

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

In the Matter of the Appeal of	:	
	:	
MAPLEWOOD ASSISTED LIVING	:	Decision After
Medicaid ID: 03182914	:	Hearing
	:	
from a determination by the NYS Office of the Medicaid	:	Audit Number: 19-2441
Inspector General to recover Medicaid Program	:	
overpayments.	:	
	:	

Before: Natalie J. Bordeaux
Administrative Law Judge

Hearing Date: November 17, 2020
The record closed February 12, 2021

Held via: Cisco WebEx Videoconference

Parties: New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
By: Kathleen Dix, Esq.

Maplewood Assisted Living
205 State Street Road
Canton, New York 13617
By: Kimberly Blair, Administrator

JURISDICTION

The New York State Office of the Medicaid Inspector General (OMIG) determined to seek restitution of payments made under the Medicaid Program to Maplewood Assisted Living (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:	Rachel Bill, Management Specialist 2 Eugene Greco, Director, Managed Care Network Providers and Fee-for-Service
OMIG exhibits:	1-16
Appellant witnesses:	Kimberly Blair, Administrator and Vice President of Operations Stacey Cannizzo, Vice President Clinical and Quality Services, and Corporate Compliance Officer, United Helpers ¹
Appellant exhibit:	A

A transcript of the hearing was made. (T 1-134.) Each party submitted a post-hearing brief.

FINDINGS OF FACT

1. The Appellant is an Assisted Living Program (ALP) located in Canton and is enrolled as a provider in the New York State Medicaid Program. (T 11.)
2. By letter dated April 18, 2019, the Appellant was advised that the OMIG would audit the Appellant's records regarding billings for ALP services paid by the Medicaid Program during the period January 1, 2014 through December 31, 2016. (Exhibit 1.)

¹ United Helpers is the Appellant's corporate owner. (T 5.)

3. During the period January 1, 2014 through December 31, 2016, the Appellant was paid \$1,188,964.31 for 954 claims submitted to the Medicaid Program for ALP services.

(Exhibits 2, 4, 6, 8.)

4. On May 14, 2019, an entrance conference was held with OMIG auditors and members of the Appellant's management. The nature and extent of the audit was discussed pursuant 18 NYCRR § 517.3(f). (Exhibit 2.)

5. After the May 14, 2019 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, 2014 through December 31, 2016 (the audit sample), for which the auditors required supporting documentation. (Exhibit 3.)

6. On October 30, 2019, an exit, or closing conference was held pursuant to 18 NYCRR § 517.5(a), during which the auditors discussed their findings with the Appellant's representatives. Documentation deficiencies were organized into 14 disallowance categories. The auditors identified 92 claims with at least one error, for a total sample overpayment of \$76,938.93. (Exhibit 4.)

7. In response to the preliminary findings identified in the exit conference, the Appellant submitted additional documentation to the auditors to support its entitlement to Medicaid payments for the sampled claims. (Exhibit 5.)

8. On December 3, 2019, the OMIG issued a draft audit report to the Appellant, which identified 78 claims with at least one error organized into 10 disallowance categories, and disallowed payments totaling \$79,522.76. The draft audit report also advised the Appellant that the audit employed a statistical sampling methodology to extrapolate the sample findings for disallowances in seven of the disallowance categories to an audit frame of all claims paid during

the three-year audit period. Using the extrapolation and adding the total sample overpayment from another three disallowance categories, OMIG determined preliminarily that the Medicaid overpayment received by the Appellant was \$439,835. The draft audit report offered the Appellant the opportunity to object to the proposed findings and provide additional documentation to be considered in support of the objections pursuant to 18 NYCRR § 517.5. (Exhibit 6.)

9. On January 20, 2020, the Appellant submitted its response to the draft audit report, contesting the disallowances and objecting to the extrapolation methodology employed by the OMIG. The Appellant also enclosed documentation to counter the audit findings. (Exhibit 7.)

