

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

----- X
: In the Matter of the Appeal of :
: :
: :
: **United Cerebral Palsy Association of Putnam and** : **Decision After Hearing**
: **Southern Dutchess, a/k/a Hudson Valley Cerebral Palsy** :
: :
: Provider # 02703445 :
: :
: :
: for a hearing pursuant to Part 519 of Title 18 of the :
: Official Compilation of Codes, Rules and Regulations :
: of the State of New York (NYCRR) to review a :
: determination to recover Medicaid overpayments. : **Audit #13-5288**
: :
----- X

Before: Jude Brearton Mulvey
Dawn MacKillop-Soller
Administrative Law Judges

Held At: NYS Department of Health
Menands, New York
New York, New York

Dates of Hearing: 2017: April 25, June 5, August 10, September 15
2018: March 23, April 20, May 8, June 21, July 21, 25, 26

Record closed: December 21, 2018

Parties: NYS Office of the Medicaid Inspector General
90 Church Street, 14th Floor
New York, New York 10007
By: Harry Glick, Esq.

United Cerebral Palsy Association of Putnam
& Southern Dutchess
40 Jon Barrett Road
Patterson, New York 12563-2164
By: Jeffrey J. Sherrin, Esq.
O'Connell and Aronowitz
54 State Street
Albany, New York 12207-2501

JURISDICTION

The New York State Department of Health (Department) acts as the single state agency to supervise the administration of New York’s medical assistance program (Medicaid). Public Health Law (PHL) § 201(1)(v), Social Services Law (SSL) § 363-a. The Office of the Medicaid Inspector General (OMIG), an independent office within the Department, has the authority to pursue civil and administrative enforcement actions against entities or individuals engaged in fraud, abuse, or unacceptable Medicaid practices and to recover improperly paid funds. PHL §§ 30, 31, 32. The OMIG determined to recover Medicaid Program overpayments made to United Cerebral Palsy Association of Putnam and Southern Dutchess, a/k/a Hudson Valley Cerebral Palsy (Appellant). The Appellant requested a hearing pursuant to SSL 22 and former Department of Social Services regulations at 18 NYCRR 519.4 to review the overpayment determination. The Appellant has the burden of showing that the OMIG’s determination was incorrect and that all claims submitted and denied were due and payable under the program. 18 NYCRR 519.18(d)(1).

HEARING RECORD

ALJ exhibits: ALJ 1-3
Appellant exhibits: A-W
OMIG exhibits: 1-13

Appellant witnesses: [REDACTED], statistical consultant. (Transcript 49-307.)
[REDACTED], statistical consultant. (Transcript 309- 449.)
[REDACTED], Executive Director. (Transcript 1270-1438.)
[REDACTED], Chief Financial Officer. (Transcript 1439-1591, 2045-2069.)
[REDACTED], Chief Operating Officer. (Transcript 1592-1816.)
[REDACTED], Director of Quality Improvement. (Transcript 1818-2044.)
Joanna Howard, OPWDD Director of Rate Setting. (Transcript 2115-2196.)

OMIG witnesses: Karl Heiner, Ph.D., statistical consultant. (Transcript 456-1063.)
Kevin Patrick Ryan, Deputy Inspector General. (Transcript 1063 –1137.)
Gina Caivano, Management Specialist 2. (Transcript 1155 – 1258.)

A transcript of the hearing was made. (Transcript, p. 1- 2197.) Each side submitted one brief.

FINDINGS OF FACT

1. The Appellant, United Cerebral Palsy Association of Putnam & Southern Dutchess, is licensed by the Office for People With Developmental Disabilities (OPWDD) and is enrolled as a provider in the New York State Medicaid Program. The Appellant is paid by the Medicaid Program to provide services to developmentally disabled individuals. These services include individualized day habilitation services to teach strategies for learning and completing basic living skills. The purpose of day habilitation services is to improve independence and quality of life and to enable individuals to successfully function at home, work and in the community. (Transcript, p. 1275, 1280-1281.)

2. The OMIG conducted an audit of the Medicaid claims paid to the Appellant for the period January 1, 2009 through December 31, 2011. During this audit period, the Appellant received payments totaling \$7,510,900.67 for 44,306 OPWDD day habilitation claims for habilitation services provided to Medicaid recipients. The audit consisted of a review of a random sample of 100 of those claims paid in the total amount of \$16,738.96. The purpose of the audit was to determine whether the Appellant's day habilitation program claims were in compliance with Medicaid Program requirements for payment. (Exhibit 2.)

3. In a draft audit report dated March 3, 2015, the OMIG identified 37 of 100 claims with at least 1 error and disallowed them. (Exhibit 1.)

4. On May 7, 2015, the Appellant submitted a response to the draft audit report. The Appellant offered arguments against the findings and produced records to show habilitation services were provided to the recipients. (Exhibit 10.)

5. After considering the Appellant's response to the draft audit report, the OMIG issued a final audit report dated July 2, 2015, revising its findings to identify 14 claims with at

least one error and disallowing those claims. (Samples 6, 17, 19, 23, 29, 37, 64, 76, 77, 87, 89, 96, 97 and 98.) These audit findings resulted in a sample overpayment of \$2,426.12. (Exhibit 2.)

6. The Appellant does not contest the audit findings for eight of the disallowed claims: (Samples 6, 19, 37, 64, 76, 77, 87, and 98.) The findings contested by the Appellant involve six disallowed claims with eight errors. They are:

- Missing day habilitation monthly summary note (Samples 17, 23, 29, 89 and 97.)
- Missing day habilitation service documentation (Samples 23, 29 and 96.)

7. The OMIG's restitution claim is an extrapolation based upon an audit utilizing a statistical sampling method certified as valid, in which the value of the 14 disallowed claims found in the random sample of 100 claims was projected to the total of 44,306 claims paid by Medicaid during the audit period. The total sample overpayment of \$2,426.12 was divided by 100, the total number of claims in the audit sample. This resulted in a mean overpayment per sampled claim of \$24.2612. This amount was multiplied by the 44,306 claims paid during the audit period to yield an overpayment of \$1,074,917. The OMIG's findings and the extrapolation are set forth in attachments to the draft and final audit reports. (Exhibits 1, 2, 4, 5.)

