



**Office of the
Medicaid Inspector
General**

**NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL**

**REVIEW OF SHIRE AT CULVERTON ADULT HOME
CLAIMS FOR ASSISTED LIVING PROGRAM SERVICES
PAID FROM
JANUARY 1, 2010 – DECEMBER 31, 2012**

**FINAL AUDIT REPORT
AUDIT #: 14-1637**

**Dennis Rosen
Medicaid Inspector General**

June 23, 2015



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

June 23, 2015

[REDACTED]
DePaul Kenwell
3456 Delaware Avenue
Kenmore, New York 14217

Re: Final Audit Report
Audit #: 14-1637
Provider ID #: [REDACTED]
FEIN: [REDACTED]

Dear [REDACTED]

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Shire at Culverton Adult Home" (Provider) paid claims for Assisted Living Program services covering the period January 1, 2010, through December 31, 2012.

In the attached final audit report, the OMIG has detailed our scope, procedures, laws, regulations, rules and policies, sampling technique, findings, provider rights, and statistical analysis.

The OMIG has attached the sample detail for the paid claims determined to be in error. This final audit report incorporates consideration of any additional documentation and information presented in response to the draft audit report dated April 17, 2015. The mean point estimate overpaid is \$433,740. The lower confidence limit of the amount overpaid is \$166,420. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit. This audit may be settled through repayment of the lower confidence limit of \$166,420.

If the Provider has any questions or comments concerning this final audit report, please contact [REDACTED] at [REDACTED] or through email at [REDACTED]. Please refer to report number 14-1637 in all correspondence.

Sincerely,

[REDACTED]

Division of Medicaid Audit, Rochester
Office of the Medicaid Inspector General

[REDACTED]

Enclosure CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED

Cc: [REDACTED]

Enclosure CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED

[REDACTED]

Enclosure CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED

[REDACTED]

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.ny.gov

The mission of the Office of the Medicaid Inspector General (OMIG), as mandated by New York Public Health Law § 31 is to preserve the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds.

DIVISION OF MEDICAID AUDIT

The Division of Medicaid Audit professional staff conducts audits and reviews of Medicaid providers to assess compliance and program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; to assess the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and, to reduce the potential for fraud, waste and abuse.

DIVISION OF MEDICAID INVESTIGATIONS

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, penalties, and improves the quality of care for the state's most vulnerable population.

DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION

The Division of Technology and Business Automation will continue to support the data needs for the OMIG in the form of audit and investigative support, data mining and analysis, system match and recovery, through the use of commercial data mining products and procurement of expert service consultants.

OFFICE OF COUNSEL TO THE MEDICAID INSPECTOR GENERAL

The Office of Counsel to the Medicaid Inspector General promotes the OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel.

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. As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. 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] and the Medicaid Provider Manuals.

An Assisted Living Program ("ALP") is an entity approved to operate, pursuant to (18 NYCRR 485.6(n)), in adult homes and enriched housing programs. The ALP is established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care, supervision, and providing or arranging for home health services to five or more eligible residents unrelated to the operator (18 NYCRR 494.2). For each Medicaid enrollee participating in the ALP, a daily rate is paid to the ALP for the provision of nine distinct home care services. No additional fee-for-service billing can be made for these home care services.

Services covered under the daily Medicaid rate and for which no additional separate billing may be made include:

- Title XIX Personal Care Services
- Home Health Aide Services
- Personal Emergency Response Services
- Nursing Services
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical supplies and equipment not requiring prior approval
- Adult Day Health Care

PURPOSE AND SCOPE

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for Assisted Living Program services complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to Assisted Living Program claims, this audit covered services paid by Medicaid from January 1, 2010, through December 31, 2012.

SUMMARY OF FINDINGS

We inspected a random sample of 100 claims with \$42,913.36 in Medicaid payments. Of the 100 claims in our random sample, 13 claims had at least one error and did not comply with state requirements. Of the 13 noncompliant claims, some contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Missing Service Documentation	8
Missing Plan of Care	5
Missing Nursing/Functional/Social Assessment	4
Missing Patient Review Instrument (PRI)	2

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$6,343.09 in sample overpayments with an extrapolated point estimate of \$433,740. The lower confidence limit of the amount overpaid is \$166,420.

