STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of	:	
SARATOGA COUNTY A.R.C.	:	**Decision After Hearing**
Medicaid ID #02248924	:	
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 #16-2418

Before:	Dawn MacKillop-Soller Administrative Law Judge
Held At:	NYS Department of Health 150 Broadway Suite 510 Menands, New York 12204
Date of Hearing:	March 8, 2017
Record closed:	June 16, 2017
Parties:	NYS Office of the Medicaid Inspector General 800 North Pearl Street Albany, New York 12204 By: Lisa Seemann, Esq. Sarah Dasenbrock, Esq.
	Saratoga County A.R.C. 16 Saratoga Bridges Boulevard Ballston Spa, New York 12020 By: Hermes Fernandez, Esq. Bond, Schoeneck & King 22 Corporate Woods Blvd. Suite 501 Albany, New York 12211

JURISDICTION

The New York State Office of the Medicaid Inspector General (OMIG), an independent office within the Department of Health (Department), has the authority to pursue civil and administrative enforcement actions against entities or individuals engaged in fraud, abuse, or unacceptable practices and to recover improperly paid funds pursuant to New York's Medicaid Program. Public Health Law (PHL) §§ 30, 31, 32, 201(1)(v), Social Services Law (SSL) § 363-a. The OMIG determined to recover Medicaid Program overpayments made to Saratoga County A.R.C. (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. (Exhibit 5.)

At the hearing, the OMIG submitted documents (Exhibits 1-12) and produced as a witness OMIG senior auditor Rosaline Renas (Transcript, p. 41.) The Appellant submitted documents (Exhibits A-D) and its witnesses were director of service coordination Charlotte Mosso (Transcript, p. 178), residential program coordinator Jessica Brown (Transcript, p. 212) and quality assurance coordinator Dorothy Brockheisen. (Transcript, p. 228.) A transcript of the hearing was made. (Transcript, p. 1-245.) Each side submitted post-hearing briefs and reply letters. The Appellant has the burden of proving 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).

FINDINGS OF FACT

1. Appellant Saratoga County A.R.C., also known as Saratoga Bridges, 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 provides individualized residential alternative (IRA) habilitation services, such as outpatient physical, occupational and speech

services to developmentally disabled individuals. The purpose of the services is to assist them in acquiring the necessary skills to successfully and independently live at home and work in the community. (Transcript, p. 32.)

2. IRA services are delivered to patients through an Individual Service Plan (ISP), which is written by a Medicaid Service Coordinator (MSC) and describes services and goals. 14 NYCRR 635-99.1(bk). Attached to the ISP is the Residential Habilitation Plan (habilitation plan), which is written by a Habilitation Service Provider or a Qualified Intellectual Developmental Professional (QIDP). This person works with an assigned individual to determine the need for habilitation services and distributes the habilitation plan to the MSC. (Transcript, p. 181-184, 214.)

3. The OMIG conducted an audit of the Medicaid claims paid to the Appellant for the period January 1, 2011 through December 31, 2013. The purpose of the audit was to determine whether the Appellant's residential habilitation program claims were in compliance with Medicaid Program requirements for payment. The Appellant received payments totaling $16,372,102.42 for 2,680 OPWDD residential habilitation claims for habilitation services provided to Medicaid recipients. The audit consisted of a review of 100 of those claims paid in the total amount of $608,707.32. (Exhibit 4.)

4. In a draft audit report dated September 16, 2016, the OMIG identified errors in 16 of the 100 claims (Samples 1, 10, 11, 12, 26, 30, 31, 36, 45, 64, 70, 74, 75, 82, 83, 89) and disallowed them. The disallowances were based on findings that in these 16 instances, the documentation failed to show revised habilitation plans were given to the service coordinator within the required 30 days. In two of those 16 instances (Samples 74 and 83), the habilitation plans also failed to include dates and signatures from the staff responsible for writing them, as

also required. These audit findings revealed overpayments in the amount of $98,318.52. (Exhibit 2.)

5. In a November 4, 2016 response to the draft audit report, the Appellant objected to the OMIG's disallowances claiming that forwarding of habilitation plans and signatures and dates on the plans are not required. (Exhibit 3.)

6. After considering the Appellant's response to the draft report, the OMIG issued a final audit report dated November 16, 2016, confirming the findings in the draft audit report and the overpayment determination of $98,318.52. By letter dated December 6, 2016, the Appellant requested a hearing. (Exhibits 4, 5.)

7. At the hearing, the Department withdrew the disallowance for Sample 70, reducing the overpayment to $92,169.29. (Transcript, p. 32.)

APPLICABLE LAW

1. The Department is authorized to require repayment of an overpayment when it has determined that a Medicaid claim has been submitted for which payment "should not have been made." An overpayment includes "any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake." 18 NYCRR 518.1(b) and (c).