APPLICABLE LAW

1. Medicaid providers are subject to audit by the Department and are required to reimburse it for discovered overpayments in accordance with Part 517. 18 NYCRR 504.8(a)(1).

2. 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).

3. When the Department has determined that any person has submitted claims for services 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).

4. 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).

5. A Medicaid provider's record-keeping obligations include:

a. [to] prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the ...New York State Department of Health.

[¶] . . . [¶]

g. to permit audits, by the persons and agencies denominated in subdivision (a) of this section, of all books and records or, in the discretion of the auditing agency, a sample thereof, relating to services furnished and payments received under the medical assistance program...including...case files and patient-specific data.

h. that the information provided in relation to any claim for payment shall be true, accurate and complete; and

i. to comply with the rules, regulations and official directives of the department. 18 NYCRR 504.3. *See Lock v. NYS Dept. of Social Services*, 220 AD2d 825, 827 (3rd Dept. 1995) *See also* 517.3(b)(1), 540.7(a)(8).

6. The requirements for habilitation plans set are forth in OPWDD regulation. An Individual Service Plan (ISP) is a written document reviewed semi-annually that describes services, personal goals, preferences, capabilities and outcomes to be achieved within specified timeframes. Attached to the ISP is the habilitation plan, which identifies supports, assistance and supervision needed to complete outcomes or goals. 14 NYCRR 635-99.1(bk).

7. Billing of habilitation services must be for a “full unit” or a “half unit.” These billing requirements are set forth in OPWDD regulations as:

- (a) The agency may bill a full unit of service when the agency delivers and documents at least two face-to-face services delivered in accordance with the individual’s day habilitation plan and provides a program day duration of four to six hours.
- (b) The agency may bill a half unit of service when the agency delivers and documents at least one face-to-face service delivered in accordance with the individual’s day habilitation plan and provides a program day duration of at least two hours. 14 NYCRR 635-10.5(c)(6)(i)(a) and (b).

8. OPWDD administrative directive ADM #2006-01 states:

A Full Unit may be billed when staff deliver and document at least two individualized face-to-face Group Day Habilitation services to a consumer during the program day, and the program day duration is four to six hours in duration. A Half Unit of Group Day Habilitation or Supplemental Group Day Habilitation may be billed when staff deliver and document at least one individualized face-to-face Group Day Habilitation service to a consumer during the program day, and the program day duration is at least two hours. ADM #2006-01, January 1, 2006, p. 3; *See also* ADM #2006-02, January 1, 2006, p. 3.

9. OPWDD administrative directive ADM #2003-03 identifies the requirements for a monthly summary note to support billing. It states:

To support service claim documentation and quality services, the service provider must assure that at least monthly, or more frequently if the provider so chooses, a narrative note is written that:

- a) summarizes the implementation of a person’s Habilitation Plan,
- b) addresses the person’s response to the services provided, and
- c) states any issues or concerns about the plan or the person. ADM #2003-03, December 5, 2003, p. 4.

10. OPWDD administrative directives require habilitation service documentation to include a narrative note or a checklist/chart with an entry made at the same time each Group Day

Habilitation service is delivered and billed. If a checklist or chart format is used, a monthly summary note is also required. ADM #2006-01, p. 5; ADM #2006-02, p. 6.

11. If there are significant changes to a habilitation plan, a subsequent revised habilitation plan is created in the following manner:

Subsequent revised Habilitation Plans, which are also written by the Habilitation Service Provider, are given to the person's service coordinator no more than 30 days after either: (a) the six-month ISP review date, or (b) the Habilitation Service Provider makes a significant change in the Habilitation Plan. ADM #2003-03, December 5, 2003, p. 2.

ISSUES

Has the Appellant met its burden of proving that the OMIG's disallowances in the final audit report were not correct?

Has the Appellant met its burden of proving that the overpayment determination in the amount of \$1,074,917 was not correct?

DISCUSSION

The final audit report disallowed 14 claims with at least one error (Samples 6, 17, 19, 23, 29, 37, 64, 76, 77, 87, 89, 96, 97 and 98.) The Appellant does not contest the disallowances of eight of those claims (Samples 6, 19, 37, 64, 76, 77, 87 and 98) and failed to offer any evidence or argument to establish the OMIG's determination was not correct. Therefore, the Appellant failed to meet its burden of proof and the disallowance of those eight claims is affirmed. The audit findings contested by the Appellant and to be decided in this hearing decision involve the remaining six disallowed claims, which have eight errors among them. They are: Missing day habilitation monthly summary note (Samples 17, 23, 29, 89 and 97) and missing day habilitation service documentation (Samples 23, 29 and 96.)

Missing Day Habilitation Monthly Summary Note, finding category 1
Samples 17, 23, 29, 89 and 97

In order to support its claims for services, the Appellant was required to document “at least monthly” the implementation of the habilitation plan and responses to services provided. ADM #2003-03, p. 4, #2006-01, p. 3. If a narrative note or a checklist or chart format was used to document Group Day Habilitation services, a monthly summary note was also required. ADM #2006-01, p. 5; ADM #2006-02, p. 6. The Appellant does not dispute that for Samples 17, 23, 29, 89 and 97, Medicaid claims were submitted for which it was unable to produce monthly summary notes.

The Appellant’s Chief Financial Officer, [REDACTED], acknowledged (Transcript, p. 2068) that the required monthly summary notes were never completed for these samples even though the OPWDD ADM “guidelines” (Transcript, p. 1573) required them. ADM #2003-03. The Appellant’s Chief Operating Officer, [REDACTED], testified that monthly summary notes must have existed “because we billed based on those documents.” (Transcript, p. 1771.) The mere suggestion that a provider once had records that it never produced is insufficient to meet its burden of proving entitlement to payment. The monthly summary notes were required and if they existed, as [REDACTED] suggested, the Appellant had an obligation to produce them for audit.

