

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

In the Matter of the Appeal of	:	
	:	
MADISON YORK ASSISTED	:	Decision After
LIVING COMMUNITY	:	Hearing
Medicaid ID: 02780610	:	
	:	
from a determination by the NYS Office of the Medicaid	:	Audit Number: 14-3479
Inspector General to recover Medicaid Program	:	
overpayments	:	
	:	

Before: Natalie J. Bordeaux
Administrative Law Judge

Hearing Dates: August 22 and October 29, 2019
March 3, April 22, May 12 and 27, June 3-4, and 23-24, 2020

Hearing Locations: New York State Department of Health
90 Church Street
New York, New York 10007

New York State Department of Health
150 Broadway
Menands, New York 12204

Cisco WebEx Videoconference

Parties: New York State Office of the Medicaid Inspector General
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JURISDICTION

The New York State Office of the Medicaid Inspector General (OMIG) determined to seek restitution of payments made under the Medicaid Program to Madison York Assisted Living Community (Appellant). The Appellant requested a hearing pursuant to Social Services Law § 22 and Department of Social Services (DSS) regulations at 18 NYCRR § 519.4 to review the OMIG’s determination.

HEARING RECORD

OMIG witnesses: Matthew Ceccucci, Management Specialist 2
Karl W. Heiner, Statistical Consultant

OMIG exhibits: 1-48, 53

Appellant witnesses: Gershon Klein, Assistant ALP operator
Eric Gilewski, Assistant Administrator
Harold Haller, Statistical Consultant

Appellant exhibits: A-E, EA¹, F-L, N, O, T

ALJ exhibits: I

A transcript of the hearing was made. (T 1-1474.) Each party submitted two post-hearing briefs. The record closed on October 2, 2020.

FINDINGS OF FACT

1. The Appellant is an Assisted Living Program (ALP) located in Queens and is enrolled as a provider in the New York State Medicaid Program. (T 59-60.)
2. By letter dated July 15, 2014, the OMIG advised the Appellant that the New York City Human Resources Administration (HRA), acting as the OMIG’s agent pursuant to a State and County Demonstration Project, would audit the Appellant’s records pertaining to claims paid

¹ Two distinct documents were marked as “Exhibit E” and moved into evidence as such: (i) a picture of the Appellant’s staircase from the basement to the sub-basement; and (ii) excerpts from “Sampling Techniques” by William G. Cochran. To avoid confusion, the latter will be cited as “Exhibit EA” in this decision.

by the Medicaid Program during the period January 1, 2009 through December 31, 2011 for ALP services. (Exhibit 22.)

3. During the period January 1, 2009 through December 31, 2011, the Appellant was paid \$13,860,082.81 for 169,961 claims submitted to the Medicaid Program for ALP services. (Exhibits 25, 27, 32.)

4. On September 11, 2014, an entrance conference was held with HRA Management Auditor Mukesh Shah, HRA Supervising Auditor Sarah Reinhold, HRA Director of Audits Gregory Maynard, and the Appellant's owner and senior members of its management. The nature and extent of the audit was discussed pursuant 18 NYCRR § 517.3(f). Although the auditors did not inform the Appellant which claims were being audited during the entrance conference, the Appellant's representatives advised the auditors that they anticipated difficulty providing supporting documentation for some claims due to damage sustained to its facility during Super Storm Sandy. (Exhibits 23 and 26; T 66, 275-77.)

5. After the September 11, 2014 entrance conference, the auditors gave the Appellant a list of 100 randomly selected ALP services claims paid by the Medicaid Program during the period January 1, 2009 through December 31, 2011 (the audit sample), for which the auditors required supporting documentation. (T 275-77.)

6. On June 19, 2015, Mr. Shah advised the Appellant that the auditors were missing specific service documentation pertaining to 26 sampled claims. (Exhibit A.)

7. By letter dated July 6, 2015, the Appellant's Administrator Gregg Bendeth provided documentation for four of the claims identified in the June 19, 2015 letter. However, he informed Mr. Shah that supporting documents pertaining to the other 22 claims "were not located and were among documents destroyed as a result of Super Storm Sandy." (Exhibit A.)

8. On November 17, 2016, an exit, or closing conference was held pursuant to 18 NYCRR § 517.5(a), during which the HRA auditors discussed their findings with the Appellant's representatives. The auditors sent the Appellant an exit conference summary before the meeting to afford the Appellant an opportunity to review the findings and provide additional supporting documentation. (Exhibits 24 and 25.)

9. On December 2, 2016, the Appellant sent HRA's Assistant Deputy Commissioner a response to the audit's preliminary findings. Among other issues raised, the Appellant explained again that requested supporting documentation for 22 sampled claims was destroyed during Super Storm Sandy on October 29, 2012 because the documents were stored in the facility basement, which sustained significant flooding and required major repairs during the storm. These claims contained dates of service ranging from December 27, 2008 through June 4, 2009 for which claims were paid between the six-month period of January 1, 2009 through June 30, 2009. The Appellant enclosed insurance claim information pertaining to the flood-related damage. (Exhibit 30.)

10. On April 13, 2018, the OMIG issued a draft audit report to the Appellant, which identified 33 claims with at least one error and disallowed payments totaling \$2,726.95. The draft audit report also advised the Appellant that the audit employed a statistical sampling methodology to extrapolate the sample findings to an audit frame of all claims paid during the three-year audit period. By using the extrapolation, OMIG determined preliminarily that the Medicaid overpayment received by the Appellant was \$4,634,751. (Exhibit 27.)

