STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of	:	
	:	**Decision**
	:	**After**
STATEWIDE AMBULETTE SERVICE, INC.	:	**Hearing**
Provider No.: 00916812	:	
	:	#13-F-2317
ALLSTAR TRANSPORTATION, LLC,	:	
ACCESSIBLE TRANSPORTATION, LLC,	:	
BASE CAR SERVICE, Inc.,	:	
ALAN HEBEL, WILLIAM TORRES,	:	
ARMANDO HERNANDEZ, and **JOSE RIVERA,**	:	
Appellants,	:	
	:	
from charges of unacceptable practices and a determination	:	
to recover Medicaid Program overpayments.	:	
	:	

Before: John Harris Terepka
Administrative Law Judge

Held at: New York State Department of Health
90 Church Street
New York, New York 10007
April 21, 22, 2015
Riverview Center, 150 Broadway
Menands, New York 12204
May 28, 2015
Record closed October 22, 2015

Parties: NYS Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
By: Timothy R. Shevy, Esq.
Danielle M. DeMers, Esq., on brief

Statewide Ambulette Service, Inc. et. al.
121 Montgomery Avenue 1st floor
Scarsdale, New York 10583
By: Linda J. Clark, Esq.
Colm Ryan, Esq.
Hiscock & Barclay LLP
80 State Street
Albany, New York 12207

JURISDICTION

The Department of Health acts as the single state agency to supervise the administration of the Medicaid Program in New York. Social Services Law 363-a. Pursuant to Public Health Law 30, 31 and 32, the New York State Office of the Medicaid Inspector General (OMIG), an independent office within the Department of Health, has the authority to pursue administrative enforcement actions against any individual or entity that engages in fraud, abuse or unacceptable practices in the Medicaid Program, and to recover improperly expended Medicaid funds.

The OMIG determined to exclude Statewide Ambulette Service, Inc. (Appellant Statewide) from the Medicaid Program and to recover Medicaid overpayments. The OMIG also determined to exclude and recover overpayments from Appellants Allstar Transportation, LLC; Accessible Transportation, LLC; Base Car Service, Inc.; Alan Hebel; William Torres; Armando Hernandez; and Jose Rivera, as affiliates of Statewide. The Appellants requested a hearing pursuant to SSL 22 and former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the OMIG determinations.

HEARING RECORD

OMIG witnesses:	Christopher Bedell	OMIG investigator
	Timothy Perry-Coon	OMIG medical assistance specialist
OMIG exhibits:	1-36	
Appellant witnesses:	Alan Hebel	Appellant
	[redacted].	
	William Torres	Appellant
	Armando Hernandez	Appellant
Appellant exhibits:	A-K	

A transcript of the hearing was made. (Transcript, 4/21/2015 pages 1-288; 4/22/2015 pages 289-564; 5/28/2015 pages 525-698.) Each side submitted two post hearing briefs.

SUMMARY OF FACTS

1. At all times relevant hereto, Appellant Statewide Ambulette Service, Inc. was an ambulette and transportation service enrolled as a provider in the New York State Medicaid Program. Statewide, with main offices in Scarsdale, New York, was started by Alan Hebel in 1985. It operates throughout the metropolitan New York City and Hudson Valley region. (Transcript, page 461.)

2. Appellant Accessible Transportation, LLC is owned by Jose Rivera. Appellant Base Car Service, Inc. is owned by William Torres. Appellant Allstar Transportation, LLC is owned by Armando Hernandez. (Transcript, page 59.) These three corporations (the entities) are not enrolled as providers in the Medicaid Program. (Transcript, page 73.)

3. During the period January 2 through July 29, 2013, Statewide was paid $2,019,198.60 by the Medicaid Program on 40,670 claims for transportation services provided to Medicaid recipients. (Transcript, pages 148, 153.)

4. By notice of agency action dated February 12, 2015, the OMIG notified the Appellants that it had determined to exclude them from the Medicaid Program because they had engaged in unacceptable practices. The notice of agency action further advised the Appellants that the OMIG had determined to seek restitution of Medicaid Program overpayments, jointly and severally from all Appellants, in the total amount of $2,019.111.80 plus interest. (Exhibit 17.)

5. The OMIG's determinations were based upon the Appellants' engaging in unacceptable practices in the Medicaid Program, primarily attributable to an unacceptable subcontracting relationship between the Appellant Statewide and the entities.

The management agreements

6. Statewide was authorized to operate as a transportation provider in the Medicaid Program. It possessed an operating certificate from the Department of Transportation (DOT) and local authorization as needed for the areas served. It maintained, as required, a roster of drivers qualified under Article 19-A of the Vehicle & Traffic Law (VTL). (Exhibits 18, 19, 20, 21; Transcript, page 44.) Accessible, Base Car, and Allstar (the entities) did not possess any of these things. (Transcript, pages 54-55, 79, 160; Exhibits 7, 8.)

7. The Medicaid claims under review were all submitted by and paid to Appellant Statewide. The transportation services were provided by drivers who were employees of Accessible, Base Car, and Allstar.

8. Pursuant to written "management agreements" between Statewide and the entities, effective January 2, 2013, Statewide kept thirty percent of each Medicaid claim and the rest went to the entity whose driver provided the service. Statewide paid for dispatching, financial functions and liability insurance, and owned the vehicles. The entities leased the vehicles from Statewide, reimbursed Statewide for vehicle insurance costs, and paid for repair and maintenance of vehicles. The entities employed the drivers and paid their wages, payroll taxes, workers compensation, disability and health insurance. (Exhibits 9-11, 14, 22-30; Transcript, pages 54-57, 63-66, 491-95.)