10. On February 24, 2020, the OMIG issued a final audit report, which adjusted the findings set forth in the draft audit report and determined that 77 claims contained at least one error with overpayments totaling \$79,322.84. The final audit report also advised the Appellant that the OMIG determined to seek restitution of Medicaid Program overpayments totaling \$437,927, derived by projecting the value of errors found in the claims identified in disallowance categories 3, 5, 6, 7, 8 and 9 to the claims universe, and adding the actual dollar disallowances for the errors found in the claims that were identified in categories 1, 2 and 4. (Exhibit 8.)

11. The OMIG organized the disallowed claims into the following categories:

1. Failure to Complete Annual Performance Evaluation (sampled claims 1-3, 5, 7-9, 12, 13, 16, 17, 20-22, 24, 25, 27-29, 31, 38, 42, 44, 46, 50, 54, 58, 59, 62, 65, 68, 70-73, 79-82, 84, 86, 89, 91, 93-95 and 98-100.)
2. Missing Documentation of a Tuberculosis Test or Follow-Up (sampled claims 2, 3, 9, 10, 12, 13, 15, 17, 20-22, 24, 25, 28, 29, 31, 38, 42, 44-46, 48, 50, 54, 58, 65, 68, 71, 73, 79, 84, 85, 89, 93 and 98-100.)
3. Plan of Care not Updated as Required (sampled claims 11, 15, 16, 19, 20, 22, 25, 26, 28, 30, 34, 37, 40, 43, 45, 53, 54, 61, 64, 68, 74, 76, 77, 83 and 94.)

4. Missing Required Health Assessment (sampled claims 2, 3, 10, 12, 15, 20, 22, 25, 28, 44-46, 48, 50, 54, 68, 79 and 85.)
5. Missing Plan of Care (sampled claims 3, 12, 32, 47, 50, 60 and 85.)
6. Missing/Invalid Signature on Medical Evaluation (sampled claims 7, 18, 32, 33, 39 and 82.)
7. Missing Entry in the Uniform Assessment System for NY (sampled claims 11, 42, 52 and 91.)
8. Missing Medical Evaluation (sampled claim 20.)
9. Invalid Service Documentation (sampled claim 69.)

(Exhibit 8.)

12. The Appellant is contesting the disallowances in categories 1 and 3. It is also contesting the OMIG's determination to extrapolate the disallowances set forth in categories 3, 5, 6, 7, 8 and 9 to the total universe of claims. (T 16-17.)

ISSUES

Was the OMIG's determination to recover Medicaid Program overpayments from the Appellant for disallowance categories 1 and 3 correct?

Was the OMIG's determination to extrapolate the findings from categories 3, 5, 6, 7, 8 and 9 to the universe of claims correct?

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). Unless expressly provided otherwise in 18 NYCRR Part 494, an ALP is subject to any other Federal, State and local laws, rules or regulations governing adult care facilities, long-term home health care programs, certified home health agencies, licensed home care agencies or personal care services. 18 NYCRR § 494.1(b). These regulations include 10 NYCRR Part 763, applicable to certified home health agencies, and Part 766, applicable to home care services agencies.

The Medicaid Program will pay an ALP for services provided to Medicaid recipients. ALP providers are paid a capitated rate in accordance with Department regulations, authorized on the basis 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-l(1)(e); 18 NYCRR § 494.5(b) and § 505.35(h)(1).

DISCUSSION

The Audit Findings

The Appellant submitted “bulk” claims for payment to the Medicaid Program, in which it billed for multiple dates of service on each of the 954 claims in the audit universe. (T 41, 56.) The auditors therefore reviewed each date of service billed within each claim of the audit sample for compliance with regulatory requirements. (T 57.) The findings were organized into nine disallowance categories shown in the Final Audit Report. The contested findings are:

Disallowance Category 1: Failure to Complete Annual Performance Evaluation.

An ALP operator must maintain personnel records for its staff. 18 NYCRR § 487.10(d)(5)(vii) and § 488.10(d)(4)(vii). For staff rendering home health services, personnel records must include performance evaluations consisting of an annual assessment of the performance and effectiveness of each person documented in writing, including at least one home visit to observe performance if the person provides services in the home. 10 NYCRR §§ 763.13(h) and (k).

