modifications and Adaptive Devices), dated May 20, 2005. According to the memorandum, a home addition is defined as any increase in the square footage of a home, any expansion beyond the existing footprint of the home, and construction of living space in a garage.

[5] Section R312.1 of the *Residential Code of New York State* (2006 edition) states that guards are required for open sides of stairways, porches, balconies, or raised floor surfaces more than 30 inches in height, except for open sides of a flight of stairs with a total rise of 30 inches or less, although handrails are still required when there are two or more risers.

SERVICES NOT PROVIDED

Federal Medicaid reimbursement is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers (section 2497.1 of the CMS *State Medicaid Manual*).

For 2 of the 137 sampled payments, the State agency claimed reimbursement for assistive technology services that were not provided to the beneficiary. Specifically, for one payment, the State agency claimed reimbursement for the installation of an automatic door opener that was not installed, and for the remaining payment, the State agency claimed reimbursement for modifications to a residence that the beneficiary did not move into.

SERVICES NOT DOCUMENTED

Medicaid providers must keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance (section 1902(a)(27) of the Act). Further, costs must be adequately documented to be allowable under Federal awards (2 CFR § 225, Appendix A, § C.1.j). Medicaid covers expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is immediately available when the claim is filed (section 2500.2 of the CMS *State Medicaid Manual*).[6]

For 1 of the 137 sampled payments, the State agency claimed reimbursement for assistive technology services for which the contractor or OPWDD could not provide documentation for payment to the vendor that provided the services.

POTENTIALLY UNALLOWABLE CLAIMS BECAUSE PAYMENT TO THE VENDOR WAS NOT DOCUMENTED

For 5 of the 137 sampled payments, the State agency issued a payment voucher to the contractor; however, we could not verify the amount paid by the contractor to the vendor that performed the services. We are setting aside a portion of these payments for resolution by CMS and the State agency to determine compliance with Federal and State reimbursement requirements.[7]

CONCLUSION

On the basis of our sample results, we estimated that the State agency improperly claimed at least $1,807,255 in Federal Medicaid reimbursement for assistive technology services that were unallowable. In addition, the State agency claimed $10,497 in Federal Medicaid reimbursement for assistive technology services that may not have complied with Federal and State requirements.

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[6] 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 place of service.

[7] The five payments totaled $64,860. Of this amount, we determined that $54,363 was allowable. We are setting aside the remaining portion of payments, totaling $10,497.

The claims for unallowable and potentially unallowable services were made because the State agency's and OPWDD's policies and procedures for overseeing and administering payments for assistive technology services did not adequately ensure that (1) services were provided only in accordance with written plans of care and (2) contractors properly claimed reimbursement for covered services and for services actually provided, maintained required documentation to support services billed, and properly allocated costs to the waiver program.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,807,255 to the Federal Government;

- work with CMS to resolve the portion of the five payments, totaling $10,497, for which the State agency may have claimed unallowable Federal Medicaid reimbursement and, if applicable, refund any unallowable amounts; and

- work with OPWDD to strengthen the agencies' policies and procedures for ensuring that (1) assistive technology services are provided only in accordance with written plans of care and (2) contractors properly claim reimbursement for covered services and for services actually provided, maintain required documentation to support services billed, and properly allocate costs to the waiver program.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our findings and recommendations and described the actions that it had taken or planned to take to address our recommendations.

The State agency's comments are included in their entirety as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed Medicaid payments to the State agency for assistive technology services during calendar years 2006 through 2008. For this period, the State agency claimed reimbursement of $15,517,290 (Federal share) for 5,236 payments for assistive technology services. We reviewed a stratified random sample of 137 of these payments totaling $1,191,602 (Federal share). A payment includes all claims paid for one beneficiary on a given date of service or contract closeout date.

We did not review the overall internal control structure of the State agency or OPWDD. Rather, we limited our review of internal controls to those applicable to our objective. We reviewed the State agency's and OPWDD's internal controls for documenting assistive technology services billed and claimed for reimbursement. We did not assess the appropriateness of assistive technology services contract amounts or terms.