11. On May 31, 2018, the Appellant submitted its response to the draft audit report, contesting the disallowances and objecting to the extrapolation methodology employed by the OMIG. (Exhibit 30.)

12. On October 10, 2018, the OMIG issued a final audit report, which reiterated the findings set forth in the draft audit report and advised the Appellant that the OMIG determined to seek restitution of Medicaid Program overpayments totaling \$4,634,751, derived by projecting the value of the 33 disallowed claims in the audit sample to the total 169,961 claims paid by the Medicaid Program during the audit period. (Exhibit 32.)

13. The OMIG organized the 33 disallowed claims into the following categories:

1. Missing Service Documentation (sampled claims 11, 15, 20, 23, 32, 33, 34, 38, 42, 45, 49, 56, 67, 68, 73, 74, 78, 89, 92, 93, 98, and 99.)
2. Missing/Invalid Signature on Medical Evaluation (sampled claims 1, 24, 36, 43, 50, 77, and 90.)
3. Failure to Complete the Medical Reassessment (sampled claims 7, 17, 41, and 81.)
4. Missing Nursing/Functional/Social Assessment (sampled claim 43.)

(Exhibit 32.)

14. After the issuance of the Final Audit Report, the OMIG agreed to withdraw the disallowances for sampled claims 1, 24, 36, 43, 50, and 77 in Disallowance Category 2, and all findings in Disallowance Category 3 (sampled claims 7, 17, 41, and 81). The total sample disallowance amount was reduced to \$2,047.94. The total overpayment amount was adjusted to \$3,483,353.47. (ALJ Exhibit I, OMIG Exhibits 46, 47; T 6-8.)

ISSUES

Was the OMIG's determination to recover Medicaid Program overpayments from the Appellant correct?

Did the Appellant establish that the OMIG's use of a simple extrapolation method to compute the overpayment amount was invalid?

APPLICABLE LAW

The Department of Health (Department) is the single state agency for the administration of the Medicaid Program in New York State. PHL § 201(1)(v); SSL § 363-a. The OMIG is an

independent office within the Department with the authority to pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts or unacceptable practices perpetrated within the Medicaid Program. Such actions may include the recovery of improperly expended Medicaid funds. PHL §§ 30-32.

By enrolling in the Medicaid Program, Medicaid providers agree to prepare and to maintain contemporaneous records demonstrating the right to receive payment under the Medicaid Program and to furnish such records and information, upon request, to the Department. Such records must be maintained for at least six years from the date of service. 18 NYCRR § 504.3(a). Medicaid providers agree to permit audits by the Department of all books and records or, in the Department's discretion, a sample thereof, relating to services furnished and payments received under the Medicaid Program, including patient histories, case files and patient-specific data. 18 NYCRR § 504.3(g), § 517.3(b), § 540.7(a)(8). In addition, Medicaid providers must comply with the rules, regulations, and official directives of the Department. 18 NYCRR § 504.3(i).

When it is determined that a provider has submitted or caused to be submitted claims for medical care, services or supplies for which payment should not have been made, the Department may require repayment of the amount determined to have been overpaid. 18 NYCRR § 504.8(a)(1) and § 518.1(b). An overpayment includes any amount not authorized to be paid under the Medicaid Program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake. 18 NYCRR § 518.1(c).

A Medicaid provider is entitled to a hearing to review the OMIG's final determination to require repayment of any overpayment or restitution. 18 NYCRR § 519.4. The Appellant has

the burden of showing by substantial evidence that the OMIG's determination was incorrect and that all claims submitted and denied were due and payable under the Medicaid Program. 18 NYCRR § 519.18(d)(1); SAPA § 306(1).

An ALP means an entity approved to operate as an adult care facility pursuant to Social Services Law § 461-1(3) and 18 NYCRR § 485.6(n), established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care, supervision, and providing or arranging for home health services to five or more eligible adults unrelated to the operator. 18 NYCRR § 494.2(a).

The Medicaid Program will pay an ALP for services provided to residents who are Medicaid recipients at a capitated rate of payment in accordance with Department regulations, based upon assessments of recipients conducted pursuant to 18 NYCRR § 494.4. Services provided to Medicaid recipients include: (i) adult day health care provided in a Department-approved program; (ii) home health aide services; (iii) medical supplies and equipment not requiring prior approval by the Medicaid Program; (iv) nursing services; (v) personal care services; (vi) personal emergency response services; and (vii) physical therapy, speech therapy, and occupational therapy. SSL § 461-1(1)(e); 18 NYCRR § 494.5(b) and § 505.35(h)(1).

DISCUSSION

The Audit Findings

The auditors organized the findings into four disallowance categories shown in the Final Audit Report. After additional review, the OMIG withdrew disallowances pertaining to sampled claims 1, 24, 36, 43, 50, and 77 in Disallowance Category 2 ("Missing/Invalid Signature on Medical Evaluation") and withdrew all findings in Disallowance Category 3 ("Failure to Complete the Medical Reassessment"). Sampled claim 43 remains in dispute because of the

auditors' secondary finding in Disallowance Category 4 ("Missing Nursing/Functional/Social Assessment") for that claim. (T 6-8.)

Disallowance Category 1: Missing Service Documentation.

