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NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Acting Executive Deputy Commissioner

December 11, 2023

CERTIFIED MAIL/RETURN RECEIPT

Michael Derevlany, Esq.
NYS Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

NewCo ALP, Inc. d/b/a Island Assisted Living
800-820 Front Street
Hempstead, New York 11550

Jennie L. Shufelt, Esq.
David B. Morgen, Esq.
Hinman Straub P.C.
121 State Street
Albany, New York 12207

RE: In the Matter of NewCo ALP, Inc. d/b/a Island Assisted Living

Dear Parties:

Enclosed please find the Decision After Hearing in the above referenced matter.

If the appellant did not win this hearing, the appellant may appeal to the courts pursuant to the provisions of Article 78 of the Civil Practice Law and Rules. If the appellant wishes to appeal this decision, the appellant may wish to seek advice from the legal resources available (e.g. the appellant's attorney, the County Bar Association, Legal Aid, OEO groups, etc.). Such an appeal must be commenced within four (4) months after the determination to be reviewed becomes final and binding.

Sincerely,

Natalie J. Bordeaux

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB:nm
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

COPY

In the Matter of the Appeal of

NewCo ALP, Inc. d/b/a/
Island Assisted Living
Medicaid ID #03757384

from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments.

Decision After Hearing

#19-4608

Before: John Harris Terepka
Administrative Law Judge

Held at: New York State Department of Health
By videoconference
August 23, September 12, 2023
Record closed November 22, 2023

Parties: New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
By: Michael Derevlany, Esq.
michael.derevlany@omig.ny.gov

NewCo ALP, Inc. d/b/a/ Island Assisted Living
800-820 Front Street
Hempstead, New York 11550
By: Jennie L. Shufelt, Esq.
David B. Morgen, Esq.
Hinman Straub P.C.
121 State Street
Albany, New York 12207
jshufelt@hinmanstraub.com
dmorgen@hinmanstraub.com

JURISDICTION

The New York State Department of Health (the Department) acts as the single state agency to supervise the administration of the Medicaid Program in New York State. Public Health Law 201(1)(v); Social Services Law 363-a. The Office of the Medicaid Inspector General (OMIG) is an independent office within the Department, responsible for the Department's duties with respect to the recovery of improperly expended Medicaid funds. PHL 30, 31, 32.

The OMIG determined to seek restitution of payments made under the Medicaid Program to NewCo ALP, Inc. d/b/a/ Island Assisted Living (the Appellant). The Appellant requested a hearing pursuant to Social Services Law 145-a and 18 NYCRR 519.4 to review the determination. A hearing was originally scheduled for October 4, 2022, but was rescheduled seven times on the request of the Appellant with the OMIG's consent, and commenced on August 23, 2023.

HEARING RECORD

OMIG witnesses:	Jesse Dvorak, Medicaid integrity specialist Susan Montgomery, division director Karl W. Heiner, PhD, statistical consultant
OMIG exhibits:	1-11
Appellant witnesses:	Harold S. Haller, PhD, statistical consultant Aaron Sacks, administrator Samuel Horowitz, former administrator
Appellant exhibits:	A-P, R, S, U, V, W, Y, Z

A transcript of the proceedings was made. (Transcript pages 1-322.) After the OMIG submitted one and the Appellant submitted two post hearing briefs, the record closed on November 22, 2023.

SUMMARY OF FACTS

1. The Appellant operates a 200 bed Assisted Living Program in Nassau County and is enrolled as a provider in the New York State Medicaid Program. (Exhibit S, page 1; Transcript, pages 13, 197.)

2. The OMIG performed an audit of the Appellant's claims for services provided to Medicaid recipients and paid by the Medicaid Program. The purpose of the audit was to determine whether the Appellant's records demonstrated compliance with Medicaid Program requirements.

3. The Appellant was paid $20,394,569.88 by the Medicaid Program for 127,791 claims for services provided to Medicaid recipients during the period January 1, 2014 through December 31, 2016. The audit consisted of a review of a random sample of 100 of these claims, paid in the total amount of $15,597.13. (Exhibit 3.)

4. After reviewing the Appellant's documentation in support of its claims for Medicaid reimbursement for the services in the sample, the OMIG identified 25 violations of Medicaid Program requirements in the submission of 22 of the 100 claims, and disallowed payments in the total amount of $3,293.41. (Exhibit 3, attachment C.)

5. The OMIG issued a draft audit report dated March 21, 2022, which identified proposed findings and afforded the Appellant an opportunity to present additional documentation and argument in objection to them. (Exhibit 1.)

6. The Appellant submitted a response to the draft audit report, along with additional documentation, on May 2, 2022. (Exhibit 2, pages 1-381.)

7. By final audit report dated July 1, 2022, the OMIG notified the Appellant that after reviewing the Appellant's response, the audit findings and overpayment determination remained the same. (Exhibit 3.)

8. The audit report organized reasons for disallowances into eight categories:

1. Missing entry in the uniform assessment system for NY (UAS-NY). Fourteen claims. (Samples 3, 4, 5, 8, 15, 25, 29, 31, 41, 53, 69, 76, 77, 93.)
2. Failure to complete required in-service training for home health aide. Three claims. (Samples 11, 33, 60.)
3. No service rendered. Two claims. (Samples 73, 82.)
4. Missing documentation of a tuberculosis skin test or follow-up. Two claims. (Samples 76, 99.)
5. Missing service documentation. One claim. (Sample 65.)
6. Plan of care not updated as required. One claim. (Sample 73.)
7. Missing required health assessment. One claim. (Sample 76.)
8. Invalid service documentation. One claim. (Sample 79.)

Payments disallowed for more than one reason were only disallowed once. (Exhibit 3.)

9. The draft and final audit reports advised the Appellant that the OMIG had determined to seek restitution of Medicaid Program overpayments in the amount of $3,410,792. (Exhibits 1, 3.)

10. The restitution amount sought by the OMIG includes an extrapolation utilizing a statistical sampling method in which overpayments found among the randomly selected sample of 100 claims were projected to the total of 127,791 claims for services under audit. (Exhibits 8 & 9.) The total overpayment in the audit sample was $3,293.41. For the purposes of extrapolation, the OMIG used the overpayment findings in disallowance categories 1, 3, 5, 6 and 8, in the total amount of $2,668.55. The overpayment determination for disallowance categories 2, 4 and 7 was limited to the sample findings, however sample 76, disallowed in categories 4 and 7, was also

disallowed in category 1. The total overpayment that was not extrapolated (samples 11, 33, 60, 99) was $624.86. (Exhibit 3, attachment B.)

ISSUES

Was the OMIG's determination to recover Medicaid Program overpayments from the Appellant correct? If so, what is the amount of the overpayment?

APPLICABLE LAW

Medicaid providers are required, as a condition of their enrollment in the Medicaid Program, to comply with the rules, regulations and official directives of the Department. They must prepare and maintain contemporaneous records demonstrating their right to receive payment from the Medicaid Program and fully disclosing the nature and extent of the care, services and supplies they provide. The information provided in relation to any claim must be true, accurate and complete. All information regarding claims for payment is subject to audit, and providers are required to maintain records to support their claims for six years. 18 NYCRR 504.3(a),(h)&(i), 504.8, 517.3(b)&(c), 540.7(a)(8).