TABLE OF CONTENTS

	<u>PAGE</u>
INTRODUCTION.....	
Background	
Medicaid Program	1
New York State's Medicaid Program	1
New York State's Assisted Living Program	1
Purpose, Scope, and Methodology	
Purpose	2
Scope	2
Methodology	2
LAWS, REGULATIONS, RULES AND POLICIES.....	3-4
AUDIT FINDINGS.....	5
AUDIT FINDINGS DETAIL.....	6-8
PROVIDER RIGHTS.....	9-10
REMITTANCE ADVICE	
ATTACHMENTS:	
A – SAMPLE DESIGN	
B – SAMPLE RESULTS AND ESTIMATES	
C – DETAILED AUDIT FINDINGS	

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 State agency responsible for operating the Medicaid program. Within DOH, the Office of Health Insurance Programs administers the Medicaid program. DOH uses the electronic Medicaid New York Information system (eMedNY), a computerized payment and information reporting system, to process and pay Medicaid claims, including Assisted Living Program claims.

As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. 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] and the Medicaid Provider Manuals.

New York State's Assisted Living Program

An Assisted Living Program ("ALP") is an entity approved to operate, pursuant to (18 NYCRR 485.6(n)), in adult homes and enriched housing programs. The ALP is established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care, supervision, and providing or arranging for home health services to five or more eligible residents unrelated to the operator (18 NYCRR 494.2). For each Medicaid enrollee participating in the ALP, a daily rate is paid to the ALP for the provision of nine distinct home care services. No additional fee-for-service billing can be made for these home care services.

Services covered under the daily Medicaid rate and for which no additional separate billing may be made include:

- Title XIX Personal Care Services
- Home Health Aide Services
- Personal Emergency Response Services
- Nursing Services
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical supplies and equipment not requiring prior approval
- Adult Day Health Care

PURPOSE, SCOPE, AND METHODOLOGY

Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for Assisted Living Program services complied with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate rate or procedure codes were billed for services rendered;
- patient related records contained the documentation required by the regulations; and,
- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals.

Scope

Our audit period covered payments to the Provider for Assisted Living Program services paid by Medicaid from January 1, 2010, through December 31, 2012. Our audit universe consisted of 6,838 claims totaling \$2,746,963.95.

During our audit, we did not review the overall internal control structure of the Provider. Rather, we limited our internal control review to the objective of our audit.

Methodology

To accomplish our objective, we:

- reviewed applicable federal and state laws, regulations, rules and policies;
- held discussions with the Provider's management personnel to gain an understanding of the Assisted Living Program;
- ran computer programming application of claims in our data warehouse that identified 6,838 paid Assisted Living Program claims, totaling \$2,746,963.95;
- selected a random sample of 100 claims from the population of 6,838 claims; and,
- estimated the overpayment paid in the population of 6,838 claims.

For each sample selection we inspected, as available, the following:

- Medicaid electronic claim information
- Resident record
- Any additional documentation deemed by the Provider necessary to substantiate the Medicaid paid claim

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 and Mental Hygiene [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 System and eMedNY Provider Manual.
- Specifically, Title 18 NYCRR Section 540.6, 18 NYCRR Section 494 and 18 NYCRR Section 505.35
- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

Regulations state: "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

Regulations state: "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)

Regulations require that bills for medical care, services and supplies contain patient name, case number and date of service; itemization of the volume and specific types of care, services and supplies provided; the unit price and total cost of the care, services and supplies provided; and a dated certification by the provider that the care, services and supplies itemized have been in fact furnished; that the amounts listed are in fact 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)

Regulations state: "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)

Regulations state: "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

Regulations state: "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)

Regulations state: "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)

Regulations state: "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)

AUDIT FINDINGS

This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated April 17, 2015.

The information provided resulted in no change to any of the disallowances. The findings in the Final Audit Report are identical to those in the Draft Audit Report.