Appropriate services must be provided in accordance with a plan of care which is based upon an initial assessment and periodic reassessments. 18 NYCRR § 494.4(b).² In this category, the auditors sought documentation to determine whether services required by a resident's plan of care were performed. (T 114-15.) The 22 disallowed claims in this category (sampled claims 11, 15, 20, 23, 32, 33, 34, 38, 42, 45, 49, 56, 67, 68, 73, 74, 78, 89, 92, 93, 98, and 99) involve dates of service ranging from December 27, 2008 through June 4, 2009 for which claims were paid between the six-month period of January 1, 2009 through June 30, 2009. No findings were made in this category for claims paid during the remaining 30 months of the audit period. (Exhibit 32.)

The Appellant's obligation to prepare and maintain documentation necessary to support its right to payment is not questioned by the Appellant. (T 289.) However, the Appellant has consistently contended that supporting documentation for the disallowed claims (which the Appellant was able to provide for the other 78 claims audited) was destroyed during Superstorm Sandy, which struck the New York City area on October 29, 2012³.

The Appellant apprised the auditors of possible difficulties with obtaining documentation at the entrance conference, before it was even told which claims would be audited. The auditors were then made aware of the Appellant's difficulties with documentation for 22 of the sampled claims no later than July 2015, more than one year before the exit conference. By letter dated

² This version of 18 NYCRR § 494.4 was in effect during the audit period. However, in its current format, the requirements previously set forth in (b), are now found in (c).

³ National Weather Service Report, available at: <https://www.weather.gov/mhx/Oct292012EventReview>.

July 6, 2015, Gregg Bendeth, the Appellant's Administrator, advised HRA Management Auditor Mukesh Shah (who also participated in the entrance conference) that the Appellant was unable to locate the necessary documentation for these 22 claims because the documents were among those destroyed by Super Storm Sandy. Mr. Bendeth explained that the building experienced significant flooding in its basement and boiler room, and that many items stored there, including service documentation (aide activity sheets and toileting sheets) for 2007, 2008, and the first 6 months of 2009 "were destroyed and not salvageable". He also stated that the Appellant submitted an insurance claim and received reimbursement for the damages sustained. (Exhibit A.)

Subsequent responses by the Appellant included insurance claims paperwork, which detailed, in pertinent part, the flooding to the facility basement, damage to the boiler, and necessary repairs. These documents show that the Appellant acted quickly to restore the facility to a safe, hazard-free environment for staff and residents. Immediately after the storm subsided on October 30, 2012, the Appellant retained third-party services to replace damaged equipment associated with one of the facility's boilers. That invoice specifically states that the boiler room was "under water." (Exhibits 26 and 30.) Although the auditors deemed this information insufficient to excuse the Appellant's failure to produce the supporting documentation for the 22 sampled claims, they did not request additional information from the Appellant. (T 275-76.)

After advising the auditors that the required service documentation for these claims was destroyed during the storm, the Appellant attempted to address the auditors' requests by providing such information as was available for each sampled claim, including census data to show that a resident was in the building on the date of service, plans of care, and payroll records for staff who were assigned to provide assistance to those residents. (T 279-80.)

Gershon Klein, who is tasked with the Appellant's daily operations, testified that the Appellant maintains a daily activity sheet for all residents to confirm that staff renders services in accordance with the plan of care, and a toileting sheet for residents who need assistance with toileting. He explained that ALP staff prepare two daily activity sheets per resident each week (one sheet for the a.m. shift and another sheet for the p.m. sheet) and toileting sheets are typically used for a total of two weeks before a new one is prepared. (T 239-44.)

During the audit period, daily activity sheets were maintained in paper format. Although a photocopy was initially made for the billing department's use and kept in a central office to ensure that claims submitted to the Medicaid Program were adequately and properly documented, original sheets were placed in the resident's binder. Once the Appellant received payment for the claim, the billing department shredded its copy. As files became too thick from the accumulation of required paperwork, older daily activity sheets and toileting sheets were culled from the files (at least once each year but more frequently depending upon individual file thickness) and placed in standard bankers boxes or old photocopy paper boxes, which were labeled by the period of service to which the service documents pertained. Service documentation was stored separately from other documentation. (T 248-53, 259-63, 285.) Boxes were stacked, with bottom boxes positioned several inches above the floor. (T 321-22.)

The boxes containing service documents were kept in the facility basement and sub-basement, an area approximately six feet below the basement which also houses the facility's two boilers, hot water tanks, circuit breaker box, and six electrical pumps installed to remove water from the basement. Between forty and fifty boxes of documents, stacked three levels high, were kept in the basement. Boxes nearest the floor were placed on 5-inch skids. The sub-basement housed approximately 60 boxes of patient documents, with up to 30 stored on a pallet

nearest the stairway leading to the basement, and another 30 boxes stored in a back area. Boxes were stacked at three or four boxes high. (T 330, 332, 337-38.)

Upon entering the basement in the early morning of the storm on October 29, 2012, Mr. Gilewski, who is responsible for the Appellant's building operations, observed that water had entered from the New York City sewer system and had reached as high as nineteen steps from the ground floor. The boxes of records in the sub-basement were submerged in water. While it was difficult to identify the exact height of the flooding in the basement and sub-basement due to staff's continued removal of water during the storm, the Appellant's witnesses all credibly testified that flooding reached at least 44 inches in the sub-basement. The flooding caused the sub-basement's electric pumps, which were also nearly submerged, to catch fire. The boiler room was completely submerged in water. Although Mr. Gilewski swiftly shut off the gas lines and worked with other facility personnel to drain water from the basement and sub-basement out onto the street, oil and outflow from the sewer mixed in with the water flooding the basement and sub-basement. (T 263-72, 329-40; Exhibits B-E.)

