G.S. BURTON DEVELOPMENT, LLP
SUMMIT COUNTY

COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JANUARY 1, 2012 THROUGH DECEMBER 31, 2014

Dave Yost · Auditor of State

G.S. BURTON DEVELOPMENT, LLP
SUMMIT COUNTY

TABLE OF CONTENTS

THIS PAGE INTENTIONALLY LEFT BLANK

INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH REQUIREMENTS OF THE MEDICAID PROGRAM APPLICABLE TO HOME AND COMMUNITY BASED WAIVER SERVICES

Sherice Burton, Chief Executive Officer
G.S. Burton Development, LLP
304 Shawnee Path
Akron, Ohio 44305

Dear Ms. Burton:

We examined your (the Provider) compliance with specified Medicaid requirements for service documentation and service authorization related to the provision of homemaker/ personal care services and non-medical transportation (per trip) services during the period of January 1, 2012 through December 31, 2014. We also tested compliance with service documentation and service authorization requirements for select homemaker/personal care on-site/on-call, per mile transportation and adult day support services for this same time period. We reviewed the Provider's records to determine if it had support for services billed to and paid by Ohio Medicaid and compared the elements contained in the documentation to the Medicaid rules. In addition, we determined if the services were authorized in an individual service plans (ISP) and reviewed personnel records for a select number of employees to test aide and driver qualifications. The accompanying Compliance Examination Report identifies the specific requirements examined.

Provider's Responsibility

The Provider entered into an agreement with the Ohio Department of Medicaid (ODM) to provide services to Medicaid recipients (the Provider Agreement). The Provider Agreement outlines the responsibility to adhere to the terms of the agreement, state statutes and rules, federal statutes and rules, and the regulations and policies set forth in the Medicaid Handbook including the duty to maintain records supporting claims for reimbursement made by Ohio Medicaid. Therefore, the Provider is responsible for complying with the requirements and laws outlined by the Medicaid program.

Auditor's Responsibility

Our responsibility is to express an opinion on the Provider's compliance with the specified Medicaid requirements based on our examination. Our examination was performed under our authority in Section 117.10 of the Ohio Revised Code and conducted in accordance with the American Institute of Certified Public Accountants' attestation standards and, accordingly, included examining, on a test basis, evidence supporting the Provider's compliance with those Medicaid requirements and performing such other procedures as we considered necessary in the circumstances. We believe our examination provides a reasonable basis for our opinion. However, our examination does not provide a legal determination on the Provider's compliance with the specified Medicaid requirements.

Internal Control Over Compliance

The Provider is responsible for establishing and maintaining effective internal control over compliance with the Medicaid requirements. We did not perform any test of the internal controls and we did not rely on the internal controls in determining our examination procedures. Accordingly, we do not express an opinion on the effectiveness of the Provider's internal control over compliance.

Basis for Adverse Opinion on Compliance

Our examination found material non-compliance with the requirements tested for service documentation and service authorization for homemaker/ personal care services and non-medical transportation (per trip) services.

Adverse Opinion on Compliance

In our opinion, the Provider has not complied, in all material respects, with the aforementioned requirements pertaining to the specified Medicaid requirements for the period of January 1, 2012 to December 31, 2014.

Our testing was limited to the specified Medicaid requirements detailed in the Compliance Examination Report. We did not test other requirements and, accordingly, we do not express an opinion on the Provider's compliance with other requirements.

We found the Provider was overpaid by Ohio Medicaid for services rendered between January 1, 2012 and December 31, 2014 in the amount of $895,617.06. This finding plus interest in the amount of $55,908.59 totaling $951,525.65 is due and payable to ODM upon its adoption and adjudication of this examination report. When the Auditor of State identifies fraud, waste or abuse by a provider in an examination,[1] any payment amount in excess of that legitimately due to the provider will be recouped by ODM, the state auditor, or the office of the attorney general. Ohio Admin Code § 5160-1-29(B)

This report is intended solely for the information and use of the ODM, the Ohio Department of Developmental Disabilities, the Ohio Attorney General's Office, the U.S. Department of Health and Human Services/Office of Inspector General, and other regulatory and oversight bodies, and is not intended to be, and should not be used by anyone other than these specified parties.