9. Upon being advised by the OMIG that it considered the provision of Medicaid services under the management agreements to constitute unacceptable subcontracting arrangements, the Appellants immediately cancelled and rescinded the management agreements. (Exhibit 16, attachment 1 thereto; Transcript, pages 505-506.)

Other disallowances

10. The OMIG issued a notice of proposed agency action dated September 27, 2013. (Exhibit 15.) In addition to the findings that an unacceptable subcontracting arrangement existed between Statewide and the entities, the notice advised the Appellants of three other categories of disallowance for failure to document licensure and other state qualifications for drivers. Pursuant to DSS regulations at 18 NYCRR 515.6, the notice of proposed agency action offered the Appellants an opportunity to submit arguments and documents they wanted to be considered in response to the proposed action.

11. The Appellants submitted documents and a written response to the notice of proposed agency action. (Exhibit 16.) The OMIG issued its February 12, 2015 notice of agency action thereafter, without changing any of its findings with regard to any of the Appellants. (Exhibit 17.) The OMIG did remove another individual Appellant from the notice because he was no longer an owner of Statewide. (Exhibit 17, paragraph 24.)

12. a. The notice of proposed agency action disallowed 2,922 claims in the amount of $162,583.61 "because the 13 drivers' licenses used to bill for these 2,922 claims because they were not 19-A qualified and there identity could not be verified [sic]." (Exhibit 15, first paragraph 21.)

b. The Appellants' response to the notice of proposed agency action included documentation identifying the drivers who provided the services and verifying that they were qualified under Article 19-A of the VTL or that 19-A qualification was not required for the service billed. (Exhibit 16, pages 9-12 and attachments; Transcript, pages 242-45, 379.)

c. The OMIG's notice of agency action disallowed the same 2,922 claims "because the 13 drivers' licenses used to bill for these 2,922 claims because they were not 19-A qualified and there identity could not be verified [sic]." (Exhibit 17, paragraph 20.) The OMIG withdrew this finding on the third hearing day. (Transcript, 5/28/2015 page 530; OMIG brief, page 3.)

13. a. The notice of proposed agency action disallowed 850 claims in the amount of $44,423.58 "because the 5 drivers' licenses used to bill for

these claims are invalid NYS DMV driver's license numbers." (Exhibit 15, first paragraph 22.)

b. The Appellants' response to the notice of proposed agency action explained that typographical errors had been made in the reporting of five driver's license numbers. The Appellants provided documentation consistent with this claim, including photocopies of the five drivers licenses, showing the correct license numbers. In all five instances a one digit error in the nine digit number was made in the electronically submitted Medicaid claim. The error was then repeated in subsequent electronically submitted claims involving the same driver. (Exhibit 16, pages 13-15 and attachments; Transcript, pages 248-54, 260-61.)

14. a. The notice of proposed agency action disallowed 9,029 claims in the amount of $335,959.65 "because all 9,029 claims failed to submit a driver's license number on these claims." (Exhibit 15, first paragraph 23.)

b. The Appellants' response to the notice of proposed agency action pointed out that the Medicaid Program's electronic claims system did not require or even allow the reporting of driver's license numbers on the upstate region livery service claims in question. The Appellants' response provided documentation demonstrating this to be the case. (Exhibit 16, pages 15-16 and attachments.)

c. The OMIG's notice of agency action disallowed the same 9,029 claims "because all 9,029 claims failed to submit a driver's license number on these claims." (Exhibit 17, paragraph 22.) On the first day of the hearing, the OMIG conceded that the disallowances should not have been made. (Transcript, pages 279-80.) The OMIG withdrew this finding on the third day of the hearing. (Transcript, 5/28/2015 page 534; OMIG brief, page 3.)

ISSUES

Was the OMIG determination that Appellants engaged in unacceptable practices in the Medicaid Program correct?

Did the OMIG properly determine to impose Medicaid Program sanctions?

Was the OMIG determination to recover Medicaid Program overpayments in the amount of $2,019,111.80 correct?

APPLICABLE LAW

Former Department of Social Services regulations most pertinent to this hearing decision are at 18 NYCRR Parts 505 (medical care, in particular section 505.10,

regarding transportation for medical care), 515 (provider sanctions) and 519 (provider hearings).

An unacceptable practice in the Medicaid Program is conduct contrary to the official rules, regulations, claiming instructions or procedures of the Department. 18 NYCRR 515.2(a). Unacceptable practices include several other specifically enumerated practices also charged in this case, such as false statements (515.2(b)(2)), failure to disclose (515.2(b)(3)), and "other prohibited acts" (515.2(b)(18)). Conduct which constitutes fraud or abuse is also an unacceptable practice. 18 NYCRR 515.2(b). Upon a determination that a person has engaged in an unacceptable practice, the Department may impose one or more sanctions, including censure or exclusion from the program. 18 NYCRR 515.3(a), 515.4(a).

When the Department sanctions a person, it may also sanction any affiliate of that person. Affiliate means any person having an overt, covert or conspiratorial relationship with another such that either of them may directly or indirectly control the other. 18 NYCRR 504.1(d)(1). The Department may also require the repayment of overpayments determined to have been made as a result of an unacceptable practice. 18 NYCRR 515.3(b).

A person is entitled to a hearing to have the Department's determination reviewed if the Department imposes a sanction or requires repayment of an overpayment. 18 NYCRR 519.4. At the hearing, the Appellant has the burden of showing that the determination of the Department was incorrect and of proving any mitigating factors affecting the severity of any sanction imposed. 18 NYCRR 519.18(d).

