cc: Ms. Daniels Rivera by Scan
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NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

January 27, 2026

CERTIFIED MAIL/RETURN RECEIPT

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RE: In the Matter of Bronxwood Home for the Aged, Inc.

Dear Parties:

Enclosed please find the Decision After Hearing in the above referenced matter.

If the appellant did not win this hearing, the appellant may appeal to the courts pursuant to the provisions of Article 78 of the Civil Practice Law and Rules. If the appellant wishes to appeal this decision, the appellant may wish to seek advice from the legal resources available (e.g. the appellant's attorney, the County Bar Association, Legal Aid, OEO groups, etc.). Such an appeal must be commenced within four (4) months after the determination to be reviewed becomes final and binding.

Sincerely,

Natalie J. Bordeaux/cm

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB: cmg
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of **Bronxwood Home for the Aged, Inc.** Medicaid ID #01903162 from charges of unacceptable practices and determinations by the NYS Office of the Medicaid Inspector General to impose sanctions and seek restitution of Medicaid Program overpayments.	**Decision After Hearing** #08-1900 08-F-3711

Before: John Harris Terepka
Administrative Law Judge

Held at: New York State Department of Health
90 Church Street
New York, New York 10007
November 19 & 20, 2025
December 4, 2025, by videoconference
Record closed January 16, 2026

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

The Department of Health acts as the single state agency to supervise the administration of the Medicaid Program in New York. 42 USC 1396a; PHL 201(1)(v); SSL 363-a. The Office of the Medicaid Inspector General (OMIG), an independent office within the Department, has the authority to pursue administrative enforcement actions against any individual or entity that engages in unacceptable practices in the Medicaid Program, and to recover improperly expended Medicaid funds. PHL 30, 31 & 32.

The OMIG determined to sanction and recover Medicaid Program overpayments from Bronxwood Home for the Aged, Inc. (the Appellant). The Appellant requested a hearing pursuant to Social Services Law 145-a and former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the determinations.

HEARING RECORD

OMIG witnesses:	Nancy (Schmidt) Grandino
	Eugene Greco
	Karl Heiner, PhD
OMIG exhibits:	1-15, 17-20
Appellant witnesses:	Warren Bilker, PhD
Appellant exhibits:	A-R, U-CC, EE-LL, OO

A transcript of the hearing was made. (Transcript, pages 1-507.) The parties each submitted two post hearing briefs and the record closed on January 16, 2026.[1]

SUMMARY OF FACTS

1. At all times relevant hereto, Appellant Bronxwood Home for the Aged, Inc., located in the Bronx, New York City, was an adult care facility, enrolled as a provider in the New York State Medicaid Program and approved to operate an assisted living program (ALP) pursuant to SSL 461-l and 18 NYCRR 485.6(n).

[1]On January 17, 2026 the OMIG submitted, by email, an "affirmation of Dionne Wheatley" with attachments of additional Department records and correspondence. The hearing closed on December 4, 2025 and the record was open for briefs only until January 16. The belatedly submitted material, which was not offered at the hearing, has not been considered and is not part of this hearing record.

2. By notice dated May 1, 2008, the OMIG initiated an audit to determine whether the Appellant's records reflected compliance with Medicaid Program requirements. (Exhibit 1.) The audit commenced with an entrance conference on May 8, 2008. (Exhibit 2.)

3. During the period January 1, 2006 to December 31, 2007, the Appellant was paid for 107,608 per diem claims it submitted to the Medicaid Program for ALP services to Medicaid recipients. The Appellant was paid $8,486,349.56 by the Medicaid Program for these claims. The OMIG audit reviewed a randomly selected, stratified sample of 200 of the claims, paid in the amount of $18,738. (Exhibits 8, 12.)

4. The OMIG issued a draft audit report dated November 12, 2009, which identified one or more violations of Medicaid Program requirements in the submission of 195 of the 200 sampled claims, and disallowed payments in the total amount of $17,647.49. In addition to an audit of the Appellant's ALP claims, the draft audit report included findings from an audit of its Patient Review Instruments (PRI). The draft audit report advised the Appellant that the OMIG had preliminarily determined to seek restitution of Medicaid Program overpayments in the amount of $7,602,498.66. (Exhibit 4.)

5. The draft audit report afforded the Appellant the opportunity to submit documents and written arguments in response to the proposed action. The Appellant responded to the draft audit report on January 15, 2010. (Exhibit A.)

6. On February 16, 2016, the OMIG issued a revised draft audit report which dropped the PRI findings, disallowed 174 of the 200 sampled claims, and reduced the restitution figure to $6,903,305. (Exhibit 6.) On February 19, 2016, the OMIG also issued a notice of proposed agency action charging the Appellant with unacceptable practices and proposing, in addition to recovering the overpayments plus interest, to exclude it from the Medicaid Program for three years. (Exhibit 6a.)