AUDIT FINDINGS DETAIL

The OMIG's review of Medicaid claims paid to the Provider from January 1, 2010, through December 31, 2012, identified 13 claims with at least one error, for a total sample overpayment of \$6,343.09 (Attachment C). This audit report incorporates consideration of any additional documentation and information presented in response to the Draft Audit Report dated April 17, 2015.

1. Missing Service Documentation

By enrolling in the Medicaid program, "...[T]he provider agrees: (e) to submit claims for payment only for services actually furnished...; (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(e)-(i)

For 8 claims pertaining to 6 residents, the record did not include service documentation. For 7 claims, the Aide Activity Sheets were not available. On the remaining claim, documentation indicated the aide did not work the date in question. Documentation supplied in response to the Draft Report confirmed the aide did not work. This finding applies to Sample #'s 22, 24, 34, 53, 62, 79, 86 and 99.

2. Missing Plan of Care

Regulations state: "Appropriate services must be provided to or arranged for an eligible individual only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conduct by an assisted living program, or if the assisted living program itself is not an approved long-term home health care program or certified home health agency, by an assisted living program and a long-term home health care program or certified home health agency."

18 NYCRR Section 494.4(b)

By enrolling in the Medicaid program, the provider agrees "to (a) prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program 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. . . and to furnish such records upon request, to the Department..."

18 NYCRR Section 504.3(a)

For 5 claims pertaining to 3 residents, the record did not include a Plan of Care. For 4 claims, a Plan of Care was not completed following a hospital stay to assess a possible change in condition, nor was it documented that a change in condition was addressed. On the remaining claim, the applicable Plan of Care was missing from the resident's record. This finding applies to Sample #'s 3, 8, 40, 43 and 64.

3. Missing Nursing/Functional/Social Assessment

Regulations state that “(a) The agency shall maintain a confidential record for each patient admitted to care to include... (3) nursing assessments conducted to provide services....”
10 NYCRR Section 766.6(a)(3)

Regulations state as follows:

“(e) Before an operator admits an individual to an assisted living program, a determination must be made that the assisted living program can support the physical, supervisory and psychosocial needs of the resident.

(f) The determination referred to in subdivision (e) of this section must be based on:

- (1) a medical evaluation conducted within 30 days prior to the date of admission;
- (2) an interview between the administrator or a designee responsible for admission and retention decisions and the resident and resident’s representative(s), if any;
- (3) a preassessment screening, a nursing assessment, and an assessment of the individual’s social and functional needs and an assessment of the ability of the program to meet those needs. These assessments will be conducted by the operator and, if required, by a certified home health agency or a long-term home health care program; and
- (4) a mental health evaluation if a proposed resident has a known history of chronic mental disability, or if the medical evaluation or resident interview or any assessment suggests that such a disability exists. This evaluation will be conducted by a psychiatrist, physician, nurse, psychologist or social worker who has experience in the assessment and treatment of mental illness.

(g) A reassessment of the resident must be conducted no later than 45 days after the date of admission of the resident. In addition, reassessments must be conducted as frequently as required to respond to changes in the resident’s condition and to ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months.”

18 NYCRR Section 494.4(e)-(g)

Regulations require that the Medicaid provider agrees “to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years . . . all records necessary to disclose the nature and extent of services furnished. . . .”

18 NYCRR Section 504.3(a)

By enrolling in the Medicaid program, “[T]he provider agrees: (e) to submit claims for payment only for services actually furnished...; (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(e)-(i)

For 4 claims pertaining to 3 residents, the record did not include a Nursing/Functional/Social Assessment. A Nursing/Functional/Social Assessment was not completed following a hospital stay to assess a possible change in condition, nor was it documented that a change in condition was addressed. This finding applies to Sample #'s 3, 8, 40 and 43.

4. Missing Patient Review Instrument (PRI)

Residential health care facilities patient assessment for certified rates. (a) For the purpose of determining reimbursement rates effective January 1, 1986 and thereafter, for governmental payments, each residential health care facility shall, on an annual basis or more often as determined by the department pursuant to this Subpart, assess all patients to determine case mix intensity using the patient review criteria and standards promulgated and published by the department (Patient Review Instrument (PRI) and instructions: patient review instrument) and specified in subdivision (i) of this section.