We performed fieldwork at the State agency's offices in Albany, New York, and at beneficiaries' private residences, State- and nonprofit-operated group homes, and OPWDD's offices located throughout the State.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;

- held discussions with CMS officials to gain an understanding of CMS's waiver approval, administration, and assessment processes;

- held discussions with State agency and OPWDD officials to gain an understanding of how assistive technology services are provided under the OPWDD waiver program and to discuss the State's policies and procedures related to the administration of these services under the OPWDD waiver program;

- reconciled the OPWDD waiver program services that the State agency claimed for Federal reimbursement on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, to the payments for OPWDD waiver program services in the State's Medicaid Management Information System (MMIS) for the quarter January 1, 2008, through March 31, 2008;

- obtained from the State's MMIS a sampling frame of 5,236 payments totaling $30,346,023 ($15,517,290 Federal share) for which the State agency claimed reimbursement for assistive technology services provided during calendar years 2006 through 2008;

- selected from the sampling frame a stratified random sample of 137 payments and, for each payment, 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,
    - assistive technology services were provided pursuant to a written plan of care,
    - the services were covered under the waiver program,
    - the services were documented in accordance with Federal and State requirements, and
    - the costs were properly allocated to the waiver program; and
- estimated the unallowable Federal Medicaid reimbursement.

Appendix B contains the details of our statistical sampling methodology. Appendix C 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 objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of all payments for assistive technology services during calendar years 2006 through 2008 for which the State agency claimed Medicaid reimbursement. A payment is defined as all claims paid for one beneficiary on a given date of service or contract closeout date.

SAMPLING FRAME

The sampling frame was an Access file containing 5,236 payments for assistive technology services during calendar years 2006 through 2008 totaling $30,346,023 ($15,517,290 Federal share). The data for these payments were extracted from the State's MMIS.

SAMPLE UNIT

The sample unit was a payment for assistive technology services.

SAMPLE DESIGN

We used a stratified random sample. We separated the sampling frame into two strata as follows:

- stratum 1: payments with Federal share less than or equal to $20,000 = 5,199 payments totaling $28,472,170 ($14,563,426 Federal share).

- stratum 2: payments with Federal share greater than $20,000 = 37 payments totaling $1,873,853 ($953,864 Federal share).

SAMPLE SIZE

We selected a sample of 137 payments as follows:

- 100 payments from stratum 1 and

- 37 payments 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 payments in stratum 2.

ESTIMATION METHODOLOGY

We used the OAS statistical software to calculate our estimates. We used the lower limit of the 90-percent confidence interval to estimate the overpayment associated with the claims for unallowable assistive technology services.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Stratum	Payments in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Payments with Unallowable Services	Value of Unallowable Services (Federal Share)
1	5,199	$14,563,426	100	$237,738	23	$53,766
2	37	953,864	37	953,864	16	293,662
Total	**5,236**	**$15,517,290**	**137**	**$1,191,602**	**39**	**$347,428**

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

Point estimate	$3,088,942
Lower limit	1,807,255
Upper limit	4,370,628

APPENDIX D: SUMMARY OF DEFICIENCIES FOR EACH SAMPLED PAYMENT

Legend

1	Services not provided pursuant to a written plan of care
2	Services not covered
3	Costs for services improperly allocated to waiver program
4	Services not provided
5	Services not documented

Office of Inspector General Review Determinations for the 137 Sampled Payments

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

Sample Payment	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	No. of Deficiencies
32	X					1
33	X					1
34						
35	X					1
36						
37			X			1
38						
39	X					1
40						
41	X					1
42						
43						
44						
45						
46						
47						
48	X					1
49						
50						
51						
22						
53						
54						
55						
56						
57						
58	X					1
59						
60						
61						
62						
63						
64						
65						
66		X				1
67		X				1
68						
69						
70						
71						
72	X					1
73						
74						