2. Providers are subject to audit by the Department and are required "to reimburse the department for overpayments discovered by audits in accordance with Parts 516 and 517." 18 NYCRR 504.8(1).

3. A Medicaid provider's 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.
>
> [¶] . . . [¶]

h. that the information provided in relation to any claim for payment shall be true, accurate and complete. 18 NYCRR 504.3.

4. A fee-for-service provider's obligations also include:

> All providers … who are paid in accordance with the rates, fees and schedules established by the department, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. All records necessary to disclose the nature and extent of services furnished and the medical necessity therefore…must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. 18 NYCRR 517.3(b)(1).
>
> Information for claims for payment…must be furnished, upon request, to the department. 18 NYCRR 517.3(b)(2).

5. The requirements for habilitation plans are set forth in OPWDD regulation. They include that plans for habilitation services, such as residential, day, community, supported employment or pre-vocational services, must "be developed, and on a semiannual basis thereafter, reviewed and revised as necessary by the habilitation provider." 14 NYCRR 635-99.1(bk).

6. OPWDD administrative directive ADM #2010-01 defines payment standards for OPWDD licensees who submit claims to the Medicaid Program. ADM #2010-01, Attachment A, includes a "(l)ist of OPWDD Guidance Documents with Payment Standards." The list includes as payment standards the "Habilitation Plan Requirements" in ADM #2003-03, December 5, 2003, p. 2, which state:

> 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.

The list also includes "IRA Residential Habilitation Service Documentation Requirements" in ADM #2002-01, September 3, 2002, p. 6, which require habilitation plans contain the following elements:

> (8.) The signature and title of the staff person writing the note.
> (9.) The date the note was written. *See also* ADM 2012-01, March 7, 2012, p. 3.

7. ADM #2010-01 also states:

> (A)ll future guidance documents and regulations issued by OPWDD which are intended to contain a payment standard will clearly identify the payment standard as such against which claims for Medicaid reimbursement will be audited. All standards in future regulations and guidance documents which do not carry this specific designation shall be considered program standards. ADM #2010-01, p. 3.

8. ADM #2012-01 restated the already existing habilitation plan requirements set forth in ADM #2010-01, Attachment A. ADM #2012-01, p. 3, 7; *See also* ADM #2003-03, p. 2, ADM #2002-01, p. 6 and OPWDD Memorandum dated May 3, 2012.

ISSUE

Has the Appellant met its burden of proving that the OMIG's determination to recover overpayments in the amount of $92,169.29 was not correct?

ANALYSIS AND CONCLUSIONS

The applicable payment standard

The issue is whether under the Medicaid Program, the Appellant was required to demonstrate the forwarding of signed and dated habilitation plans to the service coordinator. ADM #2010-01 references these requirements as payment standards "to justify habilitation service billing," and specifically references ADM #2003-03 and ADM #2002-01 as prior ADMs with the

same billing requirements. ADM #2010-01, Attachment A. It also directs all future ADM guidance documents to identify by grey lining payment standards "against which claims for Medicaid reimbursement will be audited." ADM #2010-01, p. 3.

The Appellant's objection that these payment standards were not recognized until the Spring of 2012 in ADM #2012-01 is rejected. It applies, at best, to Samples 1, 10, 12, 31, 45 and 82 because the remaining claims were made after that period. Also, it inaccurately assumes that the billing requirements did not already exist. While ADM #2010-01 projects a plan to apply grey lining to future payment standards in ADMs, ADM #2010-01 made clear that payment requirements subject to "fiscal recovery, if violated," already included habilitation plan forwarding and signatures and dates on plans. These mandatory obligations were specifically designated as billing standards in Attachment A, which incorporated ADM # 2003-03 under "Habilitation Plan Requirements" and ADM #2002-01 under "IRA Residential Habilitation Service Documentation Requirements." ADM #2010-01, p. 4 and Attachment A. ADM #2012-01 simply reiterated these pre-existing billing rules by articulating them again in accordance with the new "grey lining" policy. ADM #2012-01, p. 2 and 7. The standards themselves remained the same.

The Appellant's argument is further undermined by the testimony of director of service coordination Ms. Mosso, who described herself as an MSC and, in some of these 100 instances, the person who wrote and delivered the subject ISPs and attached habilitation plans within the "mandated timeframes." While this suggests receipt of the habilitation plans by the MSC, it does not demonstrate that the Appellant fulfilled its forwarding obligations under ADM #2010-01, Attachment A. Instead, these dual roles highlight Ms. Mosso's familiarity with the forwarding rules. Indeed, her awareness of them was made even more compelling by the "chart" – described

by her as a "schedule of responsibilities" − she maintained to show ISPs "written and disseminated," as required. (Transcript, p. 182-185. 188-189, 200-201.)