Dave Yost
Auditor of State

January 23, 2017

[1] "Fraud" is an intentional deception, false statement, or misrepresentation made with the knowledge that the deception, false statement, or misrepresentation could result in some unauthorized benefit to oneself or another person. "Waste and abuse" are practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitutes an overutilization of Medicaid covered services and result in an unnecessary cost to the Medicaid program. Ohio Admin Code § 5160-1-29(A)

COMPLIANCE EXAMINATION REPORT

Background

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. The rules and regulations that providers must follow are specified in the Ohio Administrative Code and the Ohio Revised Code. The fundamental concept underlying the Medicaid program is medical necessity of services: defined as services which are necessary for the prevention, diagnosis, evaluation or treatment of an adverse health condition. *See* Ohio Admin. Code § 5160-1-01(B) According to Ohio Admin Code § 5160-1-17.2(D), Medicaid providers must "maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions" for a period of six years from receipt of payment or until any audit initiated within the six year period is completed. Providers must furnish such records for audit and review purposes. Ohio Admin Code § 5160-1-17.2(E).

Ohio Medicaid recipients with developmental disabilities level of care required for admission to an intermediate care facility or enrollment in a home and community-based services waiver may be eligible to receive care in their homes and communities. Recipients may choose agency providers, independent providers or a combination of both. *See* Ohio Admin. Code §§ 5123-2-9-01 and 5123-2-9-11

The Provider is waiver service organization and during the examination period received reimbursement of $1,297,049.69 from the Ohio Medicaid program for 22,357 waiver services including the following:

- 15,935 non-medical transportation per trip services (procedure codes MR069 and MR070);
- 4,999 homemaker/personal care services (procedure codes MR940 and MR970);
- 827 homemaker/personal care on-site/on-call services (procedure code MR951);
- 360 waiver transportation per mile services (procedure codes MR941 and MR971); and
- 236 adult day support services (procedure codes MR006 and MR014).

These waiver services were rendered on 20,711 recipient dates of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date of service.

The Provider has two Ohio Medicaid provider numbers: 3071634 and 0089101. The second number (0089101) lists an effective Medicaid agreement date of August 1, 2013 with a service location of 541 West Avenue, Tallmadge, Ohio. No payments were made to this second number during our examination period.

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether the Provider's Medicaid claims for reimbursement complied with Ohio Medicaid regulations. Please note that all rules and code sections relied upon in this report were those in effect during the examination period and may be different from those currently in effect.

The initial scope of the engagement was limited to an examination of homemaker/personal care services and non-medical transportation (per trip) services that the Provider rendered to Medicaid recipients and received payment during the period of January 1, 2012 through December 31, 2014. Based on the results of our testing, we expanded the scope to include a limited review of the remaining waiver services rendered during the same time period: homemaker/personal care on-site/on-call, waiver transportation (per mile), and adult day support services. The scope was expanded to determine if errors found in the Provider's documentation practices were pervasive across all services.

Purpose, Scope, and Methodology (Continued)

We received the Provider's claims history from the Medicaid Information Technology System (MITS) database of services billed to and paid by Ohio's Medicaid program. From this population we selected two statistical samples as described below to facilitate a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code § 5160-1-27(B)(1).

First, we stratified the population of homemaker/personal care services (procedure codes MR940 and MR970) by RDOS into five strata using a modified cumulative frequency square root method (Dalenius-Hodge Rule). Estimates of the population overpayment standard deviation were made for each stratum using the standard deviation of the actual amount paid per claim and a 50 percent error rate. The estimated error standard deviations and means were then used to calculate an overall stratified sample. The sample size of the second stratum was adjusted upward by two records to adjust for skewness.

The final calculated sample size is shown in Table 1.

TABLE 1: Homemaker/Personal Care Services Sample

Universe/Strata	Population Size	Sample Size
Stratum 1 – RDOS with Amount Paid Less than $20	1,542	66
Stratum 2 – RDOS with Amount Paid $20 to $23.99	812	50
Stratum 3 – RDOS with Amount Paid $24 to $31.99	1,575	119
Stratum 4 – RDOS with Amount Paid $32 to $43.99	729	73
Stratum 5 – RDOS with Amount Paid $44 and Above	341	58
Total:	4,999	366

We then obtained the detailed services for the 366 RDOS selected. This resulted in a sample of 366 services.

