

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

----- X
:
In the Matter of the Request of :
:
CLEARVIEW CENTER, INC. :
:
Medicaid ID #01021874 :
:
for a hearing pursuant to Part 519 of Title 18 of the :
Official Compilation of Codes, Rules and Regulations :
of the State of New York (“NYCRR”) to review a :
determination to recover Medicaid overpayments. :
----- X

Decision After Hearing

Audit #09-5544

Before: Dawn MacKillop-Soller
Administrative Law Judge (“ALJ”)

Held At: NYS Department of Health
150 Broadway
Suite 510
Menands, New York 12204

Date of Hearing: December 10, 2015
Record closed: April 1, 2016

Parties: NYS Office of the Medicaid Inspector General
594 Delaware Avenue, 2nd Floor
Buffalo, New York 14202
By: Kendra A. Vergason, Esq.
Sarah Dasenbrock, Esq.

ClearView Center, Inc.
500 Central Avenue
Albany, New York 12206
By: Robert A. Hussar, Esq.
James W. Lytle, Esq.
Manatt, Phelps & Phillips, LLP
30 South Pearl Street
New York, New York 12207

BACKGROUND

The Department of Health (“Department”) acts as the single state agency to supervise the administration of the medical assistance program (“Medicaid”) in the state of New York. Pursuant to Public Health Law (“PHL”) §§ 30, 31 and 32, the Office of the Medicaid Inspector General (“OMIG”), an independent office within the Department, has the authority to pursue administrative enforcement actions against any provider to recover Medicaid overpayments. Pursuant to 18 NYCRR 517.3(g), the OMIG and the Office of Mental Health (“OMH”) partnered, as part of a reconciliation project, to seek recoupment of overpayments made to Clearview Center, Inc. (“Appellant”)¹ pursuant to 14 NYCRR 588.13(d) and 14 NYCRR 588.14(f). This joint effort resulted in the OMIG issuing a Final Audit Report dated July 15, 2015, stating overpayment amounts for fiscal years 2003, 2004, 2005, in the amount of \$109,880.46.

The Appellant objected to the overpayment determination as stated in the Final Audit Report and requested a hearing pursuant to 18 NYCRR 519.4(a)(2). At the hearing, the Department submitted documents (Exhibits 1-15) and presented two witnesses: Thomas Barone, OMIG management specialist (Transcript, p. 29), and Lee Aiezza, OMH director of outpatient and residential services. (Transcript, p. 9.) The Appellant also submitted documents (Exhibits A-F) and presented two witnesses: [REDACTED] (Transcript, p. 183), and [REDACTED], [REDACTED]. (Transcript, p. 220.) A transcript of the hearing was made. (Transcript, p. 1-246.) Each side submitted two post-hearing briefs. The Appellant has the burden of showing that the Department’s determination was incorrect and that all overpayments received above the annual threshold amount were allowable. 18 NYCRR 519.18(d)(1).

¹ In 2012, ClearView Center, Inc. became known as Equinox, Inc.

FINDINGS OF FACT

1. The Appellant is a not-for-profit outpatient mental health provider offering services for adults and youth related to mental and behavioral health, substance abuse, domestic violence, and homelessness. The Appellant is licensed under Article 31 of the Mental Hygiene Law (“MHL”) and enrolled in Medicaid. (Transcript, p. 20-22, 221-225.)

2. In 2009, pursuant to 18 NYCRR 517.3(g), the OMIG and the OMH partnered on a reconciliation project in order to perform a joint review (audit #09-544) of the Appellant’s Level I Comprehensive Outpatient Programs (“COPS”) and Community Support Programs (“CSP”) supplemental Medicaid payments for the timeframe January 1, 2003 through December 31, 2005. (Transcript, p. 64, 89, 124.)

3. COPS and CSP provided supplemental payments to mental health providers “for enhanced services to seriously and persistently mentally ill” individuals. (Exhibit 1.) As a licensed outpatient mental health provider, the Appellant received CSP and COPS Medicaid as supplemental add-on payments in addition to the Medicaid rate for fiscal years 2003, 2004 and 2005. (Transcript, p. 95-96.) This case does not involve a determination of whether the Appellant properly rendered or billed for services to patients or whether the supplemental payments or claim amounts were accurately calculated. (Transcript, p. 19, 21.)