When the Department has determined that claims for medical services have been submitted for which payment should not have been made, it may require repayment of the amount determined to have been overpaid. 18 NYCRR 518.1(b). An overpayment includes any amount not authorized to be paid under the Medicaid Program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake. 18 NYCRR 518.1(c).

A person is entitled to a hearing to have the Department's determination reviewed if the Department requires repayment of an overpayment. SSL 145-a(2); 18 NYCRR 519.4. At the hearing, the Appellant has the burden of showing that the determination of

the Department was incorrect and that all claims submitted and denied were due and payable under the Medicaid Program. 18 NYCRR 519.18(d).

An extrapolation based upon an audit utilizing a statistical sampling method certified as valid will be presumed, in the absence of expert testimony and evidence to the contrary, to be an accurate determination of the total overpayments made. The Appellant, however, may submit expert testimony and evidence to the contrary, or an actual accounting of all claims paid in rebuttal to the Department's proof. 18 NYCRR 519.18(g).

Regulations of the former Department of Social Services most pertinent to this hearing decision are at 18 NYCRR Parts 505 (medical care, in particular 505.35, assisted living programs); 517 (provider audits); 518 (recovery and withholding of payments or overpayments); 519 (provider hearings); and 494 (assisted living program). Also pertinent are regulations of the Department of Health at 10 NYCRR Parts 763 (certified home health agencies, long term home health care programs); and 766 (licensed home care services agencies-minimum standards).

DISCUSSION

The Appellant operates a 200-bed assisted living program approved pursuant to SSL 461-l, 18 NYCRR 485.3(n) and 18 NYCRR Part 494, that provides services to residents who are Medicaid recipients. The Appellant is paid a daily rate for each Medicaid eligible ALP resident based upon the resident's assessed level of care needs. 18 NYCRR 505.35(h)(1). (Transcript, pages 13-14, 197-98.)

For the three-year audit period under review, the Appellant was paid well over $20 million by the Medicaid Program for 127,791 claims for ALP services. (Exhibit 3.)

Payments for each per diem claim varied between $60 and $300 with a payment mean of just under $160. (Exhibit 9, page 2421.) The OMIG audit report disallowed 22 of the 100 sampled claims for 25 reasons. The disallowances were made because the OMIG determined that the services were not documented to have been provided in accordance with applicable Medicaid requirements.

The OMIG's audit procedures included issuance of a draft audit report and a review of the Appellant's lengthy written response to it, followed by issuance of the final audit report. (Exhibits 1, 2, 3.) These documents were exchanged between the parties in accordance with audit procedures set forth at 18 NYCRR 517.5 and 517.6. The audit reports set forth the OMIG's conclusions and reasons for each category of disallowance, listed every disallowed claim, and explained how the extrapolation was performed. The final audit report complies with the obligation to "clearly advise the provider... of the nature and amount of the audit findings, the basis for the action and the legal authority therefor." 18 NYCRR 517.6(b).

The Appellant claims the OMIG's use of audit protocols in the conduct of this audit constituted illegal rulemaking. (Appellant brief, pages 26-28.) The Appellant also objects that the OMIG used its March 2017 protocol in effect at the time it conducted this audit, when a November 2013 protocol which does not mention the UAS-NY system was the one in existence at the time the audited services were provided. (Appellant brief, page 13.) These objections are meritless.

The OMIG's audit protocols are not rules imposed upon providers. They are working documents for auditors, used as guidelines in their efforts to identify violations of rules and regulations. (Exhibit V, page 1.) The disallowances in this audit were not

made on the authority of audit protocols. The audit reports do not even mention protocols. As OMIG auditor Dvorak explained:

> So the protocol is just to relay – to point to regulations and guidance that have been written other places. It's just something for the auditor to use as a sort of guidance tool, so that they can very easily find relevant regulations that would apply to the error that they're currently working on. (Transcript, page 47.)

No protocol was, as the Appellant claims, "used as a basis for disallowance." (Exhibit 2, page 18.) As is set forth in the audit reports, the basis and authority for these disallowances was the Appellant's failure to document compliance with Medicaid reimbursement rules. As the Appellant itself points out, the OMIG does not make these rules; they are established by the Department and the Medicaid Program, not the OMIG. (Appellant brief, page 28.) Whatever the protocol used and whatever its date, the only pertinent issue is whether its use led the auditors to correctly identify an audit disallowance that is appropriate under those rules and requirements of the Department and the Medicaid Program.

The audit findings.

1. Missing entry in the uniform assessment system for NY (UAS-NY). Fourteen claims. (Samples 3, 4, 5, 8, 15, 25, 29, 31, 41, 53, 69, 76, 77, 93.)

In March 2013, the Department began the implementation of the Uniform Assessment System for New York (UAS-NY). The UAS-NY is a web-based software application system that has replaced assessment tools previously used for ALP recipients and instead requires entries to be made in an on-line database. Medicaid Update, February 2013, Vol. 29, No. 3; UAS-NY Transition Guide, March 4, 2013. (Exhibits 10, 11). ALPs in Nassau County were advised beginning in February 2013 that they were required to have full implementation using only the UAS-NY by February 1, 2014. (Exhibit 10, page 5; Exhibit 11, page 9.)

The UAS-NY electronic system, as OMIG division director Susan Montgomery explained, has several purposes. In addition to enabling the Department to electronically perform the RUGS-II scoring that enables a Medicaid rate to be calculated, it is intended to establish a single, unique record for individuals in the Medicaid home and community based long term care programs. The Department set up and implemented the UAS-NY

system to be on-line and with the expectation that it would be accessed and used that way. As Ms. Montgomery pointed out, "off-line client" use is allowed, but that is only by special request. Paper records, if made, must still be transferred to the system and electronically signed by a nurse in order that the data can end up in the system for use by the Department in various ways. Providers were given repeated notice and ongoing assistance from the Department on these requirements. (Transcript, pages 86-93, 95-96, 100; Exhibits 10, 11; Exhibit W, pages 15-16, 33-36, 48.)

The Department's implementation of its documentation and reimbursement requirements did not constitute rulemaking under SAPA. The Department was authorized to specify the manner in which required documentation was to be maintained in order to support Medicaid claim submissions. 18 NYCRR 504.3(f); Pharmacists Soc. of NY v. Pataki, 58 AD3d 924, 870 NYS2d 633 (3rd Dept. 2009), *lv. to appeal den.*, 12 NY 3d 710, 881 NYS2d 20 (2009). Providers were repeatedly advised of the implementation of these requirements:

> The UAS-NY will replace the DSS-4449B and DSS-4449D assessment tools used for Assisted Living Program (ALP) recipients as well as the PRI tool used for determining programmatic eligibility and RUGS-II groups used for billing. Programs will stop using the PRI tool for billing once they begin using the UAS-NY. Medicaid Update, Vol. 29, No. 3, February 2013. (Exhibit 10, page 6; *see also* Exhibit 11, page 7.)
>
> After your implementation deadline, you must administer assessments using *only* [italics in original] the UAS-NY.
>
> ...
>
> Under *extenuating circumstances*, assessors may use a paper version of the assessment instruments; in this situation, both supplements must also be completed. The information from the assessment must be entered into the UAS-NY so that the assessment may be signed. UAS-NY Transition Guide, March 4, 2013. (Exhibit 11, pages 9, 14.)
>
> The facility is required to have (1) an active Health Commerce System (HCS) account... Other than in extenuating circumstances, assessors are expected to enter responses to the assessment directly into the UAS-NY application. Dear Administrator Letter (DAL) 14-09, April 11, 2014.