In 922 instances on 49 claims, the auditors did not receive documentation showing that the Appellant conducted annual performance evaluations for staff who rendered home health aide services to Medicaid recipients. (Exhibit 8.) Paid amounts were disallowed in this category for billings in which the Appellant's supporting documentation contained a one-page form entitled, "Home Health Care Staff Supervisory Visit" in lieu of an annual evaluation.

The Appellant argues that its "Home Health Care Staff Supervisory Visit" form met the regulatory requirements for annual performance evaluations of all staff. It asserts that the supervisory visit form is more comprehensive and relevant to the requirements than the Appellant's standard annual evaluation because the supervisory visit form evaluates an employee's "overall performance." (Exhibit 7; Appellant's Brief, p. 2.) This argument is unpersuasive. The on-site supervisory visit evaluation assesses an employee on one day for one patient. (Exhibit 7, pages 394-95; T 82, 90.)

Applicable regulatory requirements require an annual assessment of staff performance and effectiveness to include at least one home visit to observe the employee's rendering of services. 10 NYCRR §§ 763.13(h) and (k). The Appellant's responsibility with respect to staff appraisal does not end with an annual on-site visit. The evaluation of an employee's on-site

performance on one date with one patient cannot reasonably be accepted as an evaluation of that employee's overall efficacy in all aspects of employee performance for the entire year.

Kimberly Blair, Vice President of Operations and Administrator acknowledged that certain aspects of the review are not listed on the one-page supervisory visit form, even though those aspects are "part of the annual process." (T 80.) The regulations require the Appellant to maintain records of all components of the annual evaluation and to provide those records to the auditors. The Appellant has not shown that the auditors overlooked information that would reasonably serve as a substitute for the annual performance evaluation.

The Appellant has failed to establish that the auditors' determination to disallow payments made for services rendered by employees, whose performance was not evaluated as required, was not correct. The disallowances in this category are upheld.

Disallowance Category 3: Plan of Care not Updated as Required.

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(c).² ALPs must maintain a confidential record for each patient admitted to care which includes an individualized plan of care. 10 NYCRR § 766.6(a)(4).

An ALP operator must ensure that the plan of care is reviewed and revised as frequently as necessary to reflect the changing care needs of the patient, but no less frequently than every six months. Each review shall be documented in the patient's clinical record, and professional personnel shall promptly alert the patient's authorized practitioner and other affected care providers to any significant changes in the patient's condition that indicate a need to alter the plan of care. 10 NYCRR § 766.3(d).

² During the audit period, these requirements were found in 18 NYCRR § 494.4(b).

The auditors identified 590 instances on 25 claims in which the records submitted to the OMIG failed to include a plan of care that was updated and reviewed at least every six months. In order to show that billings were made for services that were appropriate in accordance with a current plan of care, the Appellant would have had to provide either an updated plan of care for each resident or the original patient plan of care, along with evidence that the plan of care was timely reviewed by professional staff every six months thereafter and encompassing the date of service. By providing that information in lieu of a formalized, updated plan of care, the auditors would still be able to ensure that patients received necessary care and therefore that the Appellant's receipt of payment from the Medicaid Program was also appropriate. (T 60, 62-63, 103-04.) The auditors were willing to accept documentation of varied formats that would show the Appellant's compliance with the plan of care review requirements. (T 61-62.) Even under this liberal standard, the documentation failed to establish the existence of a current plan of care supporting the medical necessity of services billed for the dates in question.

The Appellant claims that the information provided to the auditors adequately showed that patients' plans of care were reviewed in a timely manner. In some instances, the Appellant offered progress notes indicating that a plan of care was reviewed, highlighting specific entries such as "care plan was reviewed with no changes necessary" and that a patient had a medical appointment for a "6-month check-up" and returned with no new orders. (Exhibit 7, p. 398.) However, missing from this documentation were the plans of care that were allegedly reviewed. The Appellant failed to provide plans of care that were dated and signed by professional staff. (T 43, 47, 77.)