Failure to forward claims

The Appellant also argues that without evidence of significant habilitation plan changes, the forwarding requirement does not apply and the disallowances must be reversed in any instances where there were no significant changes. (Appellant's brief, p. 8-9 and reply brief, p. 1-2.) This argument overlooks the mandatory criteria for forwarding habilitation plans, which OMIG senior auditor Ms. Renas explained apply to either significant changes or an ISP review completed. (Department's reply brief, p. 1-2.) Ms. Renas testified to the existence of significant changes to the habilitation plans for each of the 16 disallowed claims. More importantly, she confirmed that each claim involved a revised habilitation plan and an ISP review. (Transcript, p. 120, 126, 175-176.) This alone subjected the Appellant to the 30-day forwarding rule notwithstanding any significant changes. ADM #2010-01, Attachment A.

The Appellant claimed that in any event it met its documentation obligations for all the habilitation plans with the interoffice "chart" Ms. Mosso claimed was maintained. Despite ample opportunity to produce this document, including in response to the OMIG's notice of audit pursuant to 18 NYCRR 517.3(f), or as directed under 18 NYCRR 517.5(a) in response to the draft audit report, the Appellant never produced it. (Transcript, p. 118, 188, 198, 201, 206.) In defense of never making any effort to provide it, the Appellant blames the OMIG for never asking for it. (Appellant's brief, p. 6.) It was the Appellant's obligation to maintain and produce records demonstrating its compliance with billing requirements. 18 NYCRR 504.3(a), 517.3(b) and 540.7(a)(8). In claiming to have such records without ever producing them, the Appellant failed to meet its burden of proving entitlement to payment.

The Appellant also relies on its internal office "procedures" to show its compliance with habilitation plan requirements. (Appellant's brief, p. 5-7.) The Appellant's residential program coordinator, Ms. Brown, explained how habilitation plans are routinely signed and distributed the same day. Ms. Mosso discussed her general practice as an MSC of receiving habilitation plans by office drop off or inter-office mail. These efforts show internal workplace operations and how a service coordinator receives habilitation plans, yet they are not a substitute for documentation demonstrating compliance with habilitation plan procedures. 18 NYCRR 504.3(a), 517.3(b) and 540.7(a)(8). The Appellant's argument that proof of an "actual recording" is not required ignores its documentation obligations under the Medicaid Program. 18 NYCRR 504.3(a), 18 NYCRR 517.3(b) and 18 NYCRR 540.7(a)(8).

While the form of documentation required to be kept is not specified, the Appellant was still obligated, as a fee-for-service provider, to produce some type of contemporaneous documentation. In this case, for example, the OMIG permitted the Appellant to document forwarding by producing a "receipt" or paperwork uploaded to "Choices," an OPWDD database. In 84 out of the 100 claims reviewed, the Appellant produced this documentation and the OMIG allowed the claims. The Appellant's failure to follow its own routine procedures to submit such contemporaneous documentation proof for the remaining 16 claims amply supports the conclusion that the Appellant failed to meet its burden of proof. (Transcript, p. 98, 117-118, 184, 225.)

Signatures and dates

Every habilitation plan is required to be signed and dated by its author. ADM #2010-01, Attachment A. The habilitation plans in Samples 74 and 83 lacked those elements. The Appellant's argument that signatures and dates are not "required" by OPWDD regulation overlooks 14 NYCRR 635-1.2(g)(1)(iii), which authorizes OPWDD to "demonstrate through policies,

procedures…or any means" directives to "establish and ensure continued compliance" with its program mandates. ADM #2010-01 established the rule of signature and dates and also requires compliance with the Medicaid Program documentation "regulations." ADM #2010-01, p. 3.

Conclusion

The Appellant failed to meet its burden of proving entitlement to payment for the claims disallowed by the OMIG. 18 NYCRR 519.18(d)(1). The Appellant's claim that it is not required to demonstrate by contemporaneous documentation forwarding of habilitation plans and signatures and dates on them disregards the Medicaid and OMRDD rules and regulations that clearly direct otherwise. Contrary to the Appellant's characterization of the disallowances as "harsh" (Appellant's brief, p. 13), the audit consisted of a review of only 100 of the 2,680 claims. Had the OMIG reviewed more of these claims, for which it paid over $16 million, it would have undoubtedly identified a far greater overpayment amount than approximately $92 thousand. (Exhibit 4.) The Medicaid program expects habilitation providers to follow the ADM guidelines – rules that apply to all habilitation providers − to ensure the safe and appropriate administration of habilitation services to developmentally disabled individuals. The disallowances are affirmed.

DECISION: The OMIG's determination to recover Medicaid Program overpayments from Saratoga County A.R.C. is affirmed. The overpayment is in the total amount of $92,169.29.

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

Dated: _____, 2017
Albany, New York

_____
Dawn MacKillop-Soller
Administrative Law Judge