Given Mr. Gilewski's responsibilities for restoring and maintaining facility equipment and overall cleanliness of the building, the boxes of records stored in the basement and sub-basement were not his primary concern. He focused on ensuring that the facility was able to provide its residents with necessary services. For similar reasons, Mr. Klein stated that he did not consider asking staff to take photographs of the damage during and after the storm. Even with photographs of the destroyed boxes, the Appellant would have been unable to prove their contents. Although he asked the Appellant's insurer to provide copies of pictures taken at the premises, it only provided Mr. Klein with pictures of the boiler. (T 299-303.)

After Mr. Gilewski and other employees successfully removed all water from the affected areas (approximately 14 hours later), they discovered that the record boxes were completely destroyed: “It looked like it would disintegrate if you tried to pick it up.” He described the boxes as a “hazard” because of the filthy, oily water in which they were soaked. (T 340.) The boxes remained in the facility for “about a week” while the Appellant assessed the damage to its equipment and procured repair services to ensure that residents received heat and hot water. Once HVAC services were functional, Mr. Gilewski and maintenance personnel proceeded to clean the mold and remnants of sewage from the basement and sub-basement. After consulting with the Administrator (Mr. Bendeth), they determined to dispose of the soaked record boxes because they were not salvageable and were deemed a health hazard because of their interaction with sewage and oil. Given the state of the destroyed boxes, including the hazardous substances that infiltrated the remnants, work was urgently undertaken by facility staff to rid the basement and sub-basement of filthy, contaminated water. Staff allowed those papers to remain on-site no longer than 7 days (one week) before disposal. (T 301-02, 340-42, 364-65.)

The OMIG takes the position that the Appellant was required to report the destruction of these medical records to the Department and attempt to salvage its wet medical records. The OMIG relies on a Department Advisory dated November 8, 2012 (issued ten days after Super Storm Sandy), addressed to “Physicians and Other Medical Practitioners.” (T 105-06.) A section entitled “Medical Records,” beginning on the middle portion of the fourth page, advises providers:

Before disposing or abandoning medical records damaged due to the hurricane, the records must be rendered unusable, unreadable, or indecipherable. It is advised that an independent expert verify that the records are not salvageable. Health care providers should maintain evidence and documentation of the destruction and consult their attorney accordingly. Paper, film, or other hard copy

records must be shredded or properly destroyed such that information that could be used to identify patients cannot be read or reconstructed...

This advisory recommends various means by which to save “wet medical records.” It does not require providers to report disposal of unsalvageable documents. (Exhibit 38, pp. 640-41.)

Furthermore, this Department advisory was issued days after the Appellant’s removal of debris, including destroyed service documentation, and thus did not exist when the Appellant decided to clear up its flooded basement in the aftermath of Super Storm Sandy. In any event, the only provision of this Advisory with which the Appellant may not have complied was the language that “advised” that an independent expert verify the condition of the records.

The OMIG has failed to identify any applicable legal requirement in effect from October 29 through November 7, 2012 that obligated the Appellant to maintain any particular kind of evidence to show that the discarded documents were not salvageable. Nor has it identified any requirement in effect from October 29, 2012 through April 30, 2015 that the Appellant notify the Department of its disposal of soaked, soiled, illegible, and utterly destroyed documentation.

The Health Insurance Portability and Accountability Act (HIPAA), requires health care providers to protect the personal information of its patients. However, it imposes no requirement on providers to maintain additional copies of patient records, try to salvage soaked paperwork, maintain evidence that documents were destroyed in an unforeseen event and/or notify a government agency that documents were destroyed. HIPAA details security standards for electronic protected health information (personally identifiable patient-related information)⁴ and notification requirements for possible security breaches related to patient-related information⁵, neither of which is relevant to the Appellant’s circumstances.

⁴ 45 CFR §§ 164.302 through 164.318. Effective January 25, 2013.

⁵ 45 CFR §§ 164.400 through 164.414. Effective September 23, 2009.

The Department did not issue blanket instructions pertaining to all Medicaid providers on how to report unexpected damage, loss, or destruction of records until May 2015.

https://www.health.ny.gov/health_care/medicaid/program/update/2015/may15_mu.pdf.⁶ That newsletter was followed by a “Dear Administrator Letter” addressed to ALPs dated June 3, 2015 which “required ALP operators to maintain both documentation and evidence of the destruction.” DAL 15-06: Safe Recordkeeping, https://www.health.ny.gov/facilities/adult_care/dear_administrator_letters/2015-06-03_dal_15-06_safe_recordkeeping.htm. This occurred nearly three years after the Appellant’s destroyed documents were discarded, more than six months after this audit began, and after the Appellant had already communicated its problems with providing the required service documentation to the auditors.

Guidance regarding destroyed documents that was in effect before, during, and in the nine days after the storm was not completely followed by the auditors tasked with leading this audit. Division of Medicaid Audit Directive No. 23 dated June 24, 2010 instructs auditors in audits “where all records in the sample period or only a portion of the sample period records were destroyed by flood, fire or other unforeseen, unintentional event and, therefore, are unavailable for review.” By the standards imposed in this directive, the Appellant’s inability to produce documentation for 22 sampled claims, or 22% of those audited, would not justify a termination of the audit. However, the missing documentation for 22 claims in one category encompassing dates of service limited to six months within the entire audit period should have prompted the auditors to

⁶ Curiously, the May 2015 Medicaid Update advises that the guidance within “supercedes [sic] the December 2012 Medicaid Update article.” Yet, the referenced December 2012 article, entitled “Medicaid Transportation Policy Loss of Records Due to Unforeseen Incident,” was addressed only to transportation providers. See https://www.health.ny.gov/health_care/medicaid/program/update/2012/dec12mu.pdf.