4. COPS and CSP payments were limited to an established and specific annual threshold cap. (Transcript, p. 130.) The OMH was responsible for performing the threshold calculations, which were based on the Appellant’s total state aid or base supplemental funding divided by the number of visits in the program clinic over the most recent three fiscal years. 14 NYCRR 588.14(d) and 592.8(3)(i). The amount of COPS or CSP money received during a fiscal period is compared to the annual threshold – If a provider is found to be above the threshold amount, “that is a liability due back to the state.” (Transcript, p. 120.)

5. Pursuant to 14 NYCRR 588.13(d), the OMH set the following thresholds to Appellant's CSP and COPS Medicaid payments: (1) CSP \$515,345.00 and COPS \$226,351.00 for 2003; (2) CSP \$518,076.09 and COPS \$249,693.00 for 2004; and (3) CSP \$627,891.00 and COPS \$274,570.00 for 2005. (Exhibits 1, 3, 5.)

6. The Appellant was paid \$544,724.23 in CSP payments and \$217,469.45 in COPS payments for 2003, \$693,339.58 in CSP payments and \$365,517.28 in COPS payments for 2004, and \$459,150.81 in CSP payments and \$241,605.2 in COPS payments for 2005. (Exhibits 1, 15.)

7. The reconciliation was determined as follows: At the end of 2003, the Appellant was paid \$29,279.23 above the CSP threshold and 8,881.55 below the COPS threshold; At the end of 2004, the Appellant was paid \$175,263.49 above the CSP threshold and \$115,824.28 above the COPS threshold; In 2005, the Appellant was paid \$168,740.19 below the CSP threshold and \$32,964.8 below the COPS threshold. The total CSP recovery for 2003 through 2005 is \$35,902.53. The total COPS recovery is \$73,977.93. Altogether, the recovery amount is \$109,880.46. (Exhibit 15.)

8. By Draft Report dated November 18, 2009, the OMIG placed the Appellant on notice of the reconciliation determination that it had received annual COPS and CSP Medicaid payments above the threshold for fiscal years 2003, 2004 and 2005. The Draft Report determined the overpayment to be \$356,229.68 (COPS overpayment of \$151,042.57 and CSP overpayment of \$205,187.11.) (Exhibit 1.) By Revised Draft Report dated November 23, 2010, the overpayment amount was reduced to \$113,486.00 (COPS overpayment of \$73,977.93 and CSP overpayment of \$39,508.07.) (Exhibits 3.)

9. Pursuant to 18 NYCRR 517.5 and 517.6 and as instructed in the Draft Report, the Appellant responded to the draft reports in letters to the OMH dated February 17, 2010 and January 25, 2011. The Appellant objected to the recoupment efforts on the basis that they were "dilatatory," resulted in a burdensome process to an already economically strained mental health care facility rendering rehabilitation services "at a loss," and on the grounds that the overpayment amount was incorrect.

(Exhibits 2, 4.)

10. Upon considering the Appellant's responses to the draft reports as required by 18 NYCRR 517.6(a), the OMIG issued a Final Audit Report dated July 15, 2015, which reduced the overpayment to \$109,880.46 (COPS overpayment of \$73,977.93 and CSP overpayment of \$35,902.53.) By letter dated July 31, 2015, the Appellant requested a hearing pursuant to 18 NYCRR 519.4(a)(2). (Exhibit 6.)

APPLICABLE LAW

1. A draft audit report and final audit report are defined in 18 NYCRR 517.2(b) as:

[T]he formal audit reports produced by the department after on-site review of a provider's records and denominated as such on their face, as well as to those notices sent to providers advising them of overpayments detected through in-house claims reviews or other post-payment reviews of a provider's claims.

2. The Department's time parameters for conducting audits to recover Medicaid overpayments to place a provider on notice of its intent to audit and its ability to enter into an agreement or undertake a combined audit with another state agency are defined, in pertinent part, in 18 NYCRR 517.3 as follows:

(b) Fee-for-service providers.

(1) All providers, who are not paid at rates or fees approved by the State Director of the Division of the Budget based upon their allowable costs of operation but who are paid in accordance with the rates, fees and schedules established by the department, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. All records necessary to disclose the nature and extent of services furnished and the medical necessity therefore...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.