These official directives of the Department are entirely consistent with applicable recordkeeping rules and regulations and providers are required to comply with them. 18 NYCRR 504.3(f).

Periodic assessments of residents must be conducted and documented at least every six months. 10 NYCRR 766.6; 18 NYCRR 494.4(h), 505.35(h)(4). (Transcript, page 15.) Resident assessments are among the instruments required on the UAS-NY system. (Exhibit 11, page 7.) In 14 instances, the Appellant did not enter the required assessments in the UAS-NY system. Instead, it printed out a paper copy of the resident's

"Personal Health Summary Report" for an assessment done six months earlier, to which a nurse then added a handwritten signature and date at the bottom. (Exhibit 2, pages 285-334; Exhibits A-N; Transcript, pages 24, 57, 259.) The new documentation consists only of an RN signature and handwritten date, with no other new information and no contemporaneous notation that a new assessment was actually done or even that the assessment done six months earlier was reviewed. According to the Appellant, this procedure was sufficient to establish compliance with interim assessment documentation and reporting requirements if "no significant change in the resident's condition had occurred." (Appellant brief, page 12.)

The Appellant does not claim that the assessments at issue were signed on the UAS-NY system and has offered no evidence of any "extenuating circumstances" excusing it from using the UAS-NY online. Nor does the Appellant claim it could not have used UAS-NY for these assessments. It clearly did have an online account and the ability to use it, as it had done so to enter previous assessments on UAS-NY for each one of these 14 residents. (Exhibits A-N.) It has offered no explanation for its failure to do so again beyond claiming to have believed, contrary to all the evidence of the instructions it received, that it was not required.

Mr. Horowitz, the facility administrator at the time, acknowledged, and the Appellant agrees, that annual assessments were required to be and were entered in the UAS-NY electronic system. (Transcript, page 269; Appellant brief, page 5.) He claimed, however, that if there was "no significant change" a six-month assessment did not also need to be entered in the system. A nurse simply printed and signed the Summary Report from the previous assessment and placed it in the resident file. (Transcript, pages 258-62.) The Appellant offered no evidence or authority for any such distinction in documentation and reporting requirements between one year and six-month assessments. OMIG division director Montgomery testified: "[T]he uniform assessment system is required for both assessments for A.L.P.s." (Transcript, page 100.)

Mr. Horowitz claimed the Appellant was acting on "guidance" from the Department on this point, and that it was told by OMIG representatives in a 2015 trade group conference presentation that it would be acceptable to simply print, sign and date paper copies of the last assessments. (Transcript, pages 261-65; Appellant brief, pages 6, 8.) His recollections about what providers were told during this presentation are not supported by any other evidence and are inconsistent with the actual documentation of that presentation, also submitted by Appellant, which includes:

> If the Uniform Assessment System for NY (UAS-NY) entry is missing from the patient on line file, the paid claim will be disallowed. (Exhibit W, page 33.)

An even more fundamental deficiency than failure to enter assessments on the UAS-NY system is raised by the Appellant's argument that it was entitled to comply with the six-month assessment requirements by other means. It claims that it did comply with six-month assessment requirements, pointing out that the regulations do not mention the UAS-NY system. (Transcript, pages 41, 103-104.)

According to the Appellant, the UAS-NY "replaced only the Annual Assessment forms," and so "the DSS-4569 [Assisted Living Program Interim Assessment], a tool not replaced by the UAS-NY, could still be used for the interim assessment." (Appellant brief, pages 5, 8; Reply brief, page 3.) It submitted, with its brief, Department instructions for the use of assessment forms before the UAS-NY system was introduced, which state:

> In order to streamline the reassessment and documentation process as much as possible, interim evaluation forms have been developed. These abbreviated forms may be used at the 45 day and six month reassessments if the resident's condition has not significantly changed, i.e., there is no change in the resident's RUG category. (Appellant brief, appendix I-2.)

The Appellant did not produce a DSS-4569 or any other interim assessment form for any of these 14 residents. It then also maintained, in spite of these instructions and its own claim that they still appled, that "[n]o specific form of documentation was prescribed by DOH" (Appellant reply brief, page 4) and so its disregard of existing interim assessment forms did not matter because:

> ALPs had no reason to believe that the process that applied to the Interim Assessment prior to adoption of the UAS-NY (e.g., signing and initialing the existing Annual Assessment instruments) would not continue to apply after the transition to the UAS-NY. (Appellant brief, page 7.)

The Appellant submitted no persuasive evidence or authority suggesting that simply photocopying and signing a six month old assessment summary with no documentation of a contemporaneous assessment was ever "the process that applied."

According to the Appellant, the 2015 OMIG presentation "guidance" it relies on (Exhibit W) advised providers:

> (b) the DSS-4569 (a tool not replaced by the UAS-NY) could still be used for the interim assessment (Ex. W-020); and (c) the review of the annual DSS-4449D [Nursing/Functional/Social Assessment] "can be documented on the physical document itself or the Interim Assessment" (i.e. the DSS 4569) (Ex. W-027.) (Appellant brief, pages 8-9.)

The presentation document quoted by the Appellant actually reads, more fully:

> The medical re-assessment is a follow up examination that occurs 6 months after the medical evaluation or upon a change in condition. It is the equivalent of the medical order for the service. The document (either a Medical Evaluation DSS-4449-C or Interim Assessment DSS-4569) is required when the medical evaluation is 6 months old or a change in condition has occurred. If the Re-Assessment is missing when required, the paid claim will be disallowed.

...

> This review can be documented on the Nursing/Functional/Social Assessment physical document itself, the *[sic]* Interim Assessment in the nurses section stating there has been an assessment of the patient and no condition change exists. The review can also be performed on a separate document provided it has all the required elements of the original document and illustrates a review. (Exhibit W, pages 20, 27.)

The Interim Assessment form DSS-4569, a copy of which was attached to the Appellant's brief, asks not only for a description of any changes in status, current medications, and skilled professional services, but for signed statements from both a physician and nurses explicitly affirming that they have examined and conducted a reassessment of the resident. (Appellant brief, page 4 & appendix I-1.) Administrator Horowitz also testified:

> Q. Are you familiar with the term interim assessment or reassessment?
> A. Yes.
> Q. What is that?
> A. So every six months the – the nurse – the facility nurse would review the annual... Generally, a either a – a four four four nine C was used or there was is a D.O.H. form. The interim assessment form, the number eludes me, I think it's four five something, something. I think that's what the official number of the name of the document is. But either way it would be, you know, that document filled out and also signed by – also signed by the doctor. In addition to a list of the current medication, which would also be signed by the doctor, a new plan of care, which would be done by the facility nurse and the annual U.A.S., which was done six months prior, was reviewed and signed by the nurse.
> ... if there was no significant change, they would review that annual U.A.S. from six months prior and date it the same time as the -- when, you know, whenever the six-month review was due, along with the rest of the papers that go with it. (Transcript, pages 258-259.)

The only records the Appellant offered, both in its lengthy response to the draft audit findings and at the hearing, were printed copies of UAS-NY Personal Health Summary Reports done six months earlier, each with a signature and new date handwritten by the same nurse at the bottom of the page. (Exhibit 2, pages 285-334; Exhibits A-N.) It presented no "rest of the papers that go with it" either in response to the draft audit report or at this hearing.