The Appellant also unpersuasively argues that the amounts paid on these claims “cannot constitute an overpayment subject to recoupment” as monthly summary notes are not required to exist at the time the claim is submitted and paid. (Appellant’s brief p. 8-9; Transcript, p. 2051-2052, 2065.) According to the Appellant, there were instances in which it provided the service and submitted its claim before the monthly summary note was due to be written. A provider is not excused from its obligations to produce the documentation required to support its claims simply

because its internal procedures include creation of monthly summary notes “after the month is done.” (Appellant brief, p. 9.) 18 NYCRR 504.3(i), 517.3(b)(1), 540.7(a)(8).

Equally without merit is the Appellant’s claim that the monthly summary note requirement has been met if the OMIG considers the “context of the services” provided and the “limitations of its clients.” (Appellant’s brief, p. 14.) According to the Appellant, the records it submitted contain “all of the information normally seen on a monthly summary note,” excusing it from producing actual monthly summary notes. (Appellant’s brief, p. 14-17.) The alternative records relied upon by the Appellant to justify its failure to produce a monthly summary note include a “grid,” which the Appellant produced for Samples 17, 89 and 97. This grid used by the Appellant is equivalent to the “checklist or chart format,” for which a monthly summary note is also required. ADM #2006-01, p. 5; ADM #2006-02, p. 6.

The Appellant’s suggestion in its brief (p. 13) that the OMIG must sift through other documents “in the client’s chart that contains the substance of what the OMIG claims to have been seeking” misstates the ADM directives, which do not contemplate reconstructing a monthly summary note from other documents in the record. ADM #2003-03. [REDACTED] testimony that a monthly summary note summarizes data from the grid does not establish that the grid replaces a monthly summary note. (Transcript, p. 1631.) To the contrary, the Appellant’s resort to a grid or checklist/chart format specifically required it to also document a monthly summary note. (Transcript, p. 1176-1177.) *See* ADM #2006-01, p. 5, ADM #2006-02, p. 6. The Appellant’s Director of Quality Improvement, [REDACTED], acknowledged that these ADMs do not “say” that any other document replaces it. (Transcript, p. 2029.)

The purpose of the monthly summary note requirement is to enable a thorough review of the circumstances of services and goals worked on that month to ensure these vulnerable

individuals received appropriate care and services. (Transcript, p. 1177-1178.) This critical information is relied upon by staff to organize care and services moving forward as part of an individual's ISP, which is worked on every six months to "sustain the person in his/her chosen environment." 14 NYCRR 635-99.1(bk). The Appellant's argument that these requirements can be ignored on the supposition that the information can somehow be inferred in a chart, is rejected.

The Appellant's contention that the OMIG had a "single-minded focus on the existence or not of a single piece of paper" (Appellant's brief, p. 14) is contrary to all the evidence. The OMIG considered all records the Appellant submitted, including Medicaid service coordinator (MSC) notes, to document a monthly summary note. (Transcript, p. 1172-1173.) The MSC notes, which the Appellant produced for these samples, were rejected because they only document no "significant changes." (Exhibits A, 10; Appellant's brief, p. 14-17.) Whether significant changes exist or not is not the standard for monthly summary notes and is only relevant when habilitation plans require revisions, a subject not under review. ADM #2003-03, December 5, 2003, p. 2. ██████████ explained that monthly summary notes track "the individual's progress or lack of progress as well as their satisfaction within the program and how they're doing," suggesting that they document any goal progress, even when there is none. (Transcript, p. 1978.) MSC notes recording "no significant changes" do not satisfy this requirement.

Sample 17

- Sample 17, date of service ██████████ 2011

██████████ of 2010 ISP, grid and MSC notes from ██████████, 2010, ██████████ of 2010 and ██████████ of 2010. (Appellant's brief, p. 13; Exhibit 10, p. 5525-5535, 5553-5557, 5891.)

The MSC notes from ██████████ and ██████████ 2010 and ISP from ██████████ 2010, do not apply to August, as the Appellant's witnesses, ██████████ and ██████████ conceded. (Transcript, 1182, 1660, 1662, 1701, 1850.) Records for months other than the month for which

the summary note is missing are not documentation of the missing summary note. The MSC notes from [REDACTED] and [REDACTED] are also unsigned. It is not an “arbitrary standard,” as claimed by the Appellant, to require a signature to identify who provided the services for which the Appellant was paid. (Appellant’s brief, p. 14; Transcript, p. 1660, 1662.) The grid, which fails to provide “a monthly summary of goals” (Transcript, p. 1182) is also no replacement for a monthly summary note. (Transcript, p. 2029.) To the contrary, the Appellant’s use of the grid format in the chart mandated documentation of a monthly summary note. ADM #2006-01, ADM #2006-02.

- Sample 23, date of service [REDACTED], 2011

Day habilitation program goal plan methodology sheet (goal sheet) effective [REDACTED] of 2010 through [REDACTED] of 2011 and MSC notes from [REDACTED] and [REDACTED] of 2011. (Appellant’s brief, p. 14-15; Exhibit 10, p. 5583-5593, 5595-5597, 5625-5635.)

The unsigned MSC note from [REDACTED] references contact with the patient on [REDACTED] contemporaneous with the [REDACTED] date of service, but [REDACTED] agreed that it fails to summarize the individual’s goal progress, a fundamental requirement of monthly summary notes. (Transcript, p. 1187, 1664.) She also agreed that the [REDACTED] MSC is not contemporaneous, a conclusion that can also be made for the [REDACTED] MSC note. (Transcript, p. 1665.) The goal sheets effective [REDACTED] 2010 through [REDACTED] of 2011 are also insufficient documentation to substantiate this claim because they fail to summarize the individual’s day habilitation program and goals and were created almost one year prior to the date of service. (Transcript, p. 1188-1189, 1711.)