10 NYCRR Section 86-2.30

By enrolling in the Medicaid program, “[...]the provider agrees: (e) to submit claims for payment only for services actually furnished...; (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(e)-(i)

“...The PRI score is used to determine the RUG category that is used to reimburse the ALP for services provided to residents enrolled in the ALP. A true and accurate representation of the resident must be reflected on the PRI and substantiated in the medical record to support the Medicaid payment. Fiscal penalties will be assessed to providers for the inappropriate practice of claiming services not provided to or needed by ALP residents (*18 NYCRR Section 515.2*).....Providers are reminded that they are responsible for ensuring that assessments are completed accurately and reflect the needs of the resident being evaluated for admission to or for continued stay in the ALP. Lack of appropriate documentation to support the assigned RUG grouping and subsequent payment may result in fiscal penalties being assessed.”

DAL HCBS 08-02, January 23, 2008

The Purpose of the Patient Review Instrument (PRI) is a “pre-admission review to a Residential Health Care Facility (RHCF) from the hospital and community based residences and facilities, such as personal dwelling, domiciliary care facility/adult home and congregate housing.”

Instructions Form DOH-694

For 2 claims pertaining to 2 residents, the record did not include a PRI. A PRI was not completed following a hospital stay to assess a possible change in condition, nor was it documented that a change in condition was addressed. This finding applies to Sample #'s 40 and 43.

PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the lower confidence limit amount of \$166,420, one of the following repayment options must be selected within 20 days from the date of this letter:

OPTION #1: Make full payment by check or money order within 20 days of the date of the final audit report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #14-1637
Albany, New York 12237

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the final audit report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 50% withhold after 20 days until the agreement is established. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
Phone #: [REDACTED]
Fax#: [REDACTED]

If you choose not to settle this audit through repayment of the lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the point estimate of \$433,740. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

General Counsel
Office of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, NY 12204

Questions regarding the request for a hearing should be directed to Office of Counsel, at [REDACTED].

Issues you may raise shall be limited to those issues relating to determinations contained in the final audit report. Your hearing request may not address issues regarding the methodology used to determine the rate, or any issue that was raised at a proceeding to appeal a rate determination.

At the hearing you have the right to:

- a) be represented by an attorney or other representative, or to represent yourself;
- b) present witnesses and written and/or oral evidence to explain why the action taken is wrong; and
- c) cross examine witnesses of the Department of Health and/or the OMIG.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid Program, take action where appropriate, and recover monies owed through the initiation of a civil lawsuit or other legal mechanisms including but not limited to the recovery of state tax refunds pursuant to Section 206 of the Public Health Law and Section 171-f of the State Tax Law.

**NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE**

NAME AND ADDRESS OF AUDITEE

DePaul Kenwell
3456 Delaware Avenue
Kenmore, New York 14217

AMOUNT DUE: \$166.420

PROVIDER ID #

AUDIT #14-1637

AUDIT

TYPE

PROVIDER
 RATE
 PART B
 OTHER:

CHECKLIST

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: *New York State Department of Health*
3. Record the Audit Number on your check.
4. Mail check to:

New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #14-1637
Albany, New York 12237

Thank you for your cooperation.

SAMPLE DESIGN

The sample design used for Audit #14-1637 was as follows:

- Universe - Medicaid claims for Assisted Living Program services paid during the period January 1, 2010, through December 31, 2012.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for Assisted Living Program services paid during the period January 1, 2010, through December 31, 2012.
- Sample Unit - The sample unit is a Medicaid claim paid during the period January 1, 2010, through December 31, 2012.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 100 claims.

SAMPLE RESULTS AND ESTIMATES

Universe Size	6,838
Sample Size	100
Sample Value	\$ 42,913.36
Sample Overpayments	\$ 6,343.09
Confidence Level	90%

Extrapolation of Sample Findings

Sample Overpayments	\$ 6,343.09
Sample Size	100
Mean Dollars in Error for Extrapolation Purposes	\$ 63.4309
Universe Size	6,838
Point Estimate of Total Dollars	\$ 433,740
Lower Confidence Limit	\$ 166,420