The very trade group that hosted the 2015 OMIG presentation on which the Appellant relies (Exhibit W) had advised its provider members the year before:

> There seemed to be disagreement between Department officials on the call, with some thinking that the UAS Summary Report signed by the physician is sufficient; and others thinking that in addition to the UAS Summary Report, the

> old ALP Interim Assessment form would be completed and signed. I emphasized the need for clear guidance on this issue as soon as possible. In the meantime, the safest route is to use both documents. (Exhibit 2, page 337.)

No contemporaneous physician's signature has been offered in connection with these interim assessments on a UAS summary report, form DSS-4449C, DSS-4569 or any other record. The Appellant ignored all of this "thinking" and advice, and rather than using "both documents" did not use either.

A signature and date added to a six month old document, with nothing more, do not document or "illustrate a review." There are no contemporaneous notations documenting that the resident was examined and the required assessment was performed. According to the Appellant, that can simply be assumed to have been done because one nurse wrote a signature and date at the bottom of a printed copy of each of the earlier assessment summaries.

The Appellant repeatedly attempted to maintain that it is "undisputed" that it actually performed, completed and documented new six-month assessments. (Appellant reply brief, pages 3, 10.) The evidence does not justify this conclusion. A new signature documents at most that an old assessment was looked at, not that a new assessment was done. As Mr. Horowitz himself testified, staff "reviewed the U.A.S," not the resident. (Transcript, pages 259-60, 262.) OMIG auditor Dvorak accurately identified and responded to the Appellant's attempt to elide this issue:

> Q. So there's no dispute, it [the assessment] was performed. Is that correct?
> A. I mean, I – I – I couldn't say that for sure. I mean, you are correct in saying that there is a signature and there is a date. But as to what exactly that means, I – I – I couldn't say. (Transcript, page 55.)

The requirements of 18 NYCRR 494.4(h) & 505.35(h)(4) are that resident assessments be conducted "in no event less frequently than once every six months," not "every six months, unless the provider does not think it is necessary." These signatures suggest that the Appellant was aware it was required to perform and document six-month assessments, but they do not show it actually did so. As the Appellant's administrator at the time of the services under audit explained, this was "Because the nurses already had a ton of work to do, and of course, patient care is – is key, you know so the more time they're on the floor, the better." (Transcript, page 262.)

These facts are significantly different from the circumstances in Able Health Services v. OMIG, 59 Misc.3d 171, 67 N.Y.S.3d 755 (Sup.Ct. Albany County 2017), where the provider also photocopied and re-signed earlier forms. The forms in that case were not offered as documentation of a required evaluation. In this case, the photocopies of previous assessments were all that the Appellant produced to document a new assessment. Nothing was produced to document that the required six-month assessments at issue were actually performed.

These facts also distinguish this case from OMIG audit administrative hearing decisions in which electronically submitted forms did not include required information, but on audit the provider was able to produce contemporaneous documentation demonstrating entitlement to payment for services that were in fact provided. Chelsea Express Transportation (#11-5528, issued 5/24/2019); David M. Poole (#2017Z31-038W, issued 3/8/2021); Statewide Ambulette (13-F-2317, issued 10/28/2015). In this case, no such contemporaneous documentation was produced.

The Appellant did not enter the interim assessments in the UAS-NY system as instructed, nor did it document the conduct of them in any other manner. Its arguments in effect amount to a claim that the advent of the UAS-NY system not only did not impose any documentation or reporting requirements for six-month assessments; it also excused the existing requirement to document the conduct of such assessments or use reporting instruments that did exist, such as the DSS-4569, leaving the Appellant free to do nothing more than simply copy, sign and date - without providing any representation or recording any current information about the resident - a six month old record.

The Appellant has not met its burden of proving the determination of the Department was incorrect and that these claims were due and payable under the Medicaid Program. 18 NYCRR 519.18(d). The disallowances are affirmed.

2. Failure to complete required in-service training for home health aide. Three claims. (Samples 11, 33, 60.)

Home health aides are required to participate in 12 hours of in-service education each year. 10 NYCRR 763.13(l)(1), 766.11(i)(1).

Sample 11, [redacted]16. Sample 60[redacted]/16. No in-service training was documented for this employee who provided care to a resident. The Appellant points out that the employee was hired on November 11, 2015. It argues that because she had one year in which to complete the 12 hours of in-service training, her provision of services in March 2016 was not in violation of the cited regulation. (Exhibit 2, pages 21, 343-44.)

The regulation does not state that new employees cannot provide any services until they have completed 12 hours of training. It requires them to complete 12 hours of training each year. These disallowances are of claims for service provided by this employee in March 2016. At that time the employee was not out of compliance with this requirement because she was still within the first year of employment. Although the evidence is that this employee ultimately was out of compliance because she did not complete any hours of training by November 2016, that is not a valid basis for disallowing the March 2016 services under audit.

OMIG auditor Dvorak did not dispute that new hires have one year to complete the 12 required hours of training. He claimed that the problem in these claims is that this employee was not documented ever to have received the required 12 hours in her first year of employment. (Transcript, page 25.) The Appellant's eventual failure to comply

with training requirements may be an appropriate survey issue, but it is not relevant to this audit of specific claims when the failure did not exist at the time of the claim.

Sample 33, [redacted]/16. The evidence does not establish when this employee was hired, nor did the Appellant claim she was a recent hire. The Appellant documented only 8 hours of in-service training for her during the entire year before the date of service. The Appellant claimed another 3 hours was also documented, but only by a start time, so the number of hours was not recorded. Even if the 3 hours are credited, that made a total of 11 hours in the year before the date of service. (Exhibit 2, pages 21, 347-353; Transcript, pages 26-27.) The employee did not complete any additional hours until June 22, 2016, over six months after the date of service. The Appellant has failed to establish compliance with 10 NYCRR 763.13(l)(1) & 766.11(i)(1) at the time the service under audit was provided.

The disallowances in the amount of $136.74 for Sample 11 and $175.69 for Sample 60 are reversed. The disallowance of $175.69 for Sample 33 is affirmed.

3. No service rendered. Two claims. (Samples 73, 82.)

Services must have been furnished to entitle the provider to payment. 18 NYCRR 540.7(a)(8).

The Appellant conceded that it was not entitled to be paid for these services because the residents were hospitalized on the dates for which services were claimed. (Exhibit 2, pages 21-22; Transcript, pages 202-203.) It initially suggested, in response to the draft audit report, that a self-disclosure it made on January 16, 2018 should excuse these "billing errors." (Exhibit 2, pages 21-22; Exhibit S.) It also acknowledged, however, that the self-disclosure it relied on "inadvertently missed" and did not include these claims. (Exhibit 2, pages 21-22; Appellant brief, page 16; Reply brief, page 12.)

After this audit was completed, the Appellant compiled what administrator Sacks called a "second self-audit," which is simply an undated list of additional claims admittedly submitted for hospitalized residents, this time including the two claims in the audit sample. (Exhibit R; Transcript, pages 203-210.) The Appellant suggested that this list of 45 overpayments is an actual accounting that rebuts the extrapolation. (Transcript, page 206; Appellant brief, page 16.)

Regulations at 18 NYCRR 519.18(g) permit an "actual accounting of all claims paid," not a list of selected overpayment admissions such as this. The Appellant offered no evidence to support the "self-audit," explanation of how it was done, or way to evaluate and determine its accuracy. This post-audit admission to 45 specific overpayments leaves 127,746 claims for which no accounting was given. To the extent it is relevant to the audit findings, it simply confirms that the Appellant did in fact, as the sample revealed, have a problem with submitting claims for residents on days they were hospitalized and not at the facility.