Second, we stratified the population of non-medical transportation (per trip) services (procedure codes MR069 and MR070) by RDOS into three strata using a modified cumulative frequency square root method (Dalenius-Hodge Rule). Estimates of the population overpayment standard deviation were made for each stratum using the standard deviation of the actual amount paid per claim and a 70 percent error rate. The estimated error standard deviations and means were then used to calculate an overall stratified sample. Stratum sample sizes were adjusted to have a minimum of 30 observations or the entire population of the stratum when the population was less than 30.

The final calculated sample size is shown in Table 2.

Purpose, Scope, and Methodology (Continued)

Table 2: Non-Medical Transportation (Per Trip) Services		
Universe/Strata	**Population Size**	**Sample Size**
Stratum 1 – RDOS with Amount Paid Less Than $20	137	30
Stratum 2 – RDOS with Amount Paid $20 to $39.99	15,783	161
Stratum 3 – RODS with Amount Paid of $40 and Above	15	15
Total:	15,935	206

We then obtained the detailed services for the 206 RDOS selected. This resulted in a sample of 206 services.

Table 3 shows the additional waiver services selected for examination as part of the expanded scope. We performed limited testing of the 107 services randomly selected.

Table 3: Additional Waiver Services		
Universe/Strata	**Population Size**	**Sample Size**
Homemaker/Personal Care On-Site/On-Call Services (procedure code MR951)	827	30
Individual Options Waiver Transportation per Mile Services (procedure code MR941)	353	30
Adult Day Support Services (procedure codes MR006 and MR014)	236	40
Level One Waiver Transportation per Mile Services (procedure code MR971)	7	7
Total:	1,423	107

An engagement letter was sent to the Provider setting forth the purpose and scope of the examination. During the entrance conference the Provider described its documentation practices and process for billing to the Ohio Medicaid program. During fieldwork we reviewed personnel records and service documentation. We sent a missing records list and a final request for information to the Provider and we reviewed all documents received for compliance.

Results

We examined 366 services in Statistical Sample 1 (homemaker/personal care services) and identified 375 errors. The overpayments identified for 289 of 366 statistically sampled RDOS (289 of 366 services) from a stratified random sample were projected to the Provider's population of paid claims for homemaker/personal care services resulting in a projected overpayment of $413,623 with a 95 percent degree of certainty that the true population overpayment amount fell within the range, after adjustment, of $389,497.26 to $438,070.92 (+/- 5.91 percent.)

Results (Continued)

An adjustment was made to the original range of $389,334 to $437,911 to correct for negative skewness in stratum 2[2]. A detailed summary of our statistical sample and projection results is presented in **Appendix I**.

We examined 206 services in Statistical Sample 2 (non-medical transportation (per trip) services) and identified 414 errors. The overpayments identified for 172 of 206 statistically sampled RDOS (172 of 206 services) from a stratified random sample were projected to the Provider's population of paid claims for non-medical transportation (per trip) services resulting in a projected overpayment of $480,084 with a 95 percent degree of certainty that the true population overpayment amount fell within the range of $446,258 to $513,911 (+/- 7.05 percent.) A detailed summary of our statistical sample and projection results is presented in **Appendix II**.

We tested 107 additional waiver services and identified 71errors that resulted in overpayment of$1,910.06. The overpayment for the additional waiver services is based only on the examination of the 107 services and was not projected to the remaining population.

While certain services had more than one error, only one finding was made per service. The non-compliance found during our examination and the basis for our findings is described below in more detail.

A. Provider Qualifications

According to Ohio Admin. Code § 5123:2-2-02(C), an agency provider shall obtain a criminal records check of an applicant and may conditionally employ an applicant for 60 days pending receipt of information concerning the criminal records check. In addition, each employee must also hold a valid first aid and cardiopulmonary resuscitation (CPR) certification per Ohio Admin. Code § 5123:2-2-01(D)(17).