7. The Appellant submitted objections to the revised draft audit report and the notice of proposed agency action on March 23, 2016. (Exhibits B, C.)

8. By notice of agency action and final audit report dated August 15, 2019, to which was attached details of its specific findings, the OMIG notified the Appellant that it had disallowed 104 of the 200 sampled claims, totaling $9,656.73, and had determined to seek restitution in the amount of $4,423,684. The notice of agency action advised the Appellant that the OMIG had determined, in addition to recovering the overpayments plus interest, to impose a Medicaid Program sanction of censure. (Exhibit 8.)

9. The OMIG's restitution claim was an extrapolation based upon a statistical sampling method in which the value of the disallowed claims found among the randomly selected stratified sample of 200 claims was projected to the total of 107,608 claims paid by the Medicaid Program during the audit period. (Exhibit 11.)

10. At the outset of this hearing, the OMIG amended its findings by withdrawing 28 sample disallowances (samples 15, 17, 18, 22, 26, 35, 39, 48, 50, 54, 55, 57, 60, 64, 65, 68, 70, 71, 92, 105, 110, 114, 132, 158, 159, 160, 191, 193) and reducing the restitution figure to $3,844,695. The OMIG also withdrew the censure or any other Medicaid Program sanction for unacceptable practices. (Transcript, pages 12-14; Exhibit 17.) The OMIG subsequently also withdrew the disallowance of sample 33. (Transcript, page 346.)

11. During the audit period, most of the Appellant's residents received their medical evaluations and assessments for Medicaid reimbursable ALP placement from the medical practice "Goldencare," operated by Dr. Owen Golden. Goldencare provided the Appellant with signed medical evaluations and assessments used to document and periodically reassess the residents' placement at the Bronxwood ALP. Goldencare and

Bronxwood were unrelated entities with separate Medicaid provider enrollments. (Exhibit 14b; Exhibit Y.)

ISSUES

Did the Appellant engage in unacceptable practices in the Medicaid Program?

Is the OMIG's determination to recover Medicaid Program overpayments from the Appellant correct? If so, what is the amount of the overpayment?

APPLICABLE LAW

Medicaid providers are required, as a condition of their enrollment in the program, to prepare, maintain and furnish to the Department upon request, contemporaneous records demonstrating their right to receive payment from the Medicaid Program and fully disclosing the nature and extent of the care, services and supplies they provide. The information provided in relation to any claim must be true, accurate and complete. All information regarding claims for payment is subject to audit for six years. 18 NYCRR 504.3(a)&(h), 517.3(b), 540.7(a)(8). Notification by the Department of its intent to audit, followed by commencement of the audit within 60 days, shall toll the six-year period for record retention and audit. 18 NYCRR 517.3(c)&(d).

When the Department has determined that claims for medical services have been submitted 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). 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).

An unacceptable practice in the Medicaid Program is conduct contrary to the official rules, regulations, claiming instructions or procedures of the Department. 18 NYCRR 515.2(a)(1). Unacceptable practices include unacceptable recordkeeping, defined

at 18 NYCRR 515.2(b)(6); false statements, defined at 18 NYCRR 515.2(b)(2); and failure to disclose, defined at 18 NYCRR 515.2(b)(3). Upon a determination that a person has engaged in an unacceptable practice, the Department may impose one or more sanctions, including censure or exclusion from the Medicaid Program. 18 NYCRR 515.3(a). The Department may also require the repayment of overpayments determined to have been made as a result of an unacceptable practice. 18 NYCRR 515.3(b), 515.9, 518.1(c).

A person is entitled to a hearing to have the Department's determination reviewed if the Department imposes a sanction or requires repayment of an overpayment. 18 NYCRR 519.4. At the hearing, the Appellant has the burden of showing that the determination of the Department was incorrect, that all claims submitted and denied were due and payable under the Medicaid Program, and of proving any mitigating factors affecting the severity of any sanction imposed. Where its determination is based upon an alleged failure to comply with generally accepted professional or medical practices or standards of health care, however, the Department has the burden of establishing the existence of such practices or standards. 18 NYCRR 519.18(d).

DSS regulations most pertinent to this hearing decision are at 18 NYCRR Parts 485, 487 & 494 (adult care facilities), and Parts 515 (provider sanctions), 517 (provider audits), 518 (recovery and withholding of payments or overpayments) and 519 (provider hearings). The New York State Medicaid Program issues Provider Manuals, which are available to all providers and include, among other things, Medicaid Program billing policies, procedures, codes and instructions. (Exhibit 15; *see* www.emedny.org.)