This case is primarily about the Department's policy with regard to subcontracting ambulette and livery services in the Medicaid Program. In order to receive payment for services to Medicaid recipients, a provider must be lawfully authorized to provide the services on the date the services are rendered. A transportation service and its drivers must comply with all requirements of the Departments of Transportation and Motor Vehicles. Ambulette drivers must be qualified under Article 19-A of the VTL, and an ambulette service operating in New York City must also be licensed by the NYC Taxi and Limousine Commission. 18 NYCRR 505.10(e)(6).

Department regulations at 18 NYCRR 504.1(d) (and similarly at 502.2(l)), define "subcontractor" as follows:

> (21) *Subcontractor* means any person to which a provider has contracted or delegated some of its management functions, or its responsibilities for providing medical care, services or supplies, or its claiming or claims preparation or processing functions or responsibilities.

More specific policy regarding subcontracting of transportation services is not directly set forth in Department regulations, but it is addressed in official directives of the Department. The New York State Medicaid Program issues Medicaid Management Information Systems (MMIS) provider manuals, which are available to all providers and include, among other things, billing policies, procedures, codes and instructions. (Exhibits E, H; www.emedny.org.) The Medicaid Program also issues a monthly Medicaid Update with additional information, policy and instructions. (Exhibit 12; Exhibit D; www.emedny.org.) Providers are obligated to comply with these official directives. 18 NYCRR 504.3(i); Lock v. NYS Department of Social Services, 220 A.D.2d 825, 632 N.Y.S.2d 300 (3d Dept. 1995); PSSNY v. Pataki, 58 A.D.3d 924, 870 N.Y.S.2d 633 (3d Dept. 2009).

The MMIS Provider Transportation Manual Policy Guidelines on subcontracting transportation services are:

> **Subcontracting Transports**
>
> Generally, ambulette providers are to deliver transportation services in vehicles owned or leased by the provider, using drivers employed by the provider. The following describes the difference between **allowable** short-term versus **unacceptable** long-term subcontracting.
>
> **Short Term Subcontracting**
>
> **…**
>
> **Long Term Subcontracting**
>
> The practice of Provider A reassigning trips to another transportation vendor in a long term arrangement with no intent to secure its own vehicles and drivers, **is unacceptable**. Such an arrangement has the potential of bypassing significant safety and financial controls that are fundamental to the integrity of the Medicaid Transportation Program.
>
> MMIS Transportation Manual Policy Guidelines, Section II, Transportation Services, Version 2013-1, January 1, 2013. (Exhibit E, Pages 21-22 of 54.)

A December 2008 Medicaid Update newsletter, sent to all providers, had previously described the policy in the same language. New York State Medicaid Update, December 2008, Volume 24, Number 14. (Exhibit 12.)

DISCUSSION

The OMIG's review of these transportation claims was conducted by its Division of Medicaid Investigations as part of a "credential verification review," and not by its Division of Medicaid Audit under its "audit protocols." (Transcript, 5/28/2015 pages 542-43, 569-70; Exhibit D.) The Appellants' argument that they have been in some way deprived of due process because the OMIG did not pursue this matter by means of an audit, is without merit. (Appellant brief, pages 22-23.) The OMIG has ample authority under PHL 32, and in particular PHL(21), to investigate and review claims and other

matters pertaining to a provider's participation in the Medicaid Program, and it has afforded the Appellants the appropriate procedures under 18 NYCRR Part 515. (OMIG reply brief, page 3.)

The Appellants also point out that the OMIG relies on Medicaid Provider Manuals and Updates, and cites no statute or regulation that explicitly states subcontracting is an unacceptable practice. (Appellants brief, page 13.) The Department has the authority to make such rules, regulations and official directives as are necessary to implement the regulations, and providers are obligated to comply with them. 18 NYCRR 504.3(i); Lock v. NYS Department of Social Services, *supra*; PSSNY v. Pataki, *supra*. The prohibition against subcontracting set forth in the Provider Manual and the Update is an appropriate application of the Department's authority under SSL 363-a(2) and related state regulations, and the OMIG's application of it in this case is affirmed.

The Appellants' objections to the findings and charges of unacceptable practices with regard to the three categories of overpayment in addition to the subcontracting, however, do have merit. The OMIG ignored documentation submitted by the Appellants in response to the proposed findings that refuted the grounds for disallowance, and instead repeated, *verbatim*, the grounds set forth in the notice of proposed agency action. It was not until the third day of this hearing that the OMIG conceded its error about two of the grounds and withdrew the findings. The OMIG's determination with regard to the third ground is reversed in this decision.

Subcontracting.

The Appellants claim that the OMIG is alleging a failure to comply with generally accepted business, accounting, professional or medical practices or standards of health

care. Appellants argue that pursuant to 18 NYCRR 519.18(d), the OMIG has the burden of proving the existence of such standards, and has failed to do so. (Appellants brief, page 9 & reply brief, page 7.) This argument is rejected. The OMIG is not alleging a failure to comply with any "generally accepted" standard. It is alleging that the prohibition against subcontracting is a Medicaid Program rule, set forth in the Department's own official directives. The issue is not whether there is a generally accepted standard, it is whether there is an applicable Medicaid Program rule that has been violated. It is concluded that there is such a rule.

The parties agree that Statewide's management agreements with the entities in no way constituted "short term" subcontracting, which the Provider Manual does permit under certain circumstances. (Exhibit E, page 22 of 54; Transcript, pages 20, 324; Appellants brief, page 13.) There was nothing short term about the arrangements in this case, which covered thousands of individual services and were intended to last for at least five years. The question is whether they constituted unacceptable long term subcontracting.