4. Missing documentation of a tuberculosis skin test or follow-up. Two claims. (Samples 76, 99.)

Personnel who have patient contact must have a documented tuberculin skin test. 10 NYCRR 763.13, 766.11. The Appellant conceded it was unable to document the required tests for personnel with patient contact in the provision of these services. (Exhibit 2, page 22.)

5. Missing service documentation. One claim. (Sample 65.)

Providers must maintain and produce records documenting entitlement to payment for a service. 18 NYCRR 504.3(a), 517.3(b)(1). The Appellant conceded the "misplacing of the service documentation for this single claim" and argued the disallowance should not be extrapolated. (Appellant brief, page 18; Exhibit 2, page 22.)

6. Plan of care not updated as required. One claim. (Sample 73.)

A plan of care for each patient must be established and reviewed every six months. Each review must be documented in the clinical record. 10 NYCRR 766.3. A plan of care had not been completed for this resident within the six months before the [redacted] 2015 date of service. The last plan of care was dated December 5, 2014.

The Appellant points out that the resident was not at the facility on [redacted] 2015, the date of service, because she was hospitalized that day. (Exhibit O.) It argues that if she was not in the facility an updated plan of care could not be done until she returned. It documented that the plan was updated on [redacted], 2015, claiming that was the day she returned. (Exhibit O, page 3; Exhibit 2, page 23; Transcript, pages 211-14; Appellant brief, page 17.)

Asked: "So could Island have assessed or developed a new plan of care for her while she was hospitalized?" OMIG auditor Dvorak conceded: "I'm not sure that that would have been possible." (Transcript, page 60.) The OMIG did not dispute the Appellant's claims that the resident was already hospitalized before [redacted] when the six month period expired, and that she returned from the hospital on [redacted] the date the plan of care was updated. (Transcript, pages 66, 221, 237-38; Exhibit Y.)

The disallowance is reversed, but as this claim was also disallowed in category 3, no service rendered, reversal does not affect the overpayment findings.

7. Missing required health assessment. One claim. (Sample 76.)

The health status of all personnel must be assessed and documented. 10 NYCRR 763.13. The Appellant conceded it was unable to document that an individual with patient contact for the sampled claim had received the required health assessment. (Exhibit 2, page 24; Transcript, pages 29-30.)

8. Invalid service documentation. One claim. (Sample 79.)

Providers are required to maintain records demonstrating the right to receive payment. 18 NYCRR 504.3(a). An operator is required to maintain staff records including staffing schedules, time and payment records. 10 NYCRR 763.13(i); 18 NYCRR 487.10(d), 488.10(d).

For sample 79, one component of the care provided on Thursday, [redacted] 2016, daily change of bed linen, was documented by the initials of an aide who did not work that day. (Exhibit P, pages 1-2; Transcript, pages 30, 67.) The Appellant agrees the aide did not work on [redacted], and claims the aide inadvertently initialed the wrong date box for a bed service. (Exhibit 2, pages 24-25; Appellant brief, pages 14-15.)

The Medicaid payment is for a per diem package of services provided to the resident pursuant to 18 NYCRR 505.35(h). (Transcript, page 70.) As administrator Sacks pointed out, the services provided under the per diem rate include home health care, medication management, dining, housekeeping, laundry and nursing management. (Transcript, page 197.) The Appellant's documentation shows that four other components of the care claimed were documented and initialed by a different aide that day, and OMIG auditor Dvorak conceded that if the one box with different initials had been blank or is disregarded, there would be no disallowance. (Exhibit P, page 1; Transcript, pages 67-71.) The disallowance is reversed.

Medicaid Program overpayments.

The 100 claim audit sample, and the 127,791 claim audit frame, consisted of paid claims for services that the Department's billing and payment records show were provided by the Appellant. Computer generated documents prepared by the Department or its fiscal agent to show the nature and amount of payments made under the Medicaid Program will be presumed, in the absence of direct evidence to the contrary, to constitute an accurate itemization of the payments made to a provider. 18 NYCRR 519.18(f). The Appellant did not offer any evidence to rebut or even question this presumption with regard to the 127,791 claims under audit. (Transcript, page 176.)

The amount disallowed for each claim in the audit sample is set forth in the exhibits attached to the final audit report. The reversal of samples 11, 60 and 79 reduced the overpayment in the sample from $3,293.41 to $2,805.29. The claims disallowed in

this audit, as affirmed in this hearing decision, were not authorized to be paid under the Medicaid Program because they were not supported by documentation demonstrating compliance with Medicaid Program requirements.

The Appellant suggested that the OMIG cannot recover overpayments if services were actually provided. (Exhibit 2, pages 2, 6; Transcript, page 14; Appellant brief, page 29; Reply brief, page 10.) It is not at all clear what the Appellant means by "services provided" in connection with assessments which are not documented to have been performed (category 1), or per diem claims for residents who were not in or not documented to have received care at the facility (category 3, 5). Services may have been performed by staff who were not shown to be trained (category 2) or screened for health issues (category 4, 7), but that hardly counts in the Appellant's favor.

In any event, recovery of overpayments is precisely what the Appellant's contractual obligations with the Medicaid Program entitle the OMIG to require if the provision of those services was not fully and properly documented in compliance with Department and Medicaid rules and regulations. 18 NYCRR 504.3, 517.3(b), 518.1; Elderwood at Grand Island v. Zucker, 188 AD3d 1580, 135 NYS3d 208 (4th Dept. 2020), *lv. denied,* 36 NY3d 910, 142 NYS3d 477 (2021). The OMIG is entitled to recover the overpayments made.

The statistical sampling and extrapolation.

The draft and final audit reports provided detailed explanations of the sampling and extrapolation methodology applied in this audit. (Exhibit 1, pages 19-20; Exhibit 3, pages 20-21.) These documents identified the disallowed claims, the audit frame from

which they were drawn and to which they were extrapolated, and the method of estimation.

An extrapolation based upon an audit utilizing a statistical sampling method certified as valid will be presumed, in the absence of expert testimony and evidence to the contrary, to be an accurate determination of the total overpayments made. 18 NYCRR 519.18(g). The OMIG submitted the required certification in the form of affidavits from Karl W. Heiner, PhD, the statistical consultant who designed the sampling and estimation methodology and the computer program that implemented it, and Theresa A. Gulum, the OMIG employee who implemented the methodology to establish the audit frame and select the random sample. (Exhibits 8, 9.)

The OMIG attached to its certification a list of the 127,791 claims under audit; a list of the 100 claims selected from that audit frame to make up the sample; and a report explaining the manner and method by which the sample was selected, the numerical order in which the random numbers for the sample were selected by the sampling program, and the statistical tests performed on the selected numbers. (Exhibit 9.)

The OMIG's statistical sampling and estimation methodology certified by Dr. Heiner has consistently been upheld in New York State Medicaid Program administrative hearings and by the New York courts, including the New York Court of Appeals. Mercy Hospital v. NYS DSS, 79 N.Y.2d 197, 581 N.Y.S.2d 628 (1992); Enrico v. Bane, 213 A.D.2d 784, 623 N.Y.S.2d 25 (3rd Dept. 1995); Clin Path, Inc. v. NYS DSS, 193 A.D.2d

1034, 598 N.Y.S.2d 583 (3rd Dept. 1993).[1] The Appellant failed to overcome the presumption of accuracy in the extrapolated overpayment.