Statistical Sample 1 - Homemaker/Personal Care Services

In addition to the requirements for an employee of an agency as listed above, homemaker/personal care aides must annually complete at least eight hours of training. *See* Ohio Admin. Code § 5123:2-9-30(C).

We haphazardly selected 15 homemaker personal care aides identified on the Provider's service documentation from our sample. From the Provider's employee roster, we determined that 10 of the 15 aides were hired during the examination period and we applied the applicable hiring requirement of a criminal background check and found three aides with no background check and six aides with background checks from approximately one to 19 months after the 60 day conditional employment period. We determined that aides with no background check were ineligible to render services during our examination period. In addition, we determined that aides with background checks that were completed after the required time frame were ineligible to render services from the end of the 60 day conditional employment period until the background check was obtained.

[2] Corrected for skewness in stratum 2 by using a method described in "Sampling Methods for the Auditor, An Advanced Treatment," by Herbert Arkin. This technique uses tables provided by E.S. Pearson and H.O. Hartley, in "Biometrika Tables for Statisticians," Vol 1, 3rd Ed., Cambridge University Press, New York, 1969, table 42.

A. Provider Qualifications (Continued)

In addition, we tested all 15 homemaker personal aides for the required first aid and CPR certifications. We found the following errors:

- 4 aides with no first aid;
- 3 aides with no CPR;
- 3 aides with lapses in first aid ranging from 5 to 14 months; and
- 3 aides with lapses in CPR ranging from 3 to 12 months.

We determined that aides with no first aid certification and/ or CPR were ineligible to render services during our examination period and aides with lapses in first aid and/or CPR certification were ineligible to render services during the lapse.

For compliance of annual training hours, we limited our testing to aides who were employed for the full calendar year. Our test of the annual training hours found the following:

- For 2012, we tested 4 aides and found 1 aide had no training hours and 3 aides completed only 2 of the required 8 hours;
- For 2013, we tested 7 aides and found 1 aide had no training hours and 6 aides completed only 2 of the required 8 hours; and
- For 2014, we tested 7 aides and found 1 aide had no training hours.

We determined that aides that were materially non-compliant with annual training hours (completing less than six of the eight required hours) were ineligible to render services in that year.

Due to the errors noted, five aides were ineligible to render services during our entire examination period and 10 aides were ineligible to render services until all hiring requirements were met and/or during the period of a lapse.

We reviewed 366 services and identified 201 services rendered by an aide who was ineligible to render services. These 201 services were used in the overall projection of $413,623.

Statistical Sample 2 - Non-Medical Transportation per Trip Services

In addition to the requirements for an employee of an agency as noted above, each driver must hold a valid driver's license, obtain a driving record prepared by the bureau of motor vehicles no earlier than 14 days prior to the date of initial employment and at least once every three years thereafter and not have more than six points on their driving record. Each driver must also complete testing for controlled substances and be determined to be drug free prior to initially providing non-medical transportation. Ohio Admin. Code § 5123:2-9-18(C)(5)

We haphazardly selected 14 drivers from the Provider's trip documentation for testing. From the Provider's employee roster, we determined that nine of the 14 drivers were hired during the examination period and we applied the applicable hiring requirements. The Provider had no personnel files for two of the 14 drivers so we could not determine if they were hired during the examination period. These two drivers are considered ineligible for the entire examination period as there was no documentation to support any of the driver qualifications.

We found the following errors in hiring requirements for the nine drivers hired during the examination period:

A. Provider Qualifications (Continued)

- 2 drivers with no criminal background check;
- 4 drivers with criminal checks ranging from 2 to 13 months after the 60 day conditional employment period;
- 1 driver with no controlled substance test;
- 4 drivers with controlled substance tests ranging from 1 week to 15 months after hire;
- 1 driver with a driving record 7 months prior to hire; and
- 2 drivers with driving records ranging from 5 to 12 months after hire.

We determined that drivers with no criminal background check, controlled substance test and/or initial driving record were ineligible to render services during our examination period. Other drivers that did not meet the qualifications were ineligible to render services until the requirement was met. Any overpayment identified for an ineligible driver accounted for the 60 day conditional employment period.