- c. Notification by the department to the provider of the department's intent to audit shall toll the six-year period for record retention and audit. The department shall not notify a provider of its intent to audit more than six years from the date of filing of the fiscal and statistical reports to be audited or six years from the date they were required to be filed, whichever is later.
- f. An on-site audit begins with an entrance conference at which the nature and extent of the audit must be discussed.

[¶] . . . [¶]

- g. Where feasible, the department shall enter into an agreement to undertake a combined audit with other organizations and agencies having audit responsibilities to satisfy the department's auditing needs. In this respect, the department reserves the right, after entering into such agreement, to use the findings of the combined audit or to perform an independent audit of either limited or comprehensive scope of the same fiscal period audited by the other organization or agency. (*See Exhibit 12.*)

3. The OMH may enter into an agreement with another state agency for the purposes of an audit, as detailed in 14 NYCRR 552.5(f):

Where feasible the Office of Mental Health may enter into an agreement with other agencies...having audit responsibilities to assist in the execution of an audit. The Office of Mental Health reserves the right after entering into any such agreement, to use the findings of the combined audit or to perform an independent audit of either limited or comprehensive scope of the same fiscal period. (*See Exhibit 13.*)

4. 18 NYCRR 518.5 provides that “when a determination is made that an overpayment has been made, any person from whom recovery is sought is entitled to a notice of the overpayment.”

5. COPS allocation is defined in former 14 NYCRR 592.4(e)² as the “maximum amount of comprehensive outpatient program reimbursement that a provider is allowed to retain in each local fiscal year.”

6. A provider's entitlement to COPS Medicaid and the methodology used to calculate the

² In 2016, the New York State Legislature repealed 14 NYCRR Part 592.

reimbursement is discussed in the former 14 NYCRR 592.8. It states, in pertinent part, the following:

- a. In addition to the medical assistance reimbursement rates available pursuant to Part 588 of this Title, providers with at least one Level I Comprehensive Outpatient Program are eligible to receive supplemental medical assistance reimbursement in accordance with the rules of this Part.
- b. Supplemental reimbursement rates shall be calculated by the Office of Mental Health.
- c. The supplemental rate for providers with at least one Level I Comprehensive Outpatient Program, shall be calculated as follows:
 - (1) For outpatient mental health programs other than clinics which are designated Level I providers pursuant to this Part, grants received for the local fiscal year ended in 2001 for upstate and Long Island based providers...as well as grants received for subsequent fiscal years which have been identified for inclusion by the Office of Mental Health shall be added, if applicable, to the annualized eligible deficit approved in the calculation of the previous supplemental rate.

[¶] . . . [¶]

- (3) The sum of grants received by the provider, as recalculated under paragraph (1)... shall be divided by the projected number of annual visits to the provider's designated programs.

7. CSP is defined in 14 NYCRR 588.14(d)(1) in pertinent part as:

(C)ommunity support program services means community-based services supported by State and local aid for local or unified services pursuant to article 41 of the Mental Hygiene Law, or community-based services supported by 100 percent State aid. (*See Exhibit A.*)

8. CSP supplemental reimbursement rate calculations are stated in 14 NYCRR 588.14(d) to be configured by “the Office of Mental Health for each eligible provider” and are defined as follows:

(3) The combined total of clinic treatment, continuing day treatment, and day treatment units of service reimbursed by medical assistance shall be calculated for each provider for each of the three local fiscal years immediately prior to the base year. (*See Exhibit A.*)

9. Recovery efforts pertaining to supplemental payments are detailed in 14 NYCRR

588.14(f):

Supplemental payments which are in excess of 100 percent of the grants calculated...will be subject to recovery by the Office of Mental Health through adjustment of future payments. In cases where recoveries are necessary, the Office of Mental Health may adjust the supplemental rate prospectively. (*See* Exhibit A.)

10. The add-on component of CSP Medicaid is explained in 14 NYCRR 588.14(e) as:

The supplemental reimbursement rate calculated pursuant to subdivision (d) of this section shall be added to the reimbursement rate for each clinic treatment, continuing day treatment, and day treatment program operated by the provider and licensed pursuant to Part 585 or 587 of this Title. (*See* Exhibit A.)