As OMIG Management Specialist and auditor Rachel Bill explained at the hearing, progress notes for the dates of service did not constitute plans of care, nor did outdated plans of

care establish that the billed services were covered by a plan of care on the dates of service. (T 49.) The Appellant provided neither timely plans of care nor adequate documentation to establish that an original or prior plan of care was reviewed by professional staff and reflected the patients' needs during the six-month period encompassing the relevant dates of service. The disallowances in this category are affirmed.

The OMIG's Extrapolation of Audit Findings to the Universe of Claims

The OMIG extrapolated the findings from categories 3, 5, 6, 7, 8 and 9 totaling \$41,991.13 to the universe of 954 claims for which it received total payments of \$1,188,964.31, resulting in a point estimate of \$400,595. The disallowances identified in categories 1, 2 and 4 were not extrapolated. Instead, those sample overpayments totaling \$37,331.71 were added to the point estimate of \$400,595. (Exhibit 8.)

The OMIG's use of statistical sampling methodology for extrapolation of the sample findings was explained to the Appellant in the entrance conference summary (Exhibit 2), the exit conference summary (Exhibit 4), the draft audit report (Exhibit 6), and the final audit report (Exhibit 8.) During the exit conference, the Appellant was also given a compact disk containing information about the universe of claims in the audit period and sample information about the claims selected for audit. (Exhibit 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. The Appellant may 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 OMIG submitted the required certifications in the form of affidavits from Dr. Karl W. Heiner, the statistical consultant who designed the sampling and estimation methodology used, and Theresa Gulum, the OMIG employee who applied the methodology to establish the audit frame and select the random sample. (Exhibits 13 and 14.) The Appellant offered neither expert testimony nor an actual accounting of all claims to establish error in the extrapolation.

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). The OMIG's selection of 100 claims from 954 paid claims afforded both the OMIG and the Appellant an efficient means by which to establish whether the Appellant had created and maintained the requisite documentation to justify its right to the Medicaid payments received for ALP services in the period reviewed.

The Appellant objected to the OMIG's extrapolation of the audit findings in disallowance categories 3, 5, 6, 7, 8 and 9 to the Appellant's entire universe of claims as punitive because the Appellant asserted that it has demonstrated overall compliance with legal requirements. (Exhibit 7.) This audit revealed errors in 77 of the 100 claims sampled, or an error rate of 77%. Those numbers do not signify overall compliance. Instead, the error rate suggests the need for significant process improvements.

It is further noted that although it was entitled to extrapolate all findings to the audit universe, the OMIG elected to extrapolate only 53% of the audit findings. This hardly suggests a punitive approach.

Indeed, Mr. Greco testified that the OMIG determined not to extrapolate all of the findings precisely to avoid punishing the Appellant. (T 57-58.) The findings in categories 3, 5, 6, 7, 8 and 9 were deemed directly related to patient care and represented an ongoing problem with respect to the Appellant's entitlement to payment for claimed services rendered. (T 65.) The findings in disallowance categories 1, 2 and 4 were not extrapolated because those findings were reflective of personnel issues and only indirectly related to patient care. (T 57-58.)

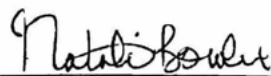
The Appellant has failed to overcome the presumption of validity afforded the statistical sampling methodology that the OMIG employed for extrapolating its audit findings, and which was certified to be valid. 18 NYCRR § 519.18(g).

DECISION

The OMIG's determination to recover Medicaid Program overpayments from the Appellant for disallowance categories 1 and 3 was correct and is affirmed.

The OMIG's determination to extrapolate the findings from categories 3, 5, 6, 7, 8 and 9 to the universe of claims was correct and is affirmed.

Dated: Menands, New York
March 3, 2021



Natalie J. Bordeaux
Administrative Law Judge