Although the Appellant's statistician, Harold S. Haller, PhD, was presented specifically for the purpose of challenging the 18 NYCRR 519.18(g) presumption of validity established by the OMIG's certification, nowhere in his testimony or report was there any mention of the OMIG certification (Exhibits 8&9), or anything it says, or indeed any indication that he had read it, knew what it contained, or was even aware it existed. (Exhibit U; Transcript, pages 121-122.)

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[1] Reported decisions affirming the 18 NYCRR 519.18(g) extrapolation methodology used in this audit also include: West Midtown Management Group, Inc. v. State of N.Y., 31 N.Y.3d 533, 81 N.Y.S.3d 343 (2018); Fast Help Ambulette, Inc. v DOH, 198 A.D.3d 756, 156 N.Y.S.3d 267 (2nd Dept. 2021); Buhlman v. OMIG, 106 A.D.3d 1504, 964 N.Y.S.2d 853 (4th Dept. 2013), *lv. to appeal den.* 22 N.Y.3d 860, 981 N.Y.S.2d 370 (2014); Sarfo v. Glass, 243 A.D.2d 824, 663 N.Y.S.2d 894 (3rd Dept. 1997); Tsakonas v. Dowling, 227 A.D.2d 729, 642 N.Y.S.2d 342 (3rd Dept. 1996); Lala v. Dowling, 226 A.D.2d 933, 640 N.Y.S.2d 933 (3rd Dept. 1996); Piasecki v. DSS, 225 A.D.2d 310, 639 N.Y.S.2d 319 (1st Dept. 1996); Polanco v. DSS, 212 A.D.2d 443, 622 N.Y.S.2d 932 (1st Dept. 1995); Kuchment v. DSS, 222 A.D.2d 806, 634 N.Y.S.2d 849 (3rd Dept. 1995); Enaw v. Dowling, 220 A.D.2d 942, 632 N.Y.S.2d 715 (3rd Dept. 1995); Lock v. DSS, 220 A.D.2d 825, 632 N.Y.S.2d 300 (3rd Dept. 1995); Ghosal v. Bane, 204 A.D.2d 215, 612 N.Y.S.2d 399 (1st Dept. 1994), *lv. denied* 84 N.Y.2d 805, 618 N.Y.S.2d 6; Ogunkoya v. DSS, 204 A.D.2d 122, 612 N.Y.S.2d 7 (1st Dept. 1994); Newman v. Dowling, 210 A.D.2d 552, 619 N.Y.S.2d 794 (3rd Dept. 1994); State v. Khan, 206 A.D.2d 732, 615 N.Y.S.2d 771 (3rd Dept. 1994); Roggeman v. Bane, 206 A.D.2d 622, 614 N.Y.S.2d 593 (3rd Dept. 1994), *lv. denied* 84 N.Y.2d 809, 621 N.Y.S.2d 518; Adrien v. Kaladjian, 199 A.D.2d 57, 605 N.Y.S.2d 33 (1st Dept. 1993); Lalani v. Bane, 199 A.D.2d 80, 605 N.Y.S.2d 48 (1st Dept. 1993); Metzies Shoe Brooklyn NY Corp. v. DSS, 151 A.D.2d 675, 542 N.Y.S.2d 731 (2nd Dept. 1989).

Recent New York State Department of Health administrative hearing decisions rejecting challenges to the OMIG's 18 NYCRR 519.18(g) extrapolation methodology include: Angels in Your Home, Inc. (#18-7593, issued 6/8/2022); Harry's Nurses Registry (#18-3900, issued 10/4/2021); Madison York Assisted Living Community (#14-3479, issued 10/30/2020); Beth Israel Medical Center (#17-8064, issued 4/24/2020); Byram Healthcare Centers (#14-2289, issued 12/16/2019); UCPA of Putnam & Southern Dutchess (#13-5288, issued 6/17/2019).

Dr. Haller testified and represented in his report that he has served as an expert witness for health care providers relative to the use of statistical methods in over 100 cases, including many appeals by fee-for-service physicians who claimed random samples were inadequate or inappropriate for extrapolation of overpayments. (Exhibit U, pages 1, 17, 26-28; Transcript, pages 120, 179-180.) When asked, Dr. Haller was unable to identify a case in which an extrapolation was invalidated by any court or tribunal on the basis of his opinion. He answered "a lot of times I don't hear the end of the story." Asked "And how many of those cases was the extrapolation found to be invalid on your testimony?" he answered "The extrapolations were all found to be invalid." Asked "and how many of these cases was your testimony that a statistical sampling and extrapolation was not valid, was that position sustained?" he responded with an evasion, not an answer: "That I actually don't have a number for you." (Transcript, pages 181-82.) He did not mention two New York State Medicaid Program provider audit hearings in which he appeared before this bureau to testify and deny the validity of the extrapolation of a simple random sample of 100 claims, the very methodology employed in this audit. His testimony disputing the validity of the OMIG's statistical sampling and extrapolation method, as certified by Dr. Heiner, was found not to be credible and was rejected in both hearings. UCPA of Putnam & Southern Dutchess, *supra at page 17*; Madison York Assisted Living Community, *supra at pages 20-26.*

Dr. Haller testified in this hearing that "there was a – a very fundamental flaw in the audit" in that the audit frame and sample were both "contaminated" because they included services for which some payments were made after the audit period. (Exhibit U, pages 4, 6, 7, 15; Transcript, pages 122, 124-126, 129.) He claimed "the extrapolation is

totally invalid because of that feature alone." (Transcript, page 136; Appellant brief, pages 18-19; Reply brief, page 11.)

Dr. Haller's claim is based on a misrepresentation of the audit and of the facts. The OMIG audit reports are poorly worded, but Mr. Dvorak testified: "Our audits are based on dates of service" (Transcript, page 37), and the OMIG's 519.18(g) certification, which Dr. Haller did not review (Transcript, pages 121-22; Exhibit U, pages 2, 29) states it is based on "payments made to the Provider for services to New York Medicaid recipients from January 1, 2014 through December 31, 2016." (Exhibit 9, point 9.) The lists of 127,791 claims in the universe and 100 claims in the sample are consistent in treating the audit frame as defined by dates of service, not dates of payment. All 127,791 claims under audit had a service date within this audit period, and the 100 claim audit sample was selected from that frame.

As Dr. Haller himself explained, an audit "frame" and an audit "universe" are not the same thing. (Transcript, page 122; Exhibit U, page 2 note 4.) His own report made clear why the Appellant's Exhibit Y, the audit universe, contains 440,404 lines giving the payment history of the audit frame of 127,791 services for which claims were submitted. (Exhibit U, pages 4-6.) Payment for some of those services was subject to various adjustments, and this audit universe payment history included some payments made after the audit period. (Transcript, pages 135, 166, 168.) The audit frame of 127,791 services, however, did not include any services provided outside of the audit period.