In addition, we tested the annual requirements for the 12 drivers in which the Provider had personnel files and noted the following errors:

- 1 driver with no first aid or CPR;
- 4 drivers with lapses in first aid and CPR ranging from 2 weeks to 12 months;
- 3 drivers in which the first aid and CPR certificates were not signed by the trainer;
- 2 drivers in which there was a driver's license only for a portion of the examination period;
- 1 driver in which the driving record indicated a license suspension for a portion of the examination period; and
- 1 driver in which the driving record indicated six points for a portion of the examination period.

We determined that drivers with no first aid and/or CPR certification were ineligible to render services during our examination period and drivers with lapses in first aid, CPR and drivers licenses were ineligible to render services during the lapse. In addition, drivers were ineligible during periods of driver's license suspension and after obtaining six or more points on their driving record.

Due to the errors noted above, six drivers were ineligible during the entire examination period and seven drivers were ineligible until all hiring requirements were met and/or during lapses in certifications. We reviewed 206 services and identified 82 services rendered by a driver who was ineligible to render services. These 82 services were used in the overall projection of $480,084.

We noted one employee where the Provider did not obtain the background check until approximately two months after the conditional employment period. This employee had certified at the time of hire that she reviewed the list of criminal codes which can result in ineligibility and had not been convicted or plead guilty to the listed crimes. Her subsequent criminal record check included two such convictions. Although her employment was after the exclusion period for these crimes and she was eligible for employment, the Provider's failure to adhere to the employee qualification requirements could have resulted in the employment of an ineligible employee and put recipients at harm.

Recommendation:

The Provider's failure to ensure hiring and ongoing requirements are met places a vulnerable population of Medicaid recipients at risk. The Provider should improve its internal controls to ensure all personnel meet applicable requirements prior to rendering direct care services and maintain appropriate documentation to demonstrate that all requirements have been met. The Provider should address the identified issues to ensure the safety of the recipients, ensure compliance with Medicaid rules and avoid future findings.

B. Service Documentation

Statistical Sample 1 – Homemaker/Personal Care Services

Documentation of homemaker services shall include date of service, place of service, description of services delivered, the signature or initials of the person delivering the service and the beginning and ending time of the service. *See* Ohio Admin Code § 5123-2-9-30(E)

We reviewed 366 services and found the following errors:

- 97 services in which the units billed exceed the units documented;
- 38 services in which there was no documentation to support the service;
- 20 services in which the documentation did not include a description of the service rendered; and
- 7 services in which the time of the service was not documented.

These 162 errors were used in the overall projection of $413,623.

Statistical Sample 2 – Non-Medical Transportation per Trip Services

Documentation of service for non-medical transportation (per trip) services shall include date of service, license plate number of the vehicle used to provide the service, signature or initials of the driver of the vehicle, names of all other passengers, beginning and ending times of the trip and beginning and ending odometer readings. *See* Ohio Admin. Code §5123:2-9-18(H)(1)

We reviewed 206 services and found the following errors:

- 80 services in which the units billed exceed the units documented;
- 48 services in which there was no documentation to support the service; and
- 7 services in which the name of the driver was not documented.

These 135 errors were used in the overall projection of $480,084.

We also noted 184 services in which the documentation did not include the license plate number of the vehicle, the odometer reading, and/or the beginning and ending time. We did not identify an overpayment for these instances of non-compliance.

Recommendation:

The Provider should develop and implement procedures to ensure that all service documentation fully complies with Medicaid requirements. In addition, the Provider should implement a quality review process to ensure that documentation is complete and accurate prior to submitting claims for reimbursement and not bill Ohio Medicaid for services when no homemaker/personal care aide is on the clock. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

C. Individual Service Plans (ISPs)

In order for homemaker/personal care and non-medical transportation per trip services to be covered, the services must be provided pursuant to an ISP. *See* Ohio Admin. Code §§ 5123:2-9-30(D) and 5123:2-9-18(D)

C. Individual Service Plans (ISPs) (Continued)

Statistical Sample 1 – Homemaker/Personal Care Services

We reviewed the ISPs for the 366 services and found 12 services with no ISP to cover the date of service. These 12 errors were used in the overall projection of $413,623.