The Appellants' contention that the arrangement between Statewide and the entities does not constitute subcontracting under any reasonable interpretation of that concept, including as set forth in the Medicaid Provider Manual and Medicaid Update, is rejected. The Appellants' attempt to characterize its arrangements as a "minor corporate restructuring" of Statewide (Appellants brief, pages 6-8) is not consistent with the establishment of three independently owned corporations that employed the drivers on their own payrolls. Statewide and Mr. Hebel had no ownership interest in any of the

entities, nor did any of the entities or their owners own any part of Statewide. (Transcript, pages 340-41, 4/22/2015 page 528.)

The Medicaid Provider Manual and Update could hardly be more explicit in their prohibition of billing for Medicaid services by one transportation provider when they were performed by employees of another:

> Generally, ambulette providers are to deliver transportation services in vehicles owned or leased by the provider, using drivers employed by the provider.

The Appellants first argue that the drivers in this case were employees of Statewide. Although they concede that the drivers were employees of the entities:

> … it is well established in New York Labor and Employment Law that more than one entity can be found to be an employee's employer depending on the definition employed. (citation omitted) Here, it is clear that Statewide, in addition to the sub-companies, was the drivers' employer. (Appellants brief, page 21.)

The Appellants rely on decisions that address the question when a company should be held to be an "employer" for the purposes of enforcing employee rights under the Fair Labor Standards Act (FLSA) and the Employee Retirement Income Security Act (ERISA). (Appellants brief, pages 18-21.)

The Appellants did not claim that Statewide has been determined to be these drivers' employer for FLSA or ERISA purposes. In any event, even if it could be said that Statewide was the employer of the drivers in some senses, in others it clearly was not. Most importantly, it is undisputed that the entities, with whom Statewide split its Medicaid payments, were employers of the drivers. Statewide did not pay the drivers for the Medicaid services they provided. Statewide paid the entities, which in turn paid wages and benefits to the drivers as their employees. (Transcript, page 494.)

The rule under review in this case exists for the purpose of protecting the integrity of the Medicaid Program, not, as in the cases cited by Appellants, employees who want to claim protections under FLSA or ERISA. The Appellant lists four factors indicating the extent to which Statewide allegedly "possessed the power to control the workers in question." (Appellants brief, pages 19-20.) The Appellants claim that Statewide:

1) had the power to hire and fire the employees;
2) supervised and controlled employee work schedules or conditions of employment;
3) determined the rate and method of payment of employees;
4) maintained employment records.

The evidence about factors 1), 2) & 3) was not compelling: There is nothing in the management agreements that reserves these powers to Statewide. The Appellants take the position that Statewide had them, without actually claiming that the entities did not also have them. In any event, the concern in this case is not whether Statewide had these powers. The concern is the extent to which the entities, not enrolled in the Medicaid Program, also had them.

A particularly significant factor in this case in deciding whether Statewide subcontracted Medicaid services, is factor 4): "maintained employment records." Article 5 of each management agreement provided:

> ARTICLE 5
> REPORTS AND RECORDKEEPING
>
> [The entity] agrees to establish and maintain record keeping, accounting and data processing systems conforming to requirements that are necessary for compliance to Federal, State and Local laws. Record keeping for Trip Tickets, Drivers Logs, Payroll Worksheets, Department of Transportation, Department of Health, Department of Social Services, Department of Motor Vehicles, Department of Labor is the strict responsibility of [the entity]. Any fines, penalties, reimbursements or payments of any kind resulting from a failure to keep the necessary records will be the sole responsibility of [the entity]. [The entity] and State[wide] shall enter into such ancillary agreements as may be necessary to fulfill the purposes of this agreement. (Exhibits 9, 10, 11.)

This issue goes to the heart of the OMIG's concern about the relationship between Statewide and the entities. Regardless of the realities of the practical relationship between Mr. Hebel and his associates, Statewide explicitly contracted with the entities to place responsibility for significant aspects of its responsibilities to the Medicaid Program on the entities. "Economic reality" may be a central inquiry for FLSA or ERISA purposes. (Appellants brief, pages 19-20.) Accountability to the Medicaid Program is the issue here. The Medicaid Program is entitled to prohibit the delegation of this provider responsibility.

The Appellants also take issue with other wording in the MMIS Provider Manual in an attempt to establish that the prohibition is only against subcontracting to another Medicaid Provider. (Appellants brief, pages 17-18 & reply brief, page 6.) The 2004 version of the Provider Manual did prohibit subcontracting or assigning trips "to another provider." (Exhibit H.) The 2008 Update and the January 2013 Provider Manual version applicable to the services in this case, however, changed "provider" to "transportation vendor." (*Compare* Exhibit H, page 24 of 31, *with* Exhibit E, page 22 of 54.)

Undeterred, the Appellants cite the definition of "vendor" given elsewhere in the 2013 Provider Manual as "a lawfully authorized provider of transportation services who is either enrolled in the Medicaid Program pursuant to 18 NYCRR 504 or authorized to receive payment." Transportation Policy Guidelines, Section IV. (Exhibit E, page 52.) According to the Appellants, the prohibition against long term subcontracting still does not apply in this case because the entities were not enrolled as providers in the Medicaid Program or authorized to receive payment, and so were not "vendors" under this

definition. (Transcript, pages 321-22, 432-34, 621-24, 630, 662, 665; Appellants brief, pages 17-18 & reply brief, page 6.)

The Appellants' argument that "transportation vendor" only means "enrolled Medicaid provider" in this context is contrary to the entire purpose of the rule against subcontracting. It makes little sense to forbid subcontracting transportation services to known Medicaid providers and yet allow it to transportation providers that are not enrolled or authorized to receive payment and are unknown to the Medicaid Program. Even the limited permission for short term subcontracting, for example, expressly restricts that activity to enrolled providers. MMIS Transportation Manual Policy Guidelines, Section II, Transportation Services, Version 2013-1, January 1, 2013 (Exhibit E, Page 22 of 54); New York State Medicaid Update, December 2008, Volume 24, Number 14 (Exhibit 12). As long term subcontracting is not permitted at all, it was hardly necessary to go into any more detail or to split hairs about what "vendor" or "provider" means in this context.