...[A]scertain the circumstances surrounding the destruction of the records. Timely independent Third Party [sic] confirmation should be obtained (i.e. - police reports, fire reports; required notification to DOH, OMH, OMRDD, State Board of Pharmacy regarding timely notice of premature destruction of records; insurance claims, bills for plumbing or repair work, etc.) Any written documentation regarding the flood/fire/event must be obtained and made part of the audit work paper file.

(Exhibit 37.)

In spite of this directive that was in effect for this audit, the supporting documentation offered by the Appellant was ignored and the auditors did not request any additional information.

The OMIG has not explained, what, if any, additional documentation would have sufficed. During direct and cross-examination of witnesses, the OMIG suggested that the Appellant's offered documentation was insufficient because it failed to show that: (1) documents were destroyed; (2) the Appellant paid for services to remove water from the "supposedly" flooded basement and mold mitigation services; and (3) repairs were made to the basement's flooring, walls, or electrical system. (T 102-04, 199.)

The Appellant was never asked for any such information (T 168), and it is unclear what purpose such documentation would have served in this audit. As the Appellant pointed out, documentation of the services it provided was not insured or insurable. Thus, third-party documentation would not discuss the damaged paperwork. (T 323-24.) Although the Appellant did not have documentation regarding water removal services or mold mitigation because those services were performed by its own staff, the OMIG understood that the Appellant's basement sustained flooding for which water would invariably need to be removed. (T 174-77.) The third-party documentation provided to the auditors evidenced significant flooding to the facility basement.

Matthew Ceccucci, OMIG Management Specialist 2 and supervisor of the County Demonstration Unit, confirmed that the OMIG reviewed the Appellant's insurance

documentation regarding the extent of damage sustained. However, he testified that the submitted documentation was insufficient pursuant to the instructions in Audit Directive No. 23. Although he opined that photographs of purported damage, written statements made when the damage was sustained, or a report to the Department regarding lost documents might have been helpful, he acknowledged the inherent uncertainty in those suggestions: “Specifically, I can’t say. It could be a number of things. We just didn’t get what that required.” (T 104-05, 195, 200.)

Mr. Ceccucci’s stated concern that the required documentation was never prepared or, alternatively, not maintained (T 114) is inconsistent with the other audit findings, which show the Appellant’s overall consistency and good document retention habits. No claims outside of this six-month period were found to be missing required service documentation, even though several claims sampled pertained to the same resident on different dates of service. (Exhibits 28 and 33.) Of the other 78 resident records that were reviewed, the OMIG now asserts only two disallowances which the Appellant does not dispute. If the OMIG genuinely has doubts about the Appellant’s compliance with documentation and recordkeeping requirements, it is entitled to conduct another audit of a different period.

The OMIG criticized the Appellant for failing to maintain a second copy of the missing documents, in either hard-copy or electronic format. (T 234.) Storing additional copies of documents is a reasonable risk minimization strategy. However, it is not a legal requirement. The Appellant acknowledges that it learned its lesson after its basement flooded and began maintaining original documents, a second hard-copy, and an electronic copy on November 23, 2012. (Exhibit A; T 287.) This change was not prompted by the commencement of this audit

but by the realization that additional copies of documents should be retained in other locations as a best practice.

The credible, consistent testimony of the Appellant's witnesses, the clear evidence that the Appellant repeatedly advised the OMIG that records were destroyed during storm-related flooding, the lack of evidence to suggest that the records would have been inadequate had they not been destroyed, and the fact that no legal requirement existed for the Appellant to notify the OMIG or any other unit within the Department on the date upon which these records were discarded, meet the Appellant's burden of proving that the disallowances in this category should be reversed.

Disallowance Category 2: Missing Signature on Medical Evaluation.

Admission and retention standards for the enriched housing program offered by adult care facilities are set forth in 18 NYCRR § 488.4. An operator of an adult care facility must not admit nor retain an individual without a determination being made that the program can support the resident's physical and social needs. Such determination must be based upon a medical evaluation written and signed by a physician. 18 NYCRR § 487.4(f)⁷ and § 488.4(d)(1)⁸. The auditors found that the medical evaluation in sampled claim 90 was not signed by a physician. The Appellant has not disputed this error. This claim was properly disallowed.

Disallowance Category 4: Missing Nursing/Functional/Social Assessment.

Before an operator admits an individual to an ALP, a determination must be made that the program can support the resident's physical, supervisory and psycho-social needs. This determination must be based, in part, on a preassessment screening, a nursing assessment, and an

⁷ This citation was in effect during the period audited. After multiple instances in which 18 NYCRR § 487.4 was re-lettered, the first occurring on 9/12/2018, the cited information is presently found in (h) of 18 NYCRR § 487.4.

⁸ This citation was in effect during the period audited and remained in effect until 8/23/2018. Since that date, this provision is found in 18 NYCRR § 488.4(e)(1).

assessment of the individual's social and functional needs and an assessment of the ability of the program to meet those needs. The assessments will be conducted by the ALP operator and, if required, by a certified home health agency or a long-term home health care program. 18 NYCRR §§ 494.4(e)-(g).⁹

The only disallowance in this category pertained to sampled claim 43, for which the auditors found that the Appellant failed to provide a nursing/functional/social assessment applicable to the claim's date of service. The Appellant has not disputed the finding that the assessment was missing. This disallowance is upheld.