- Sample 29, date of service [REDACTED], 2011

Day habilitation program goal plan methodology sheet effective [REDACTED] 2011 through [REDACTED] 2012 and ISP dated [REDACTED], 2011. (Appellant’s brief, p. 15; Exhibit 10, p. 5643-5653, 5679-5681.)

As [REDACTED] acknowledged, the ISP from [REDACTED] of 2011 was created prior to the date of

service, and so could not constitute a summary note for services provided in [REDACTED] 2011. (Transcript, p. 1667-1668, 1715.) Likewise, a goal sheet effective [REDACTED] 2011 also fails to amount to a monthly summary note for service in [REDACTED] 2011. The Appellant has not documented a summary of the individual's progress for [REDACTED]

- Sample 89, date of service [REDACTED] 2009

ISP dated [REDACTED] 2009 and revised on [REDACTED] 2009, the grid, MSC notes from [REDACTED] and [REDACTED] of 2009 and [REDACTED] and [REDACTED] of 2010 and day habilitation program goal plan methodology sheet effective [REDACTED] 2009 through [REDACTED], 2010. (Exhibit 10, p. 5771, 5773, 5777, 5799, 5795-5797, 5925-5927.)

The grid fails to document the date of service and is also inadequate documentation to meet the requirements of a monthly summary note. The Appellant's use of it also required documentation of a monthly summary note. ADM #2006-01, ADM #2006-02. A [REDACTED] 2009 MSC note documents "a face-to-face meeting that occurred on the [REDACTED] of the month, [REDACTED] weeks after the Date of Service." (Appellant's brief, p. 16.) [REDACTED] acknowledged that it only applies to [REDACTED] as opposed to addressing services and goals for the entire month. (Transcript, p. 1719-1720.) Other MSC notes prepared prior to the date of service, in [REDACTED] 2009, and afterwards, in [REDACTED] and [REDACTED] 2010, are not adequate monthly summary note documentation for [REDACTED] 2009 because they fail to detail the individual's response to services provided in [REDACTED]

- Sample 97, date of service [REDACTED] 2009

MSC note dated [REDACTED] 2009.
(Exhibit 10, p. 5937-5939.)

As in samples 17 and 89, the grid and MSC note, which show "activities for the month" and "no changes" (Appellant's brief, p. 17), are insufficient to document a monthly summary note. [REDACTED] agreed, acknowledging that neither the [REDACTED], 2009 MSC note referencing a

face-to-face meeting with the individual on [REDACTED] 2009, which she speculated addressed goals, nor any of the other records relied upon by the Appellant, comply with the ADM requiring a monthly summary note. (Transcript, p. 1961-1962, 2029.)

As OMIG witness Gina Caivano pointed out, in 94 of the 100 claims reviewed in this audit the Appellant made the necessary efforts to properly document monthly summary notes. She explained this as follows:

They usually had something that was – when they did it, they did it right. I mean they had a note in there for each month that either said monthly summary or summary note and it listed the person’s goal. (Transcript, p. 1204.)

The Appellant failed to follow its own routine procedures to submit such contemporaneous documentation. The Appellant obviously knew what was required to be documented and failed to comply in the remaining instances. The Appellant failed to meet its burden of proving entitlement to payment in samples 17, 23, 29, 89 and 97. The OMIG’s disallowances for this category are affirmed.

Missing Day Habilitation Service Documentation, finding category 3
Samples 23, 29 and 96

To justify billing full units of service for these claims, the Appellant was required to document it delivered at least two face-to-face services within a four to six hour period. ADM #2006-01, #2006-02. For 97 of the 100 claims in the sample, the Appellant produced, and the OMIG accepted, a checklist, or “grid” to document the services were provided on the date of service. It is uncontroverted that for samples 23, 29 and 96, such a checklist or grid was not submitted. In defense of its failure to submit these particular documents, the Appellant claims they are not required under Medicaid regulations. (Appellant’s brief, p. 8, 17.) The Appellant failed,

however, to produce any other documentation in their place that justify its billing for full units in these instances. 18 NYCRR 504.3(i)(a).

The Appellant argued that bus logs are analogous to the grid because they confirm the individual's presence at the program. ██████████ however, agreed that while the records are useful to confirm an individual's "presence in the program," they fail to indicate the actual services provided. (Transcript, p. 1733.) ██████████ assertion that the grid existed at the time billing was submitted does not excuse the Appellant from its obligation to maintain and produce for audit adequate documentation in support of these claims. (Transcript, p. 1865.)

The Appellant's argument that other records in the individual charts show ongoing care and monitoring, which "necessarily" means services were provided on the dates of service, is unpersuasive. (Appellant's brief, p. 17-20.) Records created prior to and after the dates of service are not contemporaneous documentation and do not verify the provision of these services. It was the Appellant's burden to produce documentation that the services it billed for were provided, which it failed to do. (Transcript, p. 1257.) The disallowances for this category are affirmed.

Rate

The amount per claim that the Appellant received for these services was established on the basis of a budget submitted by the Appellant to OPWDD, which set a unit price per claim of \$193.37 and \$192.17 for 2009, \$165.45, \$161.44 and \$166.68 for 2010 and \$159.03 and \$158.70 for 2011. (Exhibit 10; Transcript, p. 2125, 2143-2144.) The Appellant objects to the disallowance of the entire amount paid for each claim, arguing that the total overpayment includes salary and capital cost adjustment elements factored into the unit price per claim, such as costs connected to heat, hot water, air conditioning, food, electricity, transportation and leasing a building. (Appellant's brief, p. 22-23; Transcript, p. 1302-1304.)

The Appellant’s argument that portions of the claims attributable to these factors should be excluded from the overpayment calculation ignores that the Appellant is a fee for service provider, paid “in accordance with the rates, fees and schedules established by the department.” 18 NYCRR 517.3(b)(1). This is not an audit of the Appellant’s costs pursuant to 18 NYCRR 517.3(a), but an audit of its fee for service claims pursuant to 18 NYCRR 517.3(b). (Transcript, p. 1224.) Joanne Howard, OPWDD Director of Rate Setting, accurately characterized such expenses as business costs. (Transcript, p. 2146-2147.) In a fee for service audit, Ms. Howard confirmed the OMIG is entitled to recover “the total rate which is inclusive of operating and capital.” (Transcript, p. 2143.)