Sample Payment	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	No. of Deficiencies
75						
76	X					1
77	X					1
78						
79						
80						
81						
82						
83						
84						
85	X					1
86						
87						
88						
89						
90						
91						
92						
93						
94						
95					X	1
96						
97						
98						
99						
100		X				1
101						
102						
103						
104						
105						
106	X					1
107						
108						
109						
110						
111	X					1
112						
113						
114						
115						
116						
117						

Sample Payment	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	No. of Deficiencies
118						
119						
120						
121						
122	X					1
123	X					1
124						
125						
126						
127						
128	X					1
129	X					1
130						
131	X					1
132			X			1
133						
134	X					1
135	X					1
136	X		X			2
137	X					1
Category Totals	31	4	3	2	1	41*
39 Payments With Deficiencies						

*Two claims contained more than one deficiency.

APPENDIX E: STATE AGENCY COMMENTS

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

October 25, 2013

Mr. James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of the Inspector General
Jacob Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Ref. No. A-02-10-0139

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 #A-02-10-0139 entitled, "New York Claimed Some Unallowable Costs for Assistive Technology Services 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
Diane Christensen
Lori Conway
Robert Loftus
Joan Kewley
Ronald Farrell
Brian Kiernan
Elizabeth Misa
OHIP Audit BML

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New York State Department of Health
Comments on the
US Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-10-01039 Entitled
New York Claimed Some Unallowable Costs for
Assistive Technology Services Under the State's
Developmental Disabilities Waiver Program

The following are the New York State Department of Health's (Department) comments in response to the US Department of Health and Human Services, Office of Inspector General's (OIG) draft audit report A-02-10-01039 entitled, "New York Claimed Some Unallowable Costs for Assistive Technology Services Under the State's Developmental Disabilities Waiver Program."

Recommendation #1:

We recommend that the State agency refund $1,807,255 to the Federal Government.

Response #1:

We agree with the finding and recommendation to refund the federal share of $1,807,255 to the Federal Government.

Recommendation #2:

We recommend that the State agency work with Centers for Medicare and Medicaid Services (CMS) to resolve the portion of the five payments, totaling $10,497, for which the State agency may have claimed unallowable Federal Medicaid reimbursement and if applicable, refund any unallowable amounts.

Response #2:

We agree with the finding and recommendation for the State agency to work with CMS to resolve the portion of the five payments, totaling $10,497, for which the State agency may have claimed unallowable Federal Medicaid reimbursement and if applicable, refund any unallowable amounts.

Recommendation #3:

We recommend that the State agency work with the Office for People with Developmental Disabilities (OPWDD) to strengthen the agencies' policies and procedures for ensuring that (1) assistive technology services are provided only in accordance with written plans of care and (2) contractors properly claim reimbursement for covered services and for services actually provided, maintain required documentation to support services billed, and properly allocate costs to the waiver program.

Response #3:

We agree with the finding and recommendation that DOH work with OPWDD to strengthen policies and procedures in all these areas, and will take appropriate actions. Regarding written plans of care, the vast majority of the audit findings pertained to issues with them. Please note that effective October 19, 2011 OPWDD no longer funded assistive technology services under the home and community-based services (HCBS) waiver for certified individualized residential alternative (IRA) residences. As a result, this will significantly reduce the amount of services provided as well as the likeliness of a problem with plans of care recurring, as the problems found were mostly with individuals in an IRA residence. Even so, OPWDD has taken action and will continue to take corrective action. Guidance was issued related to procedures for review, approval, development and payment for an HCBS Assistive Technology Contract in August 2008 and they were updated in January 2009. In September 2013, OPWDD's waiver unit implemented a statewide workgroup to review and update policies and procedures related to assistive technology services (this workgroup includes staff from various OPWDD offices) and guidance is also being developed for service coordinators related to assistive technology services and the justification that is necessary within each person's plan of care.