The facts show the scope of the audit was straightforward and simple. Dr. Heiner's certification states, and Theresa Gulum's certification confirms: "a random sample of 100 paid claims was obtained from a population of 127,791 paid claims using a

random sample function." (Exhibit 8, page 2; Exhibit 9, pages 2-3.) As Dr. Heiner pointed out, the issue of the dates on which payment was made for the claims under review "isn't particularly relevant from a statistical point of view." (Transcript, pages 280-82.)[2] The pertinent facts are that the OMIG was auditing 127,791 paid claims for services, and that the 100 claim audit sample was randomly drawn from those 127,791 paid claims. (Transcript, pages 134, 302-305.) The Appellant's and Dr. Haller's assertions that the audit frame was somehow "corrupt" attempt to exploit poor wording in the audit report and ignore these simple facts that are readily and clearly ascertainable from the universe, frame and sample details provided.

The Appellant also seized on a passing comment by Dr. Heiner, that the OMIG must avoid overlapping audits that would result in duplicate overpayment findings (Transcript, page 280), to argue that such a concern has been created in this case. (Appellant brief, page 20.) This argument is meritless as well, and for the same reason. The claims reviewed in this audit are clearly and precisely identified by the dates of service for which they were made, leaving no uncertainty about what claims and payments were audited. There is no evidence or good reason to conclude any of these claims has been, is, or is at risk of being the subject of any other audit.

Dr. Haller's report also objected that the audit period was January 1, 2014 to December 31, 2016 but the frame did not include any claims for the first several months of 2014. (Exhibit U, page 4.) This is an even more egregious misrepresentation of the pertinent facts. Dr. Haller cited Cochrane - the very authority relied upon by Dr. Heiner

[2] Indeed, the Appellant itself claimed that the dates of payment in 2017 that Dr. Haller relied upon for his opinion that the audit was "contaminated" were also not accurate. According to its administrator Sacks, the Appellant did not receive those payments on the dates relied upon by Dr. Haller for his criticism. (Transcript, pages 249-52.)

in his certification (Exhibit 8, page 3) - to admonish: "It is well to verify that all the data are relevant to the purposes of the survey and that no essential data are omitted" (William G. Cochrane, Sampling Techniques, 3rd ed. 1977). He then complained: "OMIG provided no explanation for why the first five months of 2014 were omitted from the universe when creating the sampling frame." (Exhibit U, page 4.)

There was nothing to explain about omitted claims for the first five months because there were no such claims. The OMIG is entitled to rely on the presumption of accuracy in its records of Medicaid claims in the audit period. 19 NYCRR 519.18(f). Those records are entirely consistent with the Appellant's own representations that it did not begin operating until April 2014. (Exhibit S; Transcript, page 256.) The Appellant brought forward no evidence that there were any claims left out of the audit frame or that in any other way "essential data are omitted." Dr. Haller apparently did not ask his client or think it was "well to verify" for himself whether in fact "essential data are omitted" about claims in the first months of 2014.

Dr. Haller also testified that because most of the disallowances were for claims in the second half of the audit period, that indicates a "special cause" at work. (Transcript, pages 144, 148.) He offered a "control chart" and claimed this distribution "indicates a different standard was used for auditing approximately the first half of the sample than the second half of the sample." (Exhibit U, page 10; Transcript, pages 141-147.) Neither he nor the Appellant offered any evidence to support this bare speculation. The Appellant did not identify any disallowance that is claimed to reflect the use of a different auditing standard than used for any other claim in the sample.

Dr. Heiner agreed with Dr. Haller that a "control chart" can be useful for an organization seeking to inquire into causes and reasons for errors. Such information can be an occasion to identify patterns or causes in the data. (Transcript, pages 287-88.) The distribution of disallowances in Dr. Haller's "control chart," for example, can be explained not by some "different standard" but by the nature of one particular error responsible for most of the disallowances. Dr. Haller, who said: "their system of documentation I don't think has changed, so something else had to change" (Transcript, page 148), himself suggested the "special cause" that he finds so suspicious.

As Dr. Haller's own report pointed out, there were no claims for the first five months of 2014. This is because the Appellant did not commence operating until April 2014. The Appellant has not been accused of failing to submit initial or yearly assessments of its residents on UAS-NY. It is the subsequent six-month assessments, for which it simply printed and re-signed the previous assessments, that it is criticized for failing to conduct and document. As the facility did not begin operating until April 2014, the first of these six-month assessments would not begin to be required until the end of 2014, which explains why the disallowances began to be found in the second half of the audit period.

The Appellant's suggestion that this "special cause" is instead attributable to "guidance provided by OMIG itself" (Appellant brief, page 25) is, as has been discussed in connection with disallowance category 1, not supported by any credible evidence that it received such "guidance," or by any evidence at all that it altered its recordkeeping practices after September 2015 when, it claims, the "guidance" was given.

As Dr. Heiner pointed out, an inquiry into or the existence of a pattern such as this does not demonstrate or even suggest error or invalidity in the sampling and estimation methodology used by the OMIG. (Transcript, pages 287-288.) The purpose of this audit was not to perform an exhaustive statistical analysis with "control charts" and quality control objectives. Dr. Haller himself acknowledged "this is not a quality review" audit. (Transcript, page 172.) The purpose of the audit was to establish the existence and amount of any recoverable Medicaid overpayments.

Dr. Haller offered extensive criticisms of the extrapolation on the grounds that under the audit protocol used by the OMIG, a claim could be disallowed for as many as 27 different reasons. This formed the basis of his claim that the error rate in the sample was "an exceptionally low error rate," only 25 out of a possible 2700 (sample of 100 x 27 disallowance areas listed in the protocol), or approximately 0.9%. (Exhibit U, pages 5, 7-11, 15; Transcript, pages 137-139.) He failed to intelligibly explain or show the relevance of this "error rate" or how multiple items listed in an audit protocol leads to the conclusion "if all it takes is one to be missed to – to invalidate the – the claim and not pay – not make it payable it's basically a coin toss when you have so many criteria you're trying to meet." (Transcript, page 156; Exhibit U, page 11.)

A Medicaid provider's responsibility, as the Appellant itself asserts in denying that the OMIG is entitled to use or rely on it (Exhibit 2, pages 2, 4; Transcript, page 183; Appellant brief, pages 27-28), is not to meet an audit protocol. It is to establish it documented entitlement to payment of the claims under audit. While there may have been 27 items listed in whatever protocol may have been used by OMIG auditors to guide and focus their review, that is a number that is irrelevant to the audit findings themselves,

which are based upon the failure to document entitlement to payment of the claims as required by Medicaid reimbursement rules and regulations.

The protocol used by the OMIG happened to list 27 categories of error for auditors to look for. Dr. Haller's calculations would change with any change in that number. He was asked, and answered:

> Q. If they had written up a protocol that had listed thirty-five categories of errors, you'd be even more concerned about the accuracy of this, wouldn't you?... Twenty-seven hundred, it'd be thirty-five hundred, right?
> A. Yes, sir...
> Q. And if the only category of error in the audit protocol was not payable by the Medicaid program, these calculations in your conclusions one and two wouldn't have much force, would they?
> A. No. (Transcript, pages 174-5.)

According to Dr. Haller, the Appellant "should be complemented *[sic]* on its outstanding performance relative to meeting OMIG's 27 documentation requirements based on OMIG's audit." (Exhibit U, page 10.) Counting the ways in which claims were not disallowed, in an attempt to compliment the Appellant and criticize the OMIG for "all or nothing decision criteria" (Exhibit U, page 7) setting "an impossibly high standard to retain its payment" (Appellant reply brief, page 10) is irrelevant in an audit to determine whether the provider was entitled to payment on the claims reviewed.