The Appellant claimed – and was paid – a specific dollar amount for the provision of each service. The amount paid for each service that is not properly documented is an overpayment that the OMIG is entitled to recover. (Transcript, p. 2187.) How the amount of the fee paid for any individual service was originally set has no relevance to the issue for this audit, which is whether the Appellant has documented compliance with the requirements for claiming payment of that fee.

Medicaid Program overpayments

The audit findings for the 100 claims in the audit sample were extrapolated to the universe of 16,198 claims that the Department’s computer billing and payment records show were paid by the Medicaid Program during the audit period. (Exhibits 1, 2.) 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 presented the certification necessary to establish this presumption in the form of affidavits from statistical consultant Karl Heiner, Ph.D. and OMIG Deputy Medicaid Inspector General Kevin Ryan. (Exhibits 4, 5.)

The extrapolation procedure set forth in the OMIG's certification is authorized by the regulations and has consistently been upheld in administrative hearings and by courts, including the Court of Appeals. Mercy Hosp. of Watertown v. NYS Dept. of Social Services, 79 NY2d 197, 204 (1992); Matter of Clin Path v. NYS DSS, 193 AD2d 1034 (3d Dept. 1993); Matter of Rite Aid of New York, Inc., Dept. of Health Admin. Decision, ALJ John Harris Terepka, July 7, 2010; Matter of Pharmhealth Infusion, Dept. of Health Admin. Decision, ALJ John Harris Terepka, May 28, 2009; Matter of Niagara Pharmacy, Dept. of Health Admin. Decision, ALJ John Harris Terepka, July 20, 2011.

The Appellant has the right to submit expert testimony challenging the extrapolation or an actual accounting of all claims paid in rebuttal to the Department's proof. 18 NYCRR 519.18(g). The Court of Appeals has emphasized that "the provider, who at all times bears the burden of proving entitlement to the Medicaid funds, must be given a fair opportunity to challenge the accuracy of the estimate by attacking the reliability of the methods used or standards employed." Mercy Hosp., 79 NY2d at 204.

The Appellant concedes the OMIG's methodology certified by Dr. Heiner is valid, but claims it challenges "the OMIG's application of the methodology" as resulting in "a statistically invalid sampling and extrapolation." (Appellant's brief, p. 69, 71.) In support of this challenge, the Appellant submitted reports and testimony from statistical consultants [REDACTED] and [REDACTED] (Exhibits H, B, C.) [REDACTED] and [REDACTED] are psychologists with no formal statistical training and limited backgrounds in New York State Medicaid audits. (Exhibits E, G.) Their opinions were mostly based on experience in Medicare audit guidelines and rules not applicable to this audit. The applicable requirements for this Medicaid audit are under 18 NYCRR 519.18. It is further noted that [REDACTED] demonstrated confusion about fundamental

facts in this audit, such as the size of the universe, the definition of the audit period and the independence of the claims audited.

The OMIG's statistical expert, Dr. Heiner, on the other hand, has decades of experience specializing in statistical consultant work for the OMIG, federal courts and other administrative agencies. He has testified as an expert in statistical sampling on numerous occasions in state and federal courts, and his background includes a master's degree and doctorate in applied statistics, academic positions, publication and teaching experience in statistics. (Exhibits 4, 6.) The OMIG did not "exclude its retained statistician, Dr. Heiner, from the decision-making process over what sampling methodology to use," as suggested by the Appellant. (Appellant's brief, p. 53.) To the contrary, Dr. Heiner certified "I am the statistical consultant for the [OMIG] and for the past thirty years have been the statistician who designed and monitored sampling procedures for statistical audits carried out in behalf of the New York State Medicaid Program," including its use in this particular audit. (Exhibit 4; Transcript, p. 479, 490, 627.) The OMIG also produced Mr. Ryan, who has many years of Medicaid audit experience, including performing the audit sample selection process and certifying random samples. (Exhibits 5 and E.) Dr. Heiner and Mr. Ryan were more persuasive and credible than [REDACTED] and [REDACTED] in their opinions that the statistical sampling methodology used by the OMIG was valid. The Appellant failed to overcome the presumption of 18 NYCRR 519.18(g).

The Appellant relies in its brief (p. 35-36) on an Office of the Inspector General (OIG) report issued in September of 2018 to criticize the validity of the OMIG's statistical sampling methodology. *See* U.S. Dept. of Health and Human Services, Statistical Sampling: A Toolkit for MFCUs, OIG-12-18-1. This "toolkit," which is dated after the audit concluded, was not raised by the Appellant until after the hearing was completed. The Appellant attempts to use it to criticize

this audit without citing a single provision in it that is inconsistent with the Department's auditing procedures.

██████████ criticisms of this audit include that no audit sample "seed" was produced, no probe sample or stratified sample was done, the sample size was too small for a 90 percent confidence level, the sample was not representative, and the universe and frame were not adequately defined, normally distributed or independent. None of these objections refuted the validity of the statistical sampling method or the presumption that the overpayment determination was accurate. 18 NYCRR 519.18(g). Some of the criticisms made inaccurate factual claims about the sample, universe and frame. The remaining criticisms were that more elaborate sampling and estimation procedures might have been expected to produce more exact results. The OMIG's failure to use them did not invalidate this audit.

Dr. Heiner certified the validity of the sampling and estimate procedure in satisfaction of Medicaid regulations. (Exhibit 4; Transcript, p. 490, 734, 738.) The method employed by the OMIG was mean per unit estimate, which gives an unbiased single number, which Dr. Heiner certified as a valid and appropriate estimate of the overpayment amount. (Transcript, p. 528, 565.) Dr. Heiner confirmed that the point estimate of \$1,074,916.73 is reliable, unbiased, and is the most probable, objective estimate of the overpayment amount. (Exhibit 4; Transcript, p. 488, 690.) It represents the unbiased maximum likelihood estimate of what the OMIG auditors would have determined to be the overpayment had all 44,306 services in the universe of claims been reviewed, a process deemed overly burdensome by the Court of Appeals in confirming the use of "statistical samples to establish that overpayments have been made and to estimate their total amount." Mercy Hosp., *supra*, at 204.