Statistical Sample 2 – Non-Medical Transportation per Trip Services

We reviewed the ISPs for the 206 services and found 13 services with no ISP to cover the date of service. These 13 errors were used in the overall projection of $480,084.

Recommendation:

The Provider should establish a system to obtain the required individual service plans prior to rendering services. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Additional Waiver Services

Documentation of homemaker/personal care on-site/on-call, non-medical transportation (per mile) and adult day support services shall include date of service, place of service, description of services delivered, the signature or initials of the person delivering the service and the beginning and ending time of the service. *See* Ohio Admin. Code §§ 5123:2-9-30(E), 5123:2-9-24(E) and 5123:2-9-17(E)

In order for homemaker/personal care on-site/on-call, non-medical transportation (per mile) and adult day support services to be covered, the services must be provided pursuant to an ISP. *See* Ohio Admin. Code §§ 5123:2-9-30(D), 5123:2-9-24(D) and 5123:2-9-17(D)

Additional Waiver Services – Homemaker/Personal Care On-Site/On-Call Services

We examined 30 homemaker/personal care on-site/on-call services (procedure code MR951) and found seven services in which the units billed exceed the units documented and five services in which there was no documentation to support the service.

We identified $456.86 as an overpayment for these 12 errors.

Additional Waiver Services – Individual Option Waiver Transportation (per mile) Services

We examined 30 individual options waiver transportation (per mile) services (procedure code MR941) and identified 11 services in which there was no documentation to support the service and seven services in which the miles billed exceeded the miles documented. As a result, we identified $103.90 as an overpayment for these 18 services.

Additional Waiver Services – Adult Day Support Services

We examined 40 adult day support services (procedure codes MR006 and MR014) and identified the following errors:

- 15 services in which the time of service was not documented;
- 11 services in which the documentation did not include the place of service or a description of the service and 10 of these 11 services lacked the signature of the person delivering the service; and
- 8 services in which there was no documentation to support the service.

Additional Waiver Services (Continued)

As a result, we identified $1,286.50 as an overpayment for these 34 errors.

Additional Test 4 – Level One Waiver Transportation per Mile Services

We examined seven level one waiver transportation (per mile) services (procedure code MR971) and determined that there was no documentation to support any of these services. As a result, we identified $62.80 as an overpayment for these seven errors.

Recommendation:

The Provider should review its documentation and authorization practices for all services rendered and billed to Ohio Medicaid. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

Additional Matter that Came to Our Attention

We noted instances in which the number of hours a homemaker/personal care aide rendered services included a one-half hour deduction. For example, the service documentation shows one aide working 11 and one-half hours and then a deduction for one-half hour for a new total of 11 hours. In this instance the Provider billed Ohio Medicaid for the entire 11 and one-half hours (46 units). We inquired of the Provider who stated, "Even though they stay in the home there is plenty of down time, so for every 8 hours worked a half hour come out of their check." The Provider subsequently clarified that while a half hour break is subtracted for payroll purposes, the staff "don't get a break they are still providing services for the client they don't leave or anything". Due to these conflicting statements from the Provider, we were unable to determine whether or not employees actually rendered Medicaid services during unpaid breaks.

The Code of Federal Regulations (CFR), Title 29, § 785.19 states that bona fide meal periods are not work time and the employee must be completely relieved from duty. If employees are in fact required to render services during unpaid breaks, the practice appears to be inconsistent with the CFR. If employees do not render services during the unpaid breaks, the Provider appears to be billing Ohio Medicaid for services not rendered, resulting in an unnecessary cost to Ohio Medicaid.

Recommendation:

The Provider should review its policy regarding unpaid breaks and ensure it meets labor laws and Ohio Medicaid rules. The Provider should address the identified issue to ensure compliance with Medicaid rules and avoid future findings.

Provider Response:

The Provider submitted an official response to the results of this examination which is presented in **Appendix III**. We did not examine the Provider's response and, accordingly, we express no opinion on it.

APPENDIX I

Summary of Sample Record Analysis
Statistical Sample 1 – Homemaker/Personal Care Services

POPULATION
The population is all paid Medicaid homemaker/personal care services (procedure codes MR940 and MR970), where the service was performed and payment was made by ODM during the examination period.