Dr. Haller's characterization of the audit sample as "99.1% error free" (Exhibit U, page 11) uses an irrelevant number of items in a protocol in order to calculate a correspondingly meaningless "error free" percentage. In fact, the audit report found the error rate in the sample was 22 claims out of 100, or 22% that were determined to be recoverable overpayments. The Appellant itself stated in its response to the draft audit report: "These are extremely high levels of alleged error." (Exhibit 2, page 1.)

Dr. Haller also relied on the irrelevant number of 27 criteria in the audit protocol for his criticism of the sample size. He testified:

> The second conclusion that I drew was – was one of trying to explain, again, how difficult it is to meet multiple criteria. In this case, there are twenty-seven documentation criteria that – that were at issue. And again, those came from looking at the audit protocol... given the problem of meeting all these requirements, you need a much larger sample than a hundred. (Transcript, pages 155-156.)

It was Dr. Heiner's opinion that a sample size of 100 was large enough for simple random samples, and Dr. Haller himself acknowledged - when not objecting on the spurious basis of the number of items in a protocol - "a hundred, it's a decent sample size." (Transcript, pages 150, 308.) U.S. Department of Health and Human Services Office of the Inspector General guidance, invoked by the Appellant, not the OMIG, also recognizes the presumptive adequacy of this sample size, stating "the OIG audit group requires additional approval for any statistical samples that include fewer than 100 items." (Appellant reply brief, pages 6-7 & appendix I-5, page 17.) The New York courts have consistently agreed with Dr. Heiner and affirmed Medicaid sampling and extrapolation audits with samples of this size. *Op. cit.*

Dr. Haller's report states:

> All statistical sampling and estimation texts state that in addition to the [point estimate], there are sampling error and precision estimates that must be computed, which affect the confidence of any projection from the sample to the frame. OMIG cannot arbitrarily ignore the sampling error and precision and refer to this as statistics. (Exhibit U, page 15.)

His accusation that the OMIG statistical sampling methodology "ignores sampling error and precision" (Exhibit U, page 8) is inaccurate. As Dr. Heiner explained, the high and low point estimates referenced in the audit reports and his certification all recognized and reflected the precision of the audit as relevant. (Transcript, pages 276-77, 293.) This is

the same information about precision that Dr. Haller preferred to express as a percentage. (Transcript, pages 309-313; Exhibit 8, page 3.) The range between the high and low point affected both sides equally. Dr. Haller objected: "the probability is 50% that the OMIG's point estimate... is greater than the total [overpayment] from a complete audit of all 127,791 [claims]." (Exhibit U, page 13.) He did not mention that the probability is also 50% that it is less. (Transcript, page 173.)

Dr. Haller testified "there is no statistical text that I'm aware of which accepts as a valid estimate, the point estimate because it —it ignores uncertainty." (Transcript, page 158; Appellant brief, page 21.) Whatever the statistical texts Dr. Haller is aware of may say, and whatever they may mean by a "valid estimate," it is well settled that the point estimate is presumptively valid for the purpose of identifying an overpayment in a Medicaid audit. The Court of Appeals, rejecting a provider's argument that it was entitled to a recoupment limited to the low point, has recognized that "by regulation, OMIG's extrapolated point estimate would be presumed to be an accurate determination of the total overpayments at any hearing in the absence of expert testimony or evidence to the contrary." West Midtown, *supra.* Dr. Haller's testimony failed to overcome that presumption.

The Appellant itself concedes: "While in all sampling and extrapolation cases some margin of error will exist and must be tolerated, and Island does not contend that all sampling and extrapolation is invalid, there must be some parameters outside of which the margin of error is so significant that no meaningful conclusions can be drawn from its results." (Appellant brief, page 22.) It claims "CMS and courts have consistently articulated such standards" (Reply brief, page 9) without saying just what those standards

are, where they have been articulated, or how they differ from the standards recognized in, for example, OIG guidelines the Appellant itself cites, and in the New York court cases identified in this decision.

Dr. Haller's report concludes:

> [T]he OMIG approach is statistically meaningless, a misrepresentation of statistics, and unethical... *Statistical Methods* have **not** been used for this projection because the laws and assumptions of probability and statistics are being ignored. (Exhibit U, pages 15-16.)

Dr. Heiner's opinion and certification to the contrary, "that the sampling and extrapolation methodology used by the Department... is a statistically valid methodology" (Exhibit 8, page 4) has been repeatedly accepted in the New York courts including the Court of Appeals, which has considered and affirmed the sampling and extrapolation methodology applied in this audit and held, contrary to Dr. Haller, that it is valid for the purposes of establishing a recoverable overpayment of Medicaid funds pursuant to 18 NYCRR 519.18(g). The Appellant has failed to rebut the presumption of validity in the extrapolation.

The Appellant argued that extrapolation of claim disallowances in categories 5, 6 and 8 is not appropriate because only one disallowance was taken in each category. (Exhibit 2, pages 23-25; Appellant brief, page 18.) This objection, like Dr. Haller's focus on the 27 categories in the audit protocol, confuses the manner in which audit findings were identified, organized and summarized with the findings of disallowance themselves. The appropriateness of extrapolation is not determined by or dependent on the various ways in which an audit report might categorize and list disallowances.

Conclusion.

The overpayment must be recalculated in accordance with the methodology set forth in Exhibits 1, 3 and 8 to reflect the reversal of samples 11, 60 and 79, in the amount of $488.12. The overpayment in the sample is $2,805.29. The overpayment for extrapolation is $2,492.86. The extrapolated overpayment ($2,492.86/100 x 127,791) is $3,185,650.72. The disallowances that were not extrapolated (samples 33, 99) are in the amount of $312.43, for a total overpayment of $3,185,963.15. A restitution claim in that amount is authorized under 18 NYCRR 518.1 and 518.3.

The Appellant claims the overpayments identified in this audit are "based not on real concerns about service delivery or quality, but on "gotcha" ministerial errors that present zero risk to the Medicaid program or its recipients." (Appellant brief, pages 28-29.) Periodic and thorough assessment of resident needs is at the heart of good health care, and the six-month assessment requirement (category 1) is directly about that. Billing for care that was not provided (categories 3, 5) and the provision of care by staff who were not confirmed to have been properly trained or assessed and tested for disease (categories 2, 4, 7) are hardly "ministerial errors that present zero risk to the Medicaid program or its recipients." (Appellant brief, page 28.)

The Appellant also complains that the OMIG's disallowances "rise to the level of unconstitutional punitive damages" and "excessive fines." (Exhibit 2, page 5.) The restitution sought is neither punitive nor a penalty. It is a recovery of overpayments. This audit revealed a significant failure to comply with conditions of Medicaid reimbursement: 19 of 100 paid claims reviewed in the audit have been determined to be recoverable overpayments. The reasons justifying the disallowance of these claims

included significant disregard of resident assessment and recordkeeping requirements; billing for services that were not provided; and billing for care provided by staff not documented to be properly trained, assessed and tested. Recovery of overpayments attributable to these matters is not unreasonable.

DECISION: The OMIG's determination to recover Medicaid Program overpayments is affirmed.

The disallowances of samples 11, 60 and 79 are reversed. All other disallowances are affirmed. The total overpayment is $3,185,963.15.

This decision is made by John Harris Terepka, who has been designated to make such decisions.

DATED: Rochester, New York
December 11, 2023

John Harris Terepka
Bureau of Adjudication