The Appellants have a point that the 2013 version of the Transportation Manual is now arguably ambiguous on a narrow reading of page 22 of 54 in comparison to the definition of vendor on page 52 of 54. The Provider Manual definition, however, is directly taken from the definition of "vendor" at 18 NYCRR 505.10(b)(23). The purpose of that definition appears to relate to payment, which, pursuant to 505.10(e)(2), will only be made to the "vendor" of the transportation, in that context, the Medicaid Provider that actually performed the service.

The Provider Manual could have been revised with more precision, but the Appellants' arguments are little more than an attempt to exploit an inconsistency in

language that is, taken as a whole, quite clear in its intent. The Appellants' reading is implausible given the purpose of the prohibition, and it is a stretch to believe that it would not occur to a careful provider that submitting claims for the work of drivers employed by other and separate corporations violated the subcontracting rule.

The Appellants claim that they were careful, and that they disclosed their proposed arrangements to the Department in advance and were given approval for them. (Appellants reply brief, page 1.) Their basis for this claim is discussions in early 2013 between [redacted], an attorney who represented a number of transportation providers including Statewide at the time, and Timothy Perry-Coon, an OMIG employee whose duties included explaining Medicaid policy to providers. (Exhibit K; Transcript, pages 388-89, 600-602, 606.) Both [redacted] and Mr. Perry-Coon testified and both were credible about the content of their discussions.

Mr. Perry-Coon agreed he spoke with [redacted] about a proposed reorganization of Statewide, but said she did not inform him that the Appellants' plan was to establish "the entities" as separately owned corporations, not enrolled in the Medicaid Program, that would employ the drivers. If that arrangement had been presented to him he would have told her it was not allowable. (Transcript, pages 396-97, 403.) Indeed, after talking with [redacted] on February 6, 2013, Mr. Perry-Coon sent an email to Mr. Hebel stating that if he wanted to create a new company in order to divide up Statewide's service area, the new company would have to be enrolled in the Medicaid Program. (Exhibit 32; Transcript, pages 400-401.)

[redacted] was careful not to claim that she ever told Mr. Perry-Coon the entities would be established as separately owned corporations and that those separate

corporations, and not Statewide, would employ the drivers and be contractually responsible for recordkeeping. (Transcript, pages 650-52; Exhibit K.) She characterized the new "entities" to him as "cost centers" (Exhibit K, par.13; Transcript, pages 614-17, 632-34, 641), but acknowledged she did not identify these "regional cost centers" as separate corporations. (Transcript, page 648; Exhibit K.) She did not show him the management agreements. (Transcript, pages 402-403, 4/22/2015 pages 545-46.)

Mr. Perry-Coon explained that Medicaid wants a "one-to-one" relationship with Medicaid Providers. (Transcript, pages 395, 457-58.) As the Appellants themselves point out, the purpose of the management agreements was "to enable [each entity] to operate an independently managed branch of State's transportation service." (Exhibits 9, 10, 11, Article 6; Appellants brief, pages 7-8.) In addition to employing the drivers, under Article 5 of the management agreements the entities, and not the Medicaid Provider, Statewide, were responsible for significant aspects of the record keeping necessary to establish compliance with Medicaid reimbursement rules. (Exhibits 9-11.) It is entirely reasonable that the Medicaid Program would not want to allow providers to delegate this responsibility, even if in this particular case the entities' records were in practice readily available to Statewide.

[redacted] and the Appellants emphasized that the purpose in setting up the entities was to divide Statewide's service area, which had grown large, into regions in order to provide better and more consistent service, and to enable Mr. Hebel to recognize the contributions of his long term regional managers. (Exhibit K; Transcript, pages 487-88, 606-608.) There does not appear to be anything wrong with these purposes, which [redacted] explained to Mr. Perry-Coon. [redacted] and Mr. Hebel conceded,

however, that the Appellants did not have to set up separate corporations in order to achieve an internal restructuring into cost centers that would serve these purposes. (Transcript, pages 512, 669-72.)

The testimony of both [redacted] and Mr. Perry-Coon is fully credited. It does not support the Appellants' claim that Mr. Perry-Coon was fully informed about the arrangements established in the management agreements and advised [redacted] they would not run afoul of the subcontracting prohibition. The Appellants were not given prior Department approval for the "management agreement" arrangements now being criticized by the OMIG.

Other disallowances.

Article 19-A qualification. The notice of proposed agency action disallowed 2,922 claims, in the amount of $162,583, because the thirteen drivers reported on the claims were not qualified under VTL Article 19-A "and there identity could not be verified." (Exhibit 15, first paragraph 21.) In response, the Appellants identified the drivers and explained, and submitted documentation to establish, that eleven of them were qualified at the time the services were provided, and that the services billed for the other two drivers did not require Article 19-A certification. (Exhibit 16, pages 9-13 and attachments.)

The OMIG investigators had reviewed Statewide's May, 2013 Article 19-A roster (Transcript, page 44; Exhibit 21) only, without checking whether drivers who were not listed on the roster in May, were listed at the time they provided services. (Transcript, pages 145-46, 158-59, 178-79, 239-42.) The OMIG also apparently ignored, even when the Appellants' response pointed it out, that in two instances the claims were for livery

service provided by livery drivers, and so did not require Article 19-A certification. (Exhibit 16, page 10; Transcript, pages 209-12, 245.) With regard to drivers whose identity it claimed it could not verify, the OMIG had also failed to review employee records for the entire period under review. (Transcript, pages 204-207.)