The Overpayment in the Sample

The amount disallowed for each claim in the audit sample was listed in a schedule attached to the Final Audit Report. (Exhibit 32.) Due to adjustments made by the OMIG after the issuance of that report, the total disallowance in the sample was \$2,047.94. (Exhibit 47.) Of the remaining 24 disallowances at issue, the disallowance of 22 claims in Category 1 ("Missing Service Documentation") in the amount of \$1,903.09 are reversed. As such, the total sample overpayment is reduced to \$144.85, comprised of the affirmed disallowances for sampled claims 90 and 43 (Categories 2 and 4, respectively).

The OMIG's Statistical Sampling Methodology

The OMIG's use of statistical sampling methodology for extrapolation of the sample findings was explained to the Appellant in the exit conference summary (Exhibit 25), the draft audit report (Exhibit 27), and the final audit report (Exhibit 32). During the exit conference, the Appellant was also given a compact disk detailing the universe of claims and sample information about the claims selected for audit. (Exhibit 25.)

⁹ These citations were in effect during the period audited and through September 11, 2018. The stated requirements are presently found in 18 NYCRR §§ 494.4(f)-(h).

The overpayment amount was revised downward several times, including after the issuance of the final audit report, as the OMIG considered and accepted additional information from the Appellant. Ultimate revisions resulted in a computed point estimate of \$3,480,699.30. (Exhibit 46.) None of these revisions reflected changes in the extrapolation methodology.

An extrapolation based upon an audit utilizing a statistical sampling method certified as valid will be presumed, in the absence of expert testimony and evidence to the contrary, to be an accurate determination of the total overpayments made. 18 NYCRR § 519.18(g). The OMIG submitted the required certifications in the form of affidavits from: (1) Dr. Karl W. Heiner, the statistical consultant who designed the sampling and estimation methodology used; and (2) Kevin Ryan, the OMIG employee who applied the methodology to establish the audit frame and select the random sample. (Exhibits 46 and 47.)

The OMIG's authority to determine overpayments by extrapolating audit findings to the claims universe or population within the audit frame is well-settled. Yorktown Medical Laboratory, Inc. v. Perales, 948 F.2d 84 (2d Cir. 1991); Mercy Hospital of Watertown v. New York State Dept. of Social Services, 79 N.Y.2d 197 (1992); Piasecki v. DSS, 225 A.D.2d 310 (1st Dep't 1996); Tsakonas v. Dowling, 227 A.D.2d 729 (3d Dep't 1996); Enaw v. Dowling, 220 A.D.2d 942 (3d Dep't 1995); Enrico v. Bane, 213 A.D.2d 784 (3d Dep't 1995); State v. Khan, 206 A.D.2d 732 (3d Dep't 1994); Adrien v. Kaladjian, 199 A.D.2d 57 (3d Dep't 1993); Clin Path, Inc. v. New York State Dep't of Social Servs., 193 A.D.2d 1034 (3d Dep't 1993). These reported cases all upheld the very same extrapolation methodology employed again in this audit.

An Appellant may, however, submit expert testimony challenging the extrapolation by the Department or an actual accounting of all claims paid in rebuttal to the Department's proof. 18 NYCRR § 519.18(g). The Appellant presented Dr. Harold Haller as its expert witness to

challenge the extrapolation. Dr. Haller has performed consulting services for businesses, not-for-profit organizations, and governmental entities, primarily regarding industrial statistics and quality control for over 50 years. He has been retained by administrative law judges as an independent expert to review overpayment projections in approximately 70 appeals of Centers for Medicare and Medicaid Services (CMS) audits, most involving the Medicare Program. (T 401; Exhibit G.)

Dr. Haller's experience with New York State Medicaid Program audits was not elucidated during the hearing. However, publicly available records show that he performed statistical consulting work for at least one other Medicaid provider audited by the OMIG. In the resulting administrative decision, Dr. Haller's opinion was not found persuasive in contesting the validity of the OMIG's extrapolation methodology. *See* United Cerebral Palsy Association of Putnam and Southern Dutchess, a/k/a Hudson Valley Cerebral Palsy, Dept. of Health Admin. Hearing Decision, ALJ Dawn MacKillop-Soller, June 17, 2019.

Dr. Heiner testified in rebuttal to Dr. Haller. Over a career including more than 40 years' consultancy for the New York State Medicaid Program, he has instructed audit staff, reviewed, and certified the validity of extrapolations conducted by the OMIG. Dr. Heiner has performed hundreds of extrapolations for the OMIG and has appeared in numerous hearings requested to appeal OMIG audit findings. (T 776, 787-88.) His expert opinion has been repeatedly upheld as establishing the validity of the statistical sampling and extrapolation methodology used in New York State Medicaid Program audits.

Dr. Haller alleged that the OMIG's use of extrapolation is imprecise and its estimation is unreliable. Despite those claims, Dr. Haller characterized his report as a set of recommendations, or an alternative way of interpreting data, with the goal of showing the impact

of precision. (T 1316-18.) He did not disagree with, but instead confirmed, the three most critical points that establish the validity of the Department's extrapolation methodology: (1) that the audited claims were randomly-selected, an absolute requirement for sampling (T453, 629; Exhibit EA); (2) that the sample was unbiased (T 453); and (3) that the use of simple random sampling is an acceptable means by which to compute an overpayment (T 506). Dr. Haller acknowledged that audit plans must be made without consideration of the underlying data and before results are known. Yet, he also admitted that his recommendations were based upon a review of the audit findings. (T 639, 1324, 1454.)