An assisted living program (ALP) is an entity approved to operate pursuant to 18 NYCRR 485.6(n) 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 residents unrelated to the operator. SSL 461-l(1); 18

NYCRR 485.2(s), 494.2(a). To be approved, the ALP operator must possess or apply for certification as either an adult home or enriched housing program. 485.6(n)(5). For each of its Medicaid enrollees, a daily capitated rate is paid to the ALP for the provision of case management and care that includes nine distinct home care services. No additional fee-for-service billing can be made for these services. 18 NYCRR 494.5, 505.35(h)(1); ALP Provider Manual Policy Guidelines (Exhibit 15).

Before an operator admits an individual to an ALP, a medical evaluation must be conducted to determine eligibility for admission and Medicaid reimbursement. Each medical evaluation shall be a written and signed report from a physician. Reassessments must be conducted at least once every six months thereafter. 18 NYCRR 487.4(d-f) [now (f-h)]; 494.4(f-h).

DISCUSSION

During the period under review, the Appellant operated an adult home in the Bronx with over 300 beds, which included a 160-bed assisted living program approved to provide Medicaid reimbursable ALP services to residents. (Exhibit KK, page 2; Transcript, page 114.) The Appellant was paid by means of a daily rate for each Medicaid eligible ALP resident. For the two-year audit period, the Appellant was paid well over $8 million by the Medicaid Program for 107,608 per diem claims for ALP services. Payments for each per diem claim varied between $69 and $114 based upon the resident's assessed level of care needs. (Exhibit 12a.) The OMIG's audit disallowances were made because the OMIG determined that claims were paid for services not documented to have been provided in accordance with applicable Medicaid requirements.

The OMIG's audit procedures included an entrance and a closing conference, followed by issuance of a draft audit report and a review of the Appellant's written response to it. The OMIG then issued a revised draft audit report and a notice of proposed agency

action and afforded the Appellant another opportunity to respond. After reviewing the Appellant's objections and additional documentation, the OMIG issued the final audit report and notice of agency action. The final audit report set forth the OMIG's conclusions and reasons for each category of disallowance, listed every disallowed claim, and identified the extrapolated overpayment amount. These documents were exchanged between the parties in compliance with procedures and requirements set forth at 18 NYCRR 515.6, 517.4, 517.5 & 517.6. (Exhibits 1-8.)

The OMIG gave notice of intent to audit within six years of the claims under review and commenced the audit within 60 days thereafter. The Appellant's retention obligation to maintain and produce records demonstrating its entitlement to payment was thereby tolled. 18 NYCRR 517.3(c). The Appellant asserts, however, that the OMIG's delay thereafter in completing the audit, issuing its audit report, and scheduling a hearing when requested, was unreasonable and violates due process, and that the notice of agency action and final audit report should be dismissed for that reason. (Exhibit KK; Appellant brief, pages 3-10; Appellant reply brief, pages 9-11.)

The audit period was 2006-2007. The audit commenced in 2008, and a draft audit report was issued in 2009. (Exhibit 4.) It is the subsequent delays of which the Appellant complains. After the 2009 draft audit report was issued and the Appellant objected to it (Exhibit A), the OMIG did not issue the revised draft audit report and notice of proposed agency action seeking a Medicaid Program exclusion until 2016. (Exhibits 6, 6a.) After the Appellant again submitted objections (Exhibits B, C), the final audit report and notice of agency action were not issued until 2019. (Exhibit 8.) The August 15, 2019 notice of agency action instructed the Appellant to submit its hearing request to the OMIG Office of Counsel within 60 days. (Exhibit 8, page 95.) The Appellant submitted its hearing request

on October 10, 2019 (Exhibit 9), but the OMIG, by its general counsel Janine Y. Daniels Rivera, did not issue a hearing notice until September 4, 2025. (OMIG brief, page 2.)

The OMIG is required to commence an audit within six years, but there is no time period provided in law or regulation within which an OMIG audit is required to be completed. The Appellant argues that the time taken in this audit was unreasonable. It cites various court decisions that dismissed administrative proceedings for undue delay (Exhibit KK, pages ii-iii; Appellant brief, page 4; Appellant reply brief, pages 10-11), but most did not involve the Medicaid provider audit process that explicitly provides for a stay of Medicaid provider document retention requirements and does not specify any period within which an audit must be completed. The pertinent reported decisions cited by the Appellant are those that involve Medicaid audits pursuant to 10 NYCRR 86-2.7 and 18 NYCRR 517.3. Cortland NH v Axelrod, 66 NY2d 169, 495 NYS2d 927 (1985) accepted a 10 year delay. Clearview Center v OMIG, 172 AD3d 1582, 100 NYS3d 724 (3rd Dept 2019) accepted 6 years. Blossom View NH v Novello, 4 NY3d 581, 797 NYS2d 370 (2005) involved an audit of PRIs, which the court distinguished from 10 NYCRR 86-2.7 and 18 NYCRR 517.3 audits of fiscal and statistical records and reports. The OMIG dropped its PRI audit in this case.