11. A threshold is applied to supplemental payments in 14 NYCRR 588.13(d) and is defined

as:

Providers whose reimbursement under the medical assistance program for clinic, continuing day treatment, and/or day treatment has been supplemented in accordance with Part 592 of this Title will have this additional reimbursement limited in total to an amount established by the Commissioner which shall be subject to the availability of appropriations in the Office of Mental Health's budget. Supplemental reimbursement received in excess of this threshold will be recovered in a succeeding year through the medical assistance recovery process authorized pursuant to section 368-c of the Social Services Law. (*See* Exhibit B.)

ISSUE

Has the Appellant established that the OMIG's determination to recover an overpayment in the amount of \$109,880.46 was not correct?

ANALYSIS AND CONCLUSIONS

A. Jurisdiction

The Appellant argues that the OMIG lacks the authority to audit and recover this overpayment. The Appellant, relying on 14 NYCRR 588.14(f) and 588.13(d), claims that the OMH "has exclusive jurisdiction over the COPS and CSP programs, including the sole authority to audit and recoup any excess funds." (Appellant's brief, p. 8-9.) The Appellant's argument overlooks the language in 14

NYCRR 588.13(d), which directs recovery “through the medical assistance recovery process authorized pursuant to section 368-c of the Social Services Law.” It also misstates 14 NYCRR 588.14(f), which does not identify the OMH as the “only agency eligible” to recover overpayments, as stated by the Appellant (Appellant’s brief, p. 9), but merely describes a process by which the OMH can recover excess funds – “through the adjustment of future payments” – on a prospective basis. In contending that the OMH has “exclusive jurisdiction” over the recoupment process, the Appellant is also choosing to ignore 14 NYCRR 552.5(f), which authorizes the OMH to “enter into an agreement with other agencies” for the purposes of an audit. (Appellant’s brief, p. 8-9.)

The Appellant relies on Matter of Montefiore Medical Center, (Dept. of Health Admin. Decision, ALJ John Wiley, dated March 5, 2004), to argue that because there was no “formal written agreement between OMIG and OMH to conduct the reconciliation and recoupment,” the OMIG “lacked jurisdiction to recover the excess payments.” (Appellant’s brief, p. 13.) However, in Montefiore, (p. 12-13), the ALJ did not preclude a cooperative agreement with another agency to recover overpayments based on the absence of a written agreement. The Montefiore decision specifically references the existence of an agreement as an understanding between the parties involved in the joint audit, whether made verbally or by different means. Consistent with the Social Service and Mental Hygiene regulations, specifically 18 NYCRR 517.3(g) and 14 NYCRR 552.5(g) respectively, which mention an agreement between agencies to conduct audits “(w)here feasible,” the Montefiore decision does not require a written memorialization, as the Appellant suggests. *Id.*

The Department correctly states the OMIG’s jurisdiction in its argument that the OMIG is “authorized to pursue cooperative arrangements with other state agencies or departments, including [the OMH] when necessary to accomplish the objectives and responsibilities of the Medicaid Program” and that the OMIG’s authority extends to “recouping Medicaid funds improperly paid.” (Department brief, p. 2-3.) It is the Department, and not the OMH, that is authorized by statute and

regulation to oversee and manage these audits and recover overpayments of Medicaid funds, thereby establishing the OMIG's jurisdiction. PHL §§ 31.1(c), 32, 33; SSL § 364-a(1); 14 NYCRR 588.13.

B. Timeliness of the audit

i. Audit and notice

The Appellant raises a number of procedural objections to the OMIG's failure to issue a notice of intent to audit and to conduct entrance and exit conferences pursuant to 18 NYCRR Parts 515 and 517. The notice and conference requirements, however, apply only to on-site audits, as specifically referenced in 18 NYCRR 517.3(f) for entrance conferences, 18 NYCRR 517.3(c) for an intent to audit, and 18 NYCRR 515.5(a) for closing conferences. If the regulations intended for these auditing procedures to apply to in-house or other reviews, such as the review performed here, they would state it.