Some of Dr. Haller's criticisms are so meritless as to call his credibility into question. Dr. Haller's report cited the OMIG's revisions to the overpayment amount after withdrawing nine disallowances as proof of imprecision in the OMIG's methodology. (Exhibit G.) As set forth and explained in Dr. Heiner's certification, it is logical, obvious, and to be expected that removing several findings from an overpayment computation will decrease the total overpayment demand. (Exhibit 46; T 964.) The revisions reflected adjustments to specific sample disallowances, not to the extrapolation methodology. The downward revision reflects precision, rather than a lack of precision, in the statistical sampling methodology and shows the OMIG's willingness to accept supplemental information from providers in order to make accurate sample findings.

Dr. Haller's other criticisms are either contradictory to other statements he made, premised upon incorrect data, and/or unrelated to the information in this audit. For instance, Dr. Haller contended that an audit of only 100 claims from the audit period was too small and

imprecise, demonstrated by his review of the audit *results* that were not normally distributed¹⁰ (i.e., not falling symmetrically within a bell-curve). (Exhibit G; T 460-61, 521-26.)

Dr. Haller's critique does not establish that an invalid extrapolation methodology was employed. Both experts agreed that sampling decisions must be made before reviewing sample findings and that sample sizes cannot be adjusted after the audit is done. (T 1084-88, 1454.) The OMIG selects a sample size while planning an audit and accepts its level of precision. (T 1088.) While Dr. Heiner readily acknowledged that the OMIG's use of extrapolation would not necessarily yield the actual overpayment amount, he testified that the extrapolation methodology was more precise than other forms of estimation and, most importantly under the applicable regulations, was statistically valid. (T 1080-81, 1149-51.)

Dr. Heiner testified that a 100-claim sample in this audit was valid. Several respected statistics authorities, including Lindgren (cited by the Appellant's expert), advise that sample sizes of just 25 or 30 sufficiently capture information about an audit universe. (T 826, 841-42, 1216.) While Dr. Heiner agreed that increased sample sizes would theoretically increase the precision of the resulting extrapolation, he also pointed out that an increase in the number of claims audited did not guarantee a lower overpayment to the provider. (T 841-42.) A larger sample would result in tighter confidence intervals, with lower and upper confidence limits generally closer than would be calculated with less precision. (T 974, 978-99.) A larger sample does not necessarily mean greater accuracy, nor does it determine the validity of the point estimate. (Exhibit 53; T 1099.) Dr. Heiner affirmed that the point estimate is a good estimate of the overpayment because it is the value with the greatest probability assigned to it and is

¹⁰ Dr. Haller's report for the Hudson Valley Cerebral Palsy audit also determined that the sampling distribution in that audit yielded a non-normal distribution. United Cerebral Palsy Association of Putnam and Southern Dutchess, a/k/a Hudson Valley Cerebral Palsy, Dept. of Health Admin. Decision, ALJ Dawn MacKillop-Soller, June 17, 2019.

unbiased. (T 1053-59.) There is a 50% chance that the point estimate is too high and a 50% chance that the point estimate is too low, thereby allowing the OMIG and the provider to share the risk of the sampling error. (T 1052-53, 1279.) The Appellant's expert, Dr. Haller, concurred with that explanation. (T 451-53, 477, 527, 1331, 1342, 1360.)

The OMIG, which is tasked with recovering improperly expended Medicaid funds, is entitled to consider costs of auditing, including sample size, as a factor in allocating limited resources to fulfill its oversight responsibility for thousands of providers, millions of claims, and billions of dollars in public expenditures. Medicaid audits based on samples of 100 claims and even 50 claims have been upheld by New York courts. Tsakonas v. Dowling, *supra*; Piasecki v. DSS, *supra*; Enrico v. Bane, *supra*; Adrien v. Kaladjian, *supra*; Clin Path, *supra*. The court in Clin Path, which also employed a 100-claim audit sample, stated:

We reject petitioner's extended arguments that the accuracy of the audit method was discredited by the opinion of its expert witness, who stated that a sampling of 1,300 to 1,400 cases was necessary to get "accurate" results and that 2,400 cases were needed to get results suitable for legal proceedings. Our courts have upheld the validity of audits based upon a much smaller sampling of cases... Clin Path, *supra*.

Dr. Heiner testified that the extrapolation methodology used in this audit, whereby the mean (average) overpayment per unit in a sample is multiplied by the total number of claims in the universe, was proper and statistically valid. (T 858-59, 871, 1082.) He found the distribution of the findings to be approximately normal and positively skewed, reducing the resulting overpayment. (T 816, 893-94, 1061-65, 1082-83.) Dr. Haller agreed that the distribution of findings was positively skewed in the Appellant's favor. (T 473.) A positive skew does not invalidate an extrapolation. (T 919-20.)

Dr. Haller failed to offer a consistent or intelligible critique of the validity of the extrapolation methodology used by the Department. He asserted that the OMIG's use of a point

estimate in its overpayment demand ignores precision and is unfair to the provider. (T 513, 527-28.) Although Dr. Haller argued that precision is important in order to replicate the results obtained in the audit using other samples of 100 claims, he could not explain why the auditors would attempt to replicate the audit results. (T 703.) The standard for this audit is not precision, it is statistical validity, and fairness is not a statistical concept. (T 1304.)