It is difficult to understand how, if the OMIG actually reviewed the response to the notice of proposed agency action as it is obligated to do pursuant to 18 NYCRR 515.6(a)(4)&(b)(1), the OMIG could have reissued its proposed finding, *verbatim*, in the final notice. The OMIG claims that it did review it. (Transcript, pages 11, 112, 242.) At the hearing, however, the OMIG agreed that the information provided with the response to the notice of proposed agency action was adequate to identify the drivers and establish that the Article 19-A roster criticism was no longer an issue. (Transcript, pages 244-45, 5/28/2015 page 532.) On the third day of the hearing the OMIG withdrew these disallowances. (Transcript, 5/28/2015 page 530.)

Invalid driver's license number on claim. The notice of proposed agency action disallowed 850 claims, in the amount of $44,423, because the five driver's license numbers reported on the claims were invalid driver's license numbers. (Exhibit 15, first paragraph 22.) In response, the Appellants explained, and submitted documentation to establish, that in five instances the electronically submitted Medicaid claim reported a driver's license number that differed by one digit from the actual nine digit license number of the driver who had provided the service. The invalid number was then automatically repeated on subsequent electronically submitted claims for services by that driver. (Exhibit 16, pages 13-15 and attachments; Transcript, pages 253-54.) At the hearing, the OMIG investigator, Mr. Bedell, agreed that the five invalid license numbers

appear to be initial typographical errors that were subsequently recopied. (Transcript, pages 248-52, 260, 375.)

It is an unacceptable practice to submit an inaccurate Medicaid claim, but this accusation should be applied within reason. Would it constitute an unacceptable practice if a provider occasionally misspelled a name on a claim? Statewide's inadvertent entry of inaccurate data in these cases is hardly more culpable than the OMIG's apparent failure even to look at the Appellants' documentation and response regarding the findings of Article 19-A qualification and missing driver's license numbers.

The OMIG did not argue that these five misreported numbers caused, or might have been intended to cause, any excessive or unearned payments by the Medicaid Program or any harm to its recipients. There is no reason to suspect the Appellants used invalid numbers either for their own convenience or to shirk, shortcut or avoid their reporting responsibilities. The OMIG does not dispute that the services were provided (Transcript, pages 263), nor does any kind of advantage appear to have been gained by the Appellants as a result of these errors.

Most significantly in determining whether the Appellants engaged in unacceptable practices by violating Medicaid rules, it is clear, as it was in the instance of the Article 19-A disallowances, that Statewide did maintain and was able to produce for audit appropriate contemporaneous documentation demonstrating its right to payment as required by 18 NYCRR 504.3(a) and 540.7(a)(8). Inaccurate claims were submitted in 850 instances, but they were the product of only a few typographical errors, and contemporaneous documentation demonstrating entitlement to payment was maintained and produced when the claims were questioned during the investigation.

In charging unacceptable practices in this case because an electronically submitted claim contained a typographical error, the OMIG is confusing documentation in support of a claim, which is what Department regulations at 18 NYCRR 504.3(a) and 540.7(a)(8) require a provider to create and maintain, with the claim itself. The OMIG investigator, Mr. Bedell, testified:

> Q: So if you would go to review one of those Medicaid claims and if you were to ask the question who was the driver, you wouldn't have an answer?
>
> A: I'd have no answer. I wouldn't have anything unless I went back and asked them for their trip tickets and manually go through everything. (Transcript, page 182.)

That is precisely what an audit or claims investigation is for. These 850 disallowances are reversed.

No driver's license number on claim. The notice of proposed agency action disallowed 9,029 claims, in the amount of $335,959, because Statewide failed to submit a driver's license number on the claim. (Exhibit 15, first paragraph 23.) In response, the Appellants pointed out that these claims were for livery services provided in upstate counties. As such, they were properly claimed without a driver's license number in accordance with the Medicaid Program's own claiming procedures. (Transcript, pages 273-75.) The Appellants explained and documented this assertion in their response to the notice of proposed agency action. (Exhibit 16, pages 15-16 and attachments.)

At the hearing, the OMIG conceded that the Appellants were correct about the claim reporting issue and Statewide's compliance with the Medicaid Program's own electronic claiming procedures. (Transcript, pages 279-80.) The OMIG withdrew these disallowances on the third hearing day. (Transcript, 5/28/2015 page 534.) It is again

difficult to understand how, if the OMIG actually reviewed the response to the notice of proposed agency action as it is obligated to do pursuant to 18 NYCRR 515.6(a)(4)&(b)(1), the OMIG could have reissued its proposed findings, unchanged, in the final notice. With hundreds of thousands of dollars and a provider's Medicaid enrollment, even its existence, at stake, the OMIG surely can be expected to discharge, with a little more care, a responsibility specifically referenced in its own regulations to review a provider's responses to a notice of proposed agency action.

In this regard, the Appellants' complaint that this review was conducted by the OMIG's Division of Medicaid Investigations rather than its Division of Medicaid Audit, with its slightly different protocols (Transcript, pages 50, 300-301, 313-14, 5/28/2015 pages 542-43, 548-50, 569-70; Exhibit J), may have some validity. Part 517 regulations applicable to provider audits specifically state the Department "must consider" a response to a draft audit report. 18 NYCRR 517.6(a). The Part 515 regulations applicable to this investigation, on the other hand, simply state "after review" without explicitly stating the Department "must consider" the response. 18 NYCRR 515.6(a)(4)&(b)(1). Subtleties such as this may reveal a difference in attitude (Transcript, pages 293, 370-71), but they do not justify a difference in treatment. The OMIG's decision to conduct this review through its investigative rather than audit unit is entirely within its discretion (OMIG response brief, page 3; Transcript, page 15), but that decision does not excuse it from compliance with regulations that clearly expect in either instance that the response will be meaningfully reviewed.