A draft audit report is defined in 18 NYCRR 517.2(b) to include a formal report produced after the performance of an on-site review of a provider's records and "those notices" which are sent to providers "advising them of overpayments detected through in-house claims reviews or other post payment reviews of a provider's claims." 18 NYCRR 517.2(b). Instead of a draft audit report resulting from an on-site review, this Draft Report was one of "those notices" under the regulation resulting from "post-payment reviews" of claims performed in-house. (Transcript, p. 74, 86.) Unlike the audit in Matter of Northern Metro. Residential Healthcare Facility v. Novello, 777 NYS 2d 277, 279 (Sup. Ct., Albany Co. 2004), which the Appellant relies upon to argue that the procedural aspects of the audit were required, the audit here did not involve the Appellant producing "particular records" for review to support the Medicaid claims. In performing this audit, which it was entitled to do, the OMIG did not require anything other than what was contained in its computer systems and files.

The Draft Report is defined in the regulation for this particular type of audit, which involved post-payment reviews of the Appellant's claims, as the only notice of the audit required. 18 NYCRR

517.2(b). If the purpose in providing a notice of intent to audit, as argued by the Appellant in its reply brief (p. 10), is to apprise a provider of the review process, the issuance of the OMIG's Draft Report and the Appellant's timely response to it, satisfied that goal. (Transcript, p. 75.)

ii. Timeliness of the audit

According to the Appellant, "the OMH regulations state that recoupment for supplemental COPS payments in excess of the annual threshold 'will be recovered in a succeeding year,' which means "the year immediately following [the] payment." (Appellant's brief, p. 14 and reply brief, p. 20.) The Department argues that "a" in the regulation, as opposed to "the," implies that "recovery not be limited to a definite or specific succeeding year, but could be any succeeding year" and that "this reconciliation audit was commenced within six years of the end of the 2003 fiscal year – timely even by audit regulation standards." (Department's reply brief, p. 8, 11.)

The Department correctly argues that the reconciliation was timely commenced with its issuance of the Draft Report on November 18, 2009. (Department's brief, p. 11, 16.) In Blossom v. Nursing Home v. Novello, 4 NY3d 581, 594 (2005), the Court gave deference to the administrative agency's interpretation of its applicable regulation, which did not specify a deadline for commencing audits, and considered a recovery timeframe of more than six years as untimely. The applicable regulation, 14 NYCRR 588.13(d), permits recovery of supplemental reimbursements received above the threshold amount to occur "in a succeeding year." While the Appellant argues that "a succeeding year" under the regulation means the next year, the regulation specifically does not say this.

The Court in Blossom rejected a timeframe to initiate recoveries of Medicaid overpayments as seven years. *Id.* at 584. Here, while 14 NYCRR 588.13(d) authorizes recovery in "a succeeding year" and considers a delay in the audit process of at least one year after the payment year, it is reasonable for the Department to apply the timeframe specified in the regulation generally used for audits under 18 NYCRR Part 517, which is six years. 18 NYCRR 517.3. According to the Court in Blossom,

“[c]ourts normally ‘defer to an administrative agency’s interpretation of its regulations if not irrational.’” Blossom, 707 NY3d at 594. Since the OMIG’s reliance on the six years in the regulation is reasonable, deference should be given to such interpretation, which is consistent with the analysis in this decision. *Id.* Indeed, the Department’s OMH and OMIG witnesses agree that the agencies have as a “vetted” goal compliance with “the six-year statute,” which demonstrates their reliance on 18 NYCRR 517.3. (Transcript, p. 89, 125.)

The Appellant’s argument that the OMIG is time-barred from recovering the overpayments since the recoupment of the COPS and CSP payments involve “a multitude of services that were rendered prior to November 2003,” is misplaced. (Appellant’s brief, p. 20.) The parties do not dispute that claims were properly made between 2000 and 2003 and appropriately paid. (Transcript, p. 21.) Similar to the claims made in Matter of Northern Metro. Residential Healthcare Facility, Inc., 777 NYS at 282, and Montefiore, p. 12, this case involved claims made and paid pertaining to services rendered more than six years prior to the issuance of the Draft Report. Unlike those cases, however, the triggering event here is when the threshold adjustment occurred and not when claims were made or paid.