SAMPLING FRAME
The sampling frame was paid and processed claims from (MITS). This system contains all Medicaid payments and all adjustments made to Medicaid payments by the State of Ohio.

SAMPLE UNIT
The sampling unit was an RDOS.

SAMPLE DESIGN
We used a stratified random sample.

Description	Results
Number of Population RDOS Provided	4,999
Number of Population RDOS Sampled	366
Number of RDOS Sampled with Errors	289
Number of Population Services	4,999
Number of Population Services Sampled	366
Number of Services Sampled with Errors	289
Total Medicaid Amount Paid for Population	$587,054.17
Amount Paid for Population Services Sampled	$51,592.90
Projected Population Overpayment Amount	$413,623
Upper Limit Overpayment Estimate at 95 Percent Confidence Level	$438,070.92
Lower Limit Overpayment Estimate at 95 Percent Confidence Level	$389,497.26
Precision of Population Overpayment Projections at the 95 Percent Confidence Level	$24,447.92 (5.91%) Upper $24,125.74 (5.83%) Lower

Source: Analysis of MITS information and the Provider's records

APPENDIX II

Summary of Sample Record Analysis
Statistical Sample 2 – Non-Medical Transportation (per trip) Services

POPULATION
The population is all paid Medicaid non-medical (per trip) transportation services (procedure codes MR069 and MR070), where the service was performed and payment was made by ODM during the examination period.

SAMPLING FRAME
The sampling frame was paid and processed claims from (MITS). This system contains all Medicaid payments and all adjustments made to Medicaid payments by the State of Ohio.

SAMPLE UNIT
The sampling unit was an RDOS.

SAMPLE DESIGN
We used a stratified random sample.

Description	Results
Number of Population RDOS Provided	15,935
Number of Population RDOS Sampled	206
Number of RDOS Sampled with Errors	172
Number of Population Services	15,935
Number of Population Services Sampled	206
Number of Services Sampled with Errors	172
Total Medicaid Amount Paid for Population	$630,192.16
Amount Paid for Population Services Sampled	$12,702.30
Projected Population Overpayment Amount	$480,084
Upper Limit Overpayment Estimate at 95 Percent Confidence Level	$513,911
Lower Limit Overpayment Estimate at 95 Percent Confidence Level	$446,258
Precision of Population Overpayment Projection at the 95 Percent Confidence Level	$33,826 (+/-7.05%)

Source: Analysis of MITS information and the Provider's records

G.S. BURTON DEVELOPMENT LLP

498 South Ave, STE B Tallmadge Ohio 44278 | serenity77@att.net

February 3, 2017

To Whom It May Concern:

I am writing this letter in response to our recent audit and findings. I have had a chance to review the report and understand there is a lot of errors found. I know it is my job as the CEO to ensure that all paperwork and documentation is without error and meet the standards of Medicaid. Although there were many errors we did provide the service to our clients. There is some missing documentation that can be explained. We moved into a different office space twice and know this is why some of the documents are missing. There were also errors related to billing the incorrect amount of units, this was not done to defraud the system in any manner, but an honest error. As far as the employee files we have had compliance reviews after the dates of the audit years and have since corrected our files. We have also hired a second secretary to assist with the upkeep of the files. We have established a better system that will ensure our paperwork is correctly documented and the employee files are current and complete.

We are a good agency with a very good reputation in the community and would not put ourselves or business in a position that would jeopardize that. We love what we do and do not want the findings to impede us in anyway. You have our full cooperation and we would like to do whatever we have to so that we can keep our business and continue to serve our community. Our business grew quickly and initially it was hard to keep up with the paperwork. We are growing and learning new ways to improve daily. Although these errors were an oversight on our part we understand there is no excuse for our negligence. Thank you for your time and the opportunity to serve.

Sincerely,

Sherice Burton, M.A., QMHS
Agency Owner

Dave Yost • Auditor of State

G.S. BURTON DEVELOPMENT LLP

SUMMIT COUNTY

CLERK'S CERTIFICATION
This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
FEBRUARY 16, 2017

88 East Broad Street, Fourth Floor, Columbus, Ohio 43215-3506
Phone: 614-466-4514 or 800-282-0370 Fax: 614-466-4490
www.ohioauditor.gov