Probe/stratified sample: ██████████ suggested ways to minimize errors by stratifying the

sample and using a probe sample, two methods not required under Medicaid regulations. (Transcript, p. 129-130, 136-137.) While Dr. Heiner acknowledged that a stratified sample was possible and a probe sample might lead to a more optimal sample size, he deemed the OMIG's mean per unit estimate appropriate and statistically valid. (Transcript, p. 720-721, 739.) The argument that a stratified sample, as opposed to a simple random sample, or a probe sample are required have been rejected in prior cases involving the same methodology used in this case. In Rite Aid, ALJ Terepka determined that stratification and a probe sample are unnecessary to prove the validity of the estimation. Rite Aid, *supra*, at 35. Although such methods might produce more precise results, it does not follow that "a simple random sample is a statistically invalid choice." Bedford Stuyvesant Community Mental Health Center, Dept. of Health Admin. Decision, December 31, 2003, p. 17-18. The Appellant has failed to establish that the OMIG's decision not to use a probe or stratified sample invalidated the extrapolation. (Exhibit 4.)

Seed: The Appellant criticizes the OMIG for its failure to retain the audit "seed" used to generate the random sample numbers. (Appellant's brief, p. 40.) As pointed out by the Department in its brief, counsel for the Appellant unsuccessfully raised this same argument in Matter of New York Service Network, Inc. (Dept. of Health Administrative Decision, ALJ David Lenihan, April 25, 2010.) In that case, ALJ Lenihan determined that "the seed is not required in order to determine whether a sample actually consists of random numbers." It is merely an arbitrary number the random sampling program uses to start the random number selection process. Matter of New York Service Network, Inc., p. 19-20. As Dr. Heiner certified, it is "through the use of the program [that] the OMIG correctly generated random numbers." (Exhibit 4.)

The Appellant has not produced any evidence to suggest that not retaining the seed produced unfair or inaccurate results. Without explaining how its experts' opinions support its

argument, the Appellant offers a bare claim that “randomness of the sample” cannot be verified without producing the seed and replicating the sample. (Appellant’s brief, p. 41-43.) Dr. Heiner refuted this argument by explaining that randomness is established not by retaining the seed, but by identifying and producing the random number generator program and performing tests on the actual random numbers that were produced by that program. (Transcript, p. 540.) As Dr. Heiner pointed out, “just because you can replicate it doesn’t mean it’s random.” (Transcript, p. 544.)

The Appellant claims that Dr. Heiner failed to sufficiently test for randomness despite the uncontroverted evidence establishing that the sample in this case passed the tests that even the Appellant’s witnesses agree upon as relevant to confirm the randomness of the sample, including the Chi-Square, Runs and Kolmogorov-Smirnov. (Appellant’s brief, p. 56; Transcript, p. 220, 444-445, 540-542, 1090.) Based on the use of the random sampling program and the sample generated by it that passes these tests, Dr. Heiner certified that a valid random sample was used in this audit. (Exhibit 4; Transcript, p. 512-513.)

In its brief (p. 43), the Appellant relies on Rite Aid to argue that the OMIG’s refusal to produce the seed warrants dismissal of the extrapolation. Nowhere does that decision support the Appellant’s claim. Rite Aid agrees that the computer program is required to test the audit selection procedure for randomness. It does not hold, however, that the seed is also required, nor do any other Medicaid audit decisions issued by this tribunal. Rite Aid, *supra*, at 32. In Rite Aid, an Appellant was deprived of access to the random number generating program. In this case, the random number generator program was identified and produced for the Appellant, and the Appellant has not criticized its validity. The evidence failed to show that the OMIG did anything other than randomly select 100 numbers between 1 and 44,306.

The Appellant has not demonstrated the OMIG is required to produce non-essential information, such as the seed. The Appellant, having had the opportunity to perform its own testing, has failed to establish any reason to conclude that the actual random sampling program produced an invalid random sample. The Appellant also failed to demonstrate how or explain why it is “utterly unacceptable” for the OMIG to not have retained the seed. (Appellant’s brief, p. 41.) Dr. Heiner’s testimony that regardless of the program used, retaining the seed is not necessary to ensure randomness, is credited. (Transcript, p. 780.)

The Appellant also relies in its brief (p. 41) on the Medicare Program Integrity Manual (MPIM) and case law in support of its argument that the seed is required to fairly challenge randomness. (Exhibit N.) These resources all involve Medicare standards not applicable to Medicaid audit requirements. Maxmed Healthcare, Inc. v. Burwell, 152 F. Supp. 3d 619, 635 (W.D. Texas 2016), Global Home Care National Government Services, 2011 WL 3668242, Pruchniewski v. Leavitt, 2006 WL 2331071, John v. Sebelius, 2010 WL 3951465. Furthermore, none of these resources specifically requires retaining the seed as part of Medicare’s sampling methodology requirements. They reference resorting to using the seed number and sampling frame to replicate the sample to validate the sampling when the random numbers are missing, which is not the scenario here. *See also* MPIM, ch. 8.4.4.4.1. The Appellant’s suggestion (brief, p. 42) that these Medicare sources “strongly insist that the random seed be saved” does not establish a legal mandate. Even if such requirements did exist under the Medicare Program, they would not apply for the purposes of this Medicaid audit. 18 NYCRR 519.18.

Universe/frame: The Appellant’s brief (p. 44) inaccurately accuses the OMIG of failing to “adequately define either the universe or the frame.” The universe and frame were identified at the outset of this matter in the draft and final audit reports to show the claims paid within the audit

period. (Exhibits 1, 2.) The Appellant also received a copy of the universe of claims, of which its statistical consultants had ample opportunity to examine. (Exhibit 8.) These computer generated records, which show the payments, are presumed to constitute an accurate itemization of the claims submitted and the Appellant has failed to refute this presumption. 18 NYCRR 519.19(f).