The evidence established that the supplemental overpayments accrued at the end of each of the fiscal years 2003, 2004 and 2005. (Transcript, p. 161.) Instead of establishing the threshold for a provider for the supplemental payments on a claim-by-claim basis, Mr. Aiezza explained that the threshold was calculated as “an annual figure,” “at the end of the year,” and “after the last bill is paid.” (Transcript, p. 160.) The process was also explained in a letter from the OMH to Appellant’s counsel dated June 18, 2015. In that letter, Mr. Aiezza stated “that the COPS/CSP reconciliation/recovery process is one which results in a determination using a provider’s fiscal year threshold for the Medicaid Supplement in question compared to the sum of actual Medicaid receipts for that same fiscal year period, irrespective of [the] date of service of the paid claims.” (Exhibit 10.)

The Department accurately states the timeliness of this audit. (Department’s reply brief, p. 11.) According to Mr. Aeizza, “the 2003 through ‘5 reconciliation process was begun in 2009.” (Transcript, p. 124.) The evidence established payments in December of 2003 for services rendered prior to 2003, reaching as far back as 2001 and 2002. (Transcript, p. 157.) Despite this, the reconciliation was timely commenced within six years from the date that the overpayment accrued, which was calculated after the last payment was received at the end of the fiscal year for 2003 or December of 2003, with the issuance of the Draft Report dated November 18, 2009. (Exhibit E.)

C. Other issues raised

The Appellant argues that at the time the OMIG issued the Revised Draft Report, the initial Draft Report was “withdrawn,” which resulted in it not being placed on actual notice sufficient for it to respond to the assertion that it received COPS and CSP payments “in excess of its annual threshold” until that time. (Appellant’s brief, p. 14-15, 22.) This argument is not supported by the evidence, which never confirmed any withdrawal, and it suggests that new information was contained in the Revised Draft Report that could not have been addressed from the Draft Report. Aside from the Revised Draft Report containing a new and lower “drastically different amount,” there was no new information conveyed in the Revised Draft Report. (Exhibits. 1, 3.) In its response to both reports, Appellant’s challenges were the same and were specific to the recoupment attempts and the “amount” of the “recovery.” (Exhibits 2, 4.) The Draft Report provided Appellant with sufficient notice of the overpayment determination and the basis for it, which never changed.

Although the Appellant has not identified a statutory or regulatory timeframe that has been violated, it nonetheless contends that it has incurred “substantial prejudice” as a result of an “unreasonable delay” between the date that the audit was commenced and the audit’s completion date. (Appellant’s reply brief, p. 16.) Instead of proposing a timeframe to commence this review, the

Appellant unpersuasively argues that it has been prejudiced by the OMIG's inability to produce at hearing "individuals involved with the calculation of the COPS and CSP rates for the time period relevant to this audit." (Appellant's reply brief, p. 17.) However, under 18 NYCRR 519.17(a), the OMIG's responsibility at the hearing was to produce "a representative...to present the audit file and summarize the case," which it did. (Department's reply brief, p. 17.)

Without challenging any aspect of the overpayment amount, the Appellant argues that the delay in commencing this audit "ranged from 11 to 13 years from the time that the COPS and CSP payments were made and the administrative hearing ... held in 2015" and "up to 16 years" between the time that the services were rendered and the hearing occurred." (Appellant's brief, p. 23.) This is laches defense, which, as stated by the Department in its reply brief (p. 18), cannot be used against the state under the circumstances of this case. Matter of Cortlandt Nursing Home v. Axelrod, 495 N.Y.S.2d 927, 932 (1985). Notwithstanding the Appellant's characterizations of the audit, the threshold calculations were done within the applicable six-year statute of limitations of the issuance of the Draft Report dated November 18, 2009. The OMIG is authorized to recoup the overpayment amount.

Conclusion

The Appellant has not met its burden of proof in showing that the OMIG's determination to recover the overpayment amount was incorrect. The Appellant has failed to offer any evidence to challenge the accuracy of the OMIG's determination to recover the threshold overpayment or that the audit was untimely or improperly conducted.

DECISION:

The Department's determination in the Final Audit Report to recover \$109,880.46 for Level I COPS Medicaid overpayments in the amount of \$73,977.93 and CSP overpayments in the amount of \$35,902.53 is

affirmed.

This decision is made by Dawn MacKillop-Soller, who has been designated by the Commissioner of the New York State Department of Health to make such decisions.

Dated: _____, 2016
Albany, New York

Dawn MacKillop-Soller
Administrative Law Judge