Dr. Haller also claimed that the point estimate is not a generally accepted means of estimation for an overpayment demand. His claim was based upon his experience with CMS Medicare audits (T 527-28) which have no bearing on New York State Medicaid Program audits. His expert report similarly asserted that “[t]here is no statistical basis for an attempt by OMIG to use the point estimate to compute the demand” and that “confidence intervals used to compute a demand are meaningless for estimation” in this audit. (Exhibit G.) He then conceded at this hearing that a point estimate used with confidence intervals, as such was employed in the OMIG’s extrapolation methodology, is an acceptable method of projection. (T 1343, 1358.)

Dr. Haller also claimed that point estimates such as the mean or median are useless for estimation because they ignore data variability. (Exhibit G; T 643, 664.) However, he also recommended using the median, a method by which values are ordered in some fashion and the middle value is retrieved as a group’s representative value, to compute the overpayment in this audit. (Exhibit H; T 573-74, 1298.) He then went on to admit that he did not know if the median has ever been used in statistical sampling and extrapolation. (T 1298.)

As Dr. Heiner explained, computation of a mean encompasses variability of all data sampled, whereas use of a median does not. (T 803-05, 811-12.) Use of the median value is effective in quality control audits (Dr. Haller’s area of expertise), as this method may identify a need for process improvements. However, this method does not advance the objective of

Medicaid overpayment audits, which determines whether a provider is entitled to payment for claimed services. (T 864-65, 954-56.)

Dr. Heiner's opinion is consistent with explanations found in a widely respected statistics text by William Cochran, excerpts of which were presented by the Appellant at the hearing and which were also referenced in Dr. Haller's report. (Exhibits EA and G; T 489-90.) The excerpts included Cochran's 11 principal steps in a sample survey.¹¹ (Exhibit G.) Although Dr. Haller's report explained 6 of those steps and mentioned another 4 (10 of the 11 steps), his report omits the very first step, "Objectives of the Survey":

A lucid statement of the objectives is most helpful. Without this, it is easy in a complex survey to forget the objectives when engrossed in the details of planning, and to make decisions that are at variance with the objectives. (Exhibit EA.)

Dr. Haller's suggestion regarding use of the median does not comport with the OMIG's regulatory audit function, would not advance audit objectives, and does not invalidate the OMIG's extrapolation methodology.

Dr. Haller also asserted that treating all 169,961 claims as one universe contributed to the overall lack of precision in the estimated overpayment. He recommended using stratified sampling (analysis of each category of claims separately) to compute the overpayment, on the grounds that there are two distinct universes in this audit with significantly different distributions of overpayments: (1) January 2009 through June 2009, the period for which the Appellant established that supporting service documentation was destroyed during Super Storm Sandy; and (2) July 2009 through December 2011, the remainder of the audit period. Dr. Haller concluded that findings regarding the first "universe" cannot be extrapolated to the total number of claims paid during the entire period audited. (T 438-42, 444, 480, 529-33, 544.)

¹¹Drs. Haller and Heiner concur that surveys and audits present similar statistical sampling issues. (T 581-82, 932.)

Dr. Haller also claimed that the auditors' selection of 22 claims from the six-month period of January 1 through June 30, 2009 was both disproportionate relative to the claims universe and unlikely. His 30 simulations resulted in only 2 samples (6.7% frequency) with 22 or more claims retrieved from that period. (T 453, 455, 468-70, 1286-87; Exhibit N¹².)

Dr. Heiner conducted 1,000 simulations, from which he calculated a 29.67% likelihood that any 100-size sample would retrieve at least 22 claims from the period January 1, 2009 through June 30, 2009. (T 1416-18, 1424, 1432-45.) More claims were paid from January 1, 2009 through June 30, 2009 in proportion to the other six-month periods in the period audited. Nearly 1/5 (19.4% or 33,000) of the claims in the universe were paid in the first 6-month period, not 1/6 of claims, as might be expected if each 6 six-month period contained the same number of claims paid. Despite the experts' different estimates, neither deemed the inclusion of 22 or more claims from this period implausible.

None of the recommendations or criticisms offered by the Appellant's expert disproved the validity of the OMIG's simple extrapolation methodology. While a larger sized sample would theoretically enhance precision, the costs associated with larger audits (both to providers and the OMIG), along with a heightened likelihood of human error by both sides, does not guarantee greater efficacy or a lower overpayment demand. (T 825-26, 841-42, 974, 978-99.)

The Appellant has failed to overcome the presumption of validity afforded the statistical sampling methodology that the OMIG employed for extrapolating its audit findings, and which was certified to be valid. 18 NYCRR § 519.18(g).

¹² Despite Dr. Haller's assertion that a 100-size sample was inadequate for precision purposes given the claims population and his performance of 1,000 simulations to dispute the overpayment, he was satisfied that results of 30 simulations were adequate to gauge the likelihood of retrieving at least 22 claims from the six-month period of January 1 through June 30, 2009 from the claims universe in any such sample. (T 1282, 1287, 1410.)


DECISION

The OMIG's determination to recover Medicaid Program overpayments from the Appellant for sampled claims 11, 15, 20, 23, 32, 33, 34, 38, 42, 45, 49, 56, 67, 68, 73, 74, 78, 89, 92, 93, 98, and 99 was not correct and is reversed.

The OMIG's determination to recover Medicaid Program overpayments from the Appellant for sampled claims 43 and 90 was correct and is affirmed.

The OMIG's use of a simple extrapolation method to compute the overpayment amount was statistically valid and is entitled to a presumption of accuracy that the Appellant failed to rebut.

Dated: Menands, New York
October 30, 2020



Natalie J. Bordeaux
Administrative Law Judge