██████████ testified that two claims in the universe were left out, resulting in 44,308 claims, not 44,306 claims as stated in the audit report. According to ██████████ this error affected the probability sample. ██████████ failed to recognize that one claim in the audit frame of 44,306 appeared three times in the universe of 44,308. (Transcript, p. 79; 1121-1123.) As Mr. Ryan pointed out, ██████████ confused the audit universe with the audit frame by incorrectly attempting to “consolidate the universe into a sampling frame.” (Transcript, p. 1117.)

Mr. Ryan explained that a claim in the universe paid at \$134.09 was subsequently adjusted, resulted in a “negative amount for the same amount” and “another record” for “a revised dollar amount,” and so these two items were appropriately removed from the sampling frame. (Transcript, p. 1107, 1122.) Mr. Ryan’s explanation completely discredits ██████████ criticism. The Appellant’s claim in its brief (p. 44) that this was not all properly documented is not consistent with any of the evidence.

██████████ also claimed that the audit frame included “702 service lines worth \$38,966.58 included in the audit frame” with dates of service in 2008 affecting the “probability sample.” (Exhibit B; Transcript, p. 81.) Her testimony on this point also demonstrated her confusion about the evidence. The audit was based on payment dates, not service dates, resulting in claims with dates of service in 2008 that were actually paid within the audit period, from 2009 to 2011. ██████████ conceded on cross-examination that the universe and frame consisted of

claims paid during the audit period, not claims with dates of service in the audit period. (Appellant's brief, p. 43-44, Department's brief, p. 57; Exhibit B; Transcript, p. 79, 193.)

Central limit theorem/sample size: The Appellant's brief (p. 47-48) claimed:

Having acknowledged that the OMIG must satisfy 'the central limit theorem' (Transcript, p. 595) to allow for the use of this sampling and extrapolation methodology and having admitted that the OMIG's 100 claim sample failed to meet the minimum sample size according to Cochran's formula, Dr. Heiner has also admitted the Central Limit Theorem could not statistically support this extrapolation. (Tr. at 866-868.)

This statement completely misrepresents Dr. Heiner's testimony and the evidence. There is no foundation for these claims either in the cited transcript pages or elsewhere in the hearing record.

In its brief, the Appellant cites the testimony of its own witness, [REDACTED] that the Central Limit Theorem (CLT) states "if 'repeated random samples are done moving onward to infinity or the total size of the frame, their means would be expected to fall into a normal distribution' and that's the idea." (Appellant's brief, p. 61; Transcript, p. 71-72.) This definition is completely consistent with Dr. Heiner's testimony about the CLT as a theorem that predicts a continuum of increasing precision, a convergence on a normal distribution as more and larger samples are taken. He explained this as follows:

(S)tarts out with the sample size of one and it's not normal unless the population is normal and by the time it gets to infinity, it's normal. But all along the way, it's – it's – it's not exactly normal and it kind of builds up and – and – and so it's my opinion, that out of a sample size of a hundred, you're going to get approximately normal distribution, which I think would be the opinion of most people. (Transcript, p. 962-963.)

The agreement of the experts establishes that by using a more time consuming and costly process of selecting a bigger sample size or by averaging out more samples, the extrapolation to the universe might give a more precise result. This is because as the sample grows, so does the

precision of the estimate. As Dr. Heiner pointed out, the audit of all the claims in the universe would produce 100 percent accurate results. However, none of these factors refutes the statistical validity of the extrapolation in this audit. The Appellant failed to establish that the OMIG's selection of one random sample, as opposed to multiple samples, was in any way insufficient to "support the Central Limit Theorem upon which this methodology was based, or an acceptable precision level." (Appellant brief, page 39.)

Dr. Heiner persuasively refuted [REDACTED] criticism of the sample as not representative because it was "too small" to be "an accurate and correct picture frame." (Appellant's brief, p. 50; Transcript, p. 213.) According to [REDACTED] the sample used in this audit was "somewhere between four and sixteen times too small for a "simple sample at a ninety percent confidence level." (Transcript, p. 146.) [REDACTED] relies on RAT-STATS data derived from software used for the Medicare Program – data not controlling for this case – to claim that the OMIG should have reviewed at least 465 claims. (Transcript, p. 133-134.) Dr. Heiner, on the other hand, testified that the OMIG's sample size of 100 was not too small to be valid (Transcript, p. 511) and that there is no standard (Transcript, p. 509) for sample sizes. *See Rite Aid, supra*, at 36. His testimony is credited.

[REDACTED] failed to establish that the size of the sample invalidated this extrapolation. Indeed, the Appellant acknowledges that "there exists no legal or statistical basis for imposing a sample size floor" (brief, p. 45), which is consistent with prior administrative hearing decisions on this issue. *See Rite Aid, supra*, at 36. The Appellant criticizes the sample size of 100 as "not large enough," yet [REDACTED] conceded that a simple sample of 100 claims is a "valid methodology." (Transcript, p. 84.) A sample size of 100 is routinely used in Medicaid audits (Transcript, p. 499) and the Department's brief (p. 44-45) cites to state court decisions upholding sampling and

extrapolation cases with the same and even smaller sample sizes for audits. See Enrico v. Bane, 213 AD2d 784 (3rd Dept., 1995); Clin Path, Inc., *supra*, at 1035.

The Appellant relies in its brief (p. 50) on a federal report on statistical sampling to object that “usage of a sample size that is too small has a tremendous effect upon the reliability of the entire extrapolation,” because

[t]he point estimate is almost always considerably different from the ‘true’ value. The essence of a statistical estimate is, therefore, a statement of probability (‘confidence’ or ‘certainty’) that our calculated confidence interval contains the true but unknown population value. Federal General Accounting Office, Using Statistical Sampling, p. 64.