Unacceptable Practices.

The OMIG's determination that Statewide's subcontracting and fee splitting arrangement with the entities constituted conduct contrary to the official rules and regulations of the Department was correct. The Department has the authority to make appropriate rules regarding claiming under the Medicaid Program, and the OMIG's interpretation of the prohibition against subcontracting is consistent with the regulations and written Department policies and claiming rules.

The OMIG's interpretation of its own rule in this case is reasonable, plausible, within its discretion and is entitled to deference. The Appellants' arguments that the prohibition was in some way unclear are not persuasive. The Appellants' claim that Mr. Perry-Coon knew about and approved in advance of the arrangements now being criticized is not supported by the evidence. The charge of unacceptable practices under 18 NYCRR 515.2(a), conduct contrary to the official rules and regulations of the Department, is affirmed.

With regard to the other specified unacceptable practices charged, it does not appear that the Appellants made false statements or misrepresentations, or failed to disclose anything with the intent that unauthorized payments be made. The Appellants had no reason to do so because they did not believe they were doing anything wrong. From the start of the investigation, they were completely forthcoming and open about what they had done and why. (Transcript, pages 53-54, 70, 85, 106, 199, 500, 589; Exhibit 14.) The findings of unacceptable practices in the form of false statements under 18 NYCRR 515.2(b)(2) and failure to disclose under 18 NYCRR 515.2(b)(3) are reversed.

The evidence also fails to support a finding of "other prohibited acts" under 18 NYCRR 515.2(b)(18) or of fraud or abuse as these are defined in Department regulations:

> *Abuse* means practices that are inconsistent with sound fiscal, business, medical or professional practices and which result in unnecessary costs to the Medicaid Program, payments for services which were not medically necessary, or payments for services which fail to meet recognized standards for health care. 18 NYCRR 515.1(b)(1).

The Appellants submitted claims in violation of Medicaid claiming rules, but the evidence fails to establish that the services resulted in unnecessary costs, were not medically necessary, or failed to meet recognized standards for health care.

> *Fraud* means an intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit to the provider or another person. 18 NYCRR 515.1(b)(7).

The evidence fails to establish an intentional deception or misrepresentation was made.

With regard to the inaccurate driver's license numbers on some claims, the Appellants have persuasively established that the driver's license numbers were inadvertently misreported. These are more accurately described as typographical or clerical errors than as the submission of inaccurate claims. The typing of the wrong digit in five out of hundreds of instances was not intended and could hardly be described as a knowing act. It was not done as a reporting shortcut. The Appellants did create and maintain contemporaneous documentation demonstrating entitlement to payment, and were able to bring it forward to correct the claims when the errors were discovered. (Transcript, page 260.) In this case, a mistake of this nature, on this scale, is not an unacceptable practice, fraud, or abuse.

Medicaid Program sanction.

Upon a determination that a person has engaged in an unacceptable practice, the Department may impose one or more sanctions. 18 NYCRR 515.3(a), 515.4(a). As the main finding of unacceptable practices with regard to subcontracting is affirmed herein, the question of an appropriate sanction, if any, remains.

The OMIG's notice of agency action proposed a three year exclusion from the Medicaid Program. (Exhibit 17, page 1.)

> *Exclusion* means that items of medical care, services or supplies furnished by the provider or ordered or prescribed by the provider will not be reimbursed under the Medicaid Program. 18 NYCRR 515.1(b)(6).

On the third day of this hearing the OMIG reduced the proposed sanction to a censure. (Transcript, 5/28/2105 pages 536-37, 539; OMIG brief, page 3.)

> *Censure* means a warning that continued conduct or the type or nature cited may result in a more severe sanction. A censure may serve as a basis for imposition of a more severe sanction against the same person or an affiliate on a subsequent matter, whether or not the subsequent matter is related to the matter for which a censure was issued. 18 NYCRR 515.1(b)(2).

Pursuant to 18 NYCRR 515.4(b), in determining the sanction to be imposed the following six factors will be considered:

(1) The number and nature of the program violations or other related offenses. Over two million dollars in Medicaid reimbursement was paid in connection with these management agreements, however there is no dispute that the services for which the Medicaid Program paid were provided, and that they were appropriate services for the Medicaid recipients. As the forty thousand program violations in this case are entirely attributable to the underlying subcontracting agreements, the nature of the violation is more akin to one ongoing violation that applied to multiple claims, than to many separately committed violations.

(2) The nature and extent of any adverse impact the violations have had on recipients. There is none. There is no evidence, nor does the OMIG allege, that the services for which the Medicaid Program paid were not provided or

were not adequately provided, in vehicles and by drivers qualified to provide them.

(3) The amount of damages to the program. There is no evidence, nor does the OMIG allege, that the services for which the Medicaid Program paid were not provided or were billed in excessive amounts. Statewide was able to correct the five misreported driver's license numbers by documentation submitted in response to the notice of proposed agency action.

(4) Mitigating circumstances. The Appellants have established mitigating circumstances. The OMIG offered neither evidence nor argument to dispute their contention that the management agreements were not intended nor did they operate to take any inappropriate advantage of the Medicaid Program or to evade any supervision or record keeping or other obligation imposed by it. No such purpose is apparent in this hearing record. The Appellants sought and relied on financial and legal counsel in making the management agreements (Transcript, page 511), and were completely forthcoming with the OMIG about those arrangements. They rescinded the agreements immediately upon being advised they had run afoul of Medicaid rules. (Exhibit 16, attachment 1; Transcript, pages 365-66.)