The Appellant also repeatedly cited Cattaraugus County NH v Axelrod, 107 AD2d 950, 484 NYS2d 366 (3rd Dept 1985), an Appellate Division decision that did enjoin administrative hearings and recovery of Medicaid overpayments on grounds of unreasonable delay in scheduling the hearings. (Exhibit KK, page, 11; Appellant brief, page 4; Appellant reply brief, pages 10-11.) The Appellant did not mention in any of its three citations of this decision that the Court of Appeals, citing Cortland NH v Axelrod, *supra*, modified the Appellate Division decision to instead direct the Department to hold hearings. Cattaraugus County NH v Axelrod, 66 NY2d 1022, 499 NYS2d 398 (1985). No

case cited by the Appellant upholds the dismissal or enjoinder of a timely commenced Medicaid audit for delay either in completing it or in scheduling a hearing.

Medicaid audits are about funds provisionally paid to providers that remain subject to post payment review once timely notice of an audit is given. 18 NYCRR 517.3. An audit is of the contemporaneous documentation required to be maintained by the provider to prove entitlement to the payments. Even in the absence of any audit, the Appellant was required to maintain the documentation to support its 2006-2007 claims until 2012-2013. Once an audit is timely commenced, the provider's obligation to maintain and produce that contemporaneous documentation continues. The provider either has the appropriate documentation or it does not, and passage of time is no excuse for a failure to maintain and produce it. The Appellant did, in fact, during the audit commenced in 2008 and thereafter in its January 2010 and March 2016 responses to the draft audit findings (Exhibits A, B, C), and again at this hearing, produce voluminous records to support its objections to the findings and to refute proposed disallowances. The Appellant also admits "Bronxwood does not claim prejudice resulting from any missing documents in its own files." (Appellant reply brief, page 10.) The Appellant's complaints about "substantial prejudice to Bronxwood's ability to fully respond to the findings" are unpersuasive. (Exhibit KK, page 8; Appellant brief, pages 3-11.)

The OMIG did not address or attempt to explain the six year delay between its issuance of the draft audit report and revised draft audit report, or the further six year delay before its counsel's office scheduled this hearing. The OMIG's audit supervisor Mr. Greco only said, upon being directly questioned about the delay from 2009 until 2016, that "we have to eliminate fraud." (Transcript, page 383.) This explains nothing. The OMIG counsel's office offered no excuse or explanation, other than to allege "failed settlement

discussions" (OMIG brief, pages 2-3), for the six more years it took to schedule this hearing after receiving the request.

The OMIG is hardly to be applauded for taking fifteen years to complete this audit and schedule an administrative hearing. In particular, the six years that passed between the October 10, 2019 request for and the September 4, 2025 scheduling of a hearing is unexplained. On the other hand, there is no evidence that after obtaining a court ordered stay of recoupment and censure pending the exhaustion of this administrative appeal (Exhibit 10; Transcript, pages 10, 18), the Appellant raised any objections about not getting a hearing while those six years passed. The Appellant did not dispute or object to the OMIG's allegation that there were instead "years of failed settlement discussions" with counsel who has represented the Appellant at least since its 2010 response to the draft audit report. (OMIG brief, pages 2-3.) Bare complaints that the Appellant's "ability to operate has been fundamentally impaired" by the delay and that it was "left... in perpetual financial limbo regarding over $4.4 million in reimbursement" (Exhibit KK, pages 10-11) make a convenient but hardly convincing argument, as it was only after the OMIG did schedule this hearing in 2025 that the Appellant, by counsel who has been representing it in this matter since at least December 1, 2009 (Exhibit A, tabs 3&4), resumed its complaint about delay.

The Appellant has failed to establish that, as a matter of law, this administrative proceeding must be dismissed because of the delay. The Appellant was timely advised of its obligation to retain its records to substantiate its claims to the Medicaid payments it received. A continuation of that obligation until the audit process was completed is explicitly authorized under state regulations intended to hold providers accountable for demonstrating entitlement to the public funds they receive. The censure and collection of overpayments was stayed by court order in 2020 pending this appeal. (Exhibit 10;

Transcript, page 10.) There is no evidence that the Appellant raised any other concerns about delay after it requested this hearing until after it was scheduled. The OMIG may be responsible for delay in fulfilling its mandate to protect public funds and recover Medicaid Program overpayments, but that delay does not excuse the