This Medicaid audit used the point estimate, not the confidence interval estimate, which Dr. Heiner explained in his certification is a “commonly accepted statistical projection technique.” (Exhibit 4.) According to Dr. Heiner, the 100 claim sample provided the “sampling distribution that’s approximately normally distributed,” which, contrary to ██████████ assertion (Exhibit B), is sufficient to calculate a confidence level at “90 percent.” (Transcript, p. 501-502.) Dr. Heiner’s certification, while it calculates a 90% confidence interval estimate, makes clear that the OMIG is using the point estimate, which is the unbiased maximum likelihood estimate of the overpayment in the universe. (Exhibit 4.)

██████████ tests may show a non-normal distribution, but this has no impact on the point estimate. (Exhibit H.) An exact normal distribution is a level of precision not required under the regulations for a statistically valid extrapolated overpayment. (Transcript, p. 618.) For the mean per unit estimate, Dr. Heiner concluded that all that the OMIG needed was approximate normal distribution of the means of the sample data for the sampling distribution, which it had. (Transcript, p. 517-518, 555.) These attempts by the Appellant to show ways in which the interval estimate could be narrowed or have a more normal distribution in no way refute the presumption set forth

in Dr. Heiner's certification that "the unbiased maximum likelihood point estimate of what the Department's auditors would have determined to be overpayments in the 44,306 service population if they had audited all 44,306 services is \$1,074,916.73." (Exhibit 4.)

High dollar claims: [REDACTED] also criticized the sample unit as not independent by attacking "high dollar" amounts for the 80 beneficiaries with "high numbers of claims" out of "forty-four thousand claims." (Appellant's brief, p. 56-57; Transcript, p. 213-214.) Without explaining how this invalidated anything, [REDACTED] claimed that this resulted in "everyone having multiple claims" and that the denial of one claim resulted in all claims being denied. (Transcript, p. 101.) [REDACTED] report contradicted [REDACTED] testimony by pointing out two instances of individuals with more than one claim denied, yet with more than two claims represented in the sample. (Exhibit H.) As pointed out by the Department in its brief (p. 57), there were some claims in the sample "attributable to the same patient," but the audit methodology was to sample claims, not patients. Some patients having many claims in the universe, and others few, is irrelevant to any issue in this audit. In applying the mean per unit estimate, Dr. Heiner confirmed that every claim in the population has equal probability of being in the sample. (Transcript, p. 739.)

Sample v. frame: The Appellant failed to establish any inappropriate bias in the audit sample. (Appellant's brief, p. 56.) In this case, "bias" was disproved by Dr. Heiner's comparison of the average amount paid at about \$167 and the calculation total of about \$169, suggesting a fair result. In fact, if there is a bias in the sample, the bias is in favor of the provider. (Transcript, p. 585.) Dr. Heiner testified that he considered this point when certifying the representativeness of the sample. (Transcript, p. 843.) He explained:

But I -- I do -- but I do something that you don't know about. I -- I look at -- I look at the average book values of the sample in the population. And if it looks like it's -- the samples got book values that are too big, then I'd say that's not -- that, you know, could --

could be a bias and I have to somehow make some correction.
(Transcript, p. 842.)

The graph used by the Appellant in its brief also represents the frame as mirroring the sample, highlighting the fairness in the process. The Appellant's graph depicted in its brief (p. 58) shows that \$7,510,900.67 was paid for 44,306 services in the universe, which equals \$169.52 per service, \$16,738.96 was paid for 100 services in the sample, which equals \$167.38. The difference is about \$2.14 per claim, which is minimal and suggestive of representativeness. It also shows a number that benefits the Appellant. (Exhibit 2.)

CONCLUSION

It is undisputed that the Appellant provides important habilitation services "to support individuals with disabilities to obtain a better quality of life and a chance for success within their community." (Appellant's brief, p. 2.) In order to be paid by the Medicaid Program for accomplishing this objective, however, the Appellant is required to adhere to Medicaid Program documentation requirements, which apply equally to all habilitation providers. The Appellant's shameful attempt to blame its documentation shortfalls on one of its teachers who had "cerebral palsy" and "organizational deficiencies that impacted her maintenance of the documentation she created," while accusing the OMIG of infringing on the rights of disabled individuals in violation of laws protecting them, is rejected. (Appellant's brief, p. 25-26.) The OMIG is not "punishing" this employee for the Appellant's insufficient documentation, as the Appellant contends. (Appellant's brief, p. 27.) It was the Appellant, and not its employee, who billed and received payments from the Medicaid Program for these services. It was the Appellant's responsibility to maintain contemporaneous documentation to verify entitlement to payment for the services. 18 NYCRR 504.3(a) and (i), 517.3(b); ADM #2003, #2006-01 and #2006-02.

The Court of Appeals has fully upheld the Department's statistical sampling methodology

used in this case as neither arbitrary nor capricious, pointing out the appropriateness of this audit procedure to efficiently review Medicaid claims and calculate overpayments. Mercy Hosp., *supra*, at 204. This authority is inherent in the OMIG’s duties “to supervise the administration” of the Medicaid Program in New York State and to effectively handle and prevent fraud and abuse in connection with the millions of claims for which the Medicaid Program pays billions of dollars annually. SSL §363-a[1]; Mercy Hospital, *supra*, at 203, *citing* Matter of City of New York v. New York Com. on Cable Television, 47 NY2d 89, 92 (1979). The evidence produced by the Appellant failed to rebut the presumption of validity of the OMIG’s statistical methodology applied to this audit.

The Appellant has failed to meet its burden of proving entitlement to the overpayments identified in this audit. All fourteen disallowances in the audit sample are affirmed. The extrapolation of the sample findings to the universe of claims paid in the audit period is affirmed.

DECISION:

The OMIG’s determination to recover Medicaid Program overpayments from United Cerebral Palsy Association of Putnam & Southern Dutchess is affirmed. The overpayment is in the total amount of \$1,074,917.

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

Dated: _____, 2019
Albany, New York

Dawn MacKillop-Soller
Administrative Law Judge