(5) Other facts related to the nature and seriousness of the violations. The Appellants have been completely forthcoming about the nature of their business arrangements. The OMIG claimed there were other providers in the area able to serve these patients. (Exhibit 13; Transcript, pages 99, 103.) This does not count as a negative factor with regard to Statewide, and is now completely irrelevant because the OMIG has reduced the proposed sanction to censure.

(6) The previous record of the person under the Medicare, Medicaid and social services programs. Statewide and the individual Appellants have thirty years' experience in providing transportation in the Medicaid Program. (Transcript, pages 461, 517.) There is no evidence that the Appellants have any previous record of problems in Medicare, Medicaid or social services programs. The OMIG acknowledged as much in its discussion of the sanction in the notice of proposed agency action. (Exhibit F.)

At the hearing, the OMIG presented evidence of DMV and DOT fines in the amount of a few thousand dollars. (Exhibits 33-34; Transcript, pages 120-121, 132-33, 352-53, 473-74.) This does not count as record under Medicare, Medicaid or social services programs, nor does it support any of the charges. (Transcript, page 124.) The OMIG also presented evidence of a Medicaid exclusion of one of the drivers on Statewide's Article 19-A roster. The driver had been excluded in 1999, in connection with an ambulette provider unrelated to these Appellants. (Exhibit 35; Transcript, pages 128, 132-33.) The driver was excluded so long ago that he did not appear on the OMIG

> exclusion list database. (Transcript, pages 134-37.) None of these matters was mentioned in the notice of proposed action or the final notice of agency action. (Transcript, page 351.)

In accordance with the guidelines set forth at 18 NYCRR 515.4(b), it is concluded that the proposed censure is an appropriate sanction for Statewide and for the entities that were expressly created in furtherance of a billing arrangement that violated Medicaid reimbursement rules.

No sanction will be imposed against the four individual Appellants as affiliates. There is no question that these individuals are affiliates of Statewide, and of their respective entities, under the definition set forth at 18 NYCRR 504.1(d)(1). However, in imposing a sanction upon an affiliate, the determination must be made on a case-by-case basis giving due regard to all the relevant facts and circumstances leading to the original sanction. 18 NYCRR 515.3(c). As the Court of Appeals has recently made very clear, where an OMIG determination to impose a sanction is discretionary, the OMIG "has an obligation to explain *why* in a particular case" that exercise of discretion was thought to be warranted. Koch v. Sheehan, 21 N.Y.3d 697, 976 N.Y.S.2d 4 (2013). In this case, as in Koch, "[o]n this record, there is no telling." *Id*.

The OMIG failed to demonstrate any effort to apply 18 NYCRR 515.3(c). Simply identifying these individuals as affiliates is not a justification for sanctioning them. It is a condition precedent to an exercise of discretion whether to do so. The OMIG relies entirely upon these individuals' status as affiliates, without citing any facts or circumstances to justify why it is appropriate in this case to extend the sanction to these particular affiliates. (Exhibit F; OMIG brief, page 19.)

Mr. Hebel consulted with counsel before entering into the management agreements. (Transcript, page 511.) There is no reason to conclude that he or the other individual Appellants were either aware of or would have understood the ramifications of [redacted] failure to disclose to Mr. Perry-Coon that the entities would be established as separate corporations. Under the standard set forth in 18 NYCRR 515.3 the imposition of a sanction on these individual affiliates is not appropriate.

Restitution of overpayments.

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). The payments under review are overpayments within the meaning of this regulation. This alone, however, does not decide the question whether they should be recovered. The Department may require the repayment of overpayments determined to have been made as a result of an unacceptable practice. 18 NYCRR 515.3(b).

There is no reason in this hearing record to conclude that the unacceptable practices in this case were motivated by dishonesty or corner-cutting, resulted in any inappropriate care or took any financial advantage of the Medicaid Program, or that the Appellants engaged in the subcontracting knowing or intending it to be an unacceptable practice. The Appellants immediately terminated the subcontracting arrangements when advised by the OMIG that they were not permissible. (Exhibit 16, attachment 1 thereto; Transcript, pages 505-506.)

In the absence of any reason to believe or even suspect that any wrongdoing or intent to take advantage of the Medicaid Program is involved in this case, it is

unreasonable to demand complete restitution for services that the Appellants were able to document were provided and billed in the appropriate amount. (Transcript, pages 357-58.) Mr. Torres and Mr. Hernandez testified that the repayment of the $2 million threatens the survival of their business, and their testimony is credited. (Transcript, pages 683, 691.) Under these circumstances, restitution is not appropriate.

Previous decisions of this bureau cited by the parties (LIN-WIL, issued July 16, 2013; M.J. Trans. Corp., issued January 27, 2015), neither of which appear to involve charges of unacceptable practices, are consistent with this analysis.

DECISION: The OMIG's determination that Appellant Statewide Ambulette Service, Inc. engaged in unacceptable practices in the Medicaid Program is affirmed.

The OMIG's determination to censure Appellant Statewide, along with Accessible Transportation, LLC, Base Car Service, Inc. and Allstar Transportation, LLC, as affiliates, is affirmed.

The OMIG's determination to sanction Appellants Alan Hebel, Jose Rivera, William Torres and Armando Hernandez, as affiliates, is reversed.

The OMIG's determination to recover Medicaid Program overpayments is reversed.

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

DATED: Rochester, New York
October 28, 2015

_____/s/_____
John Harris Terepka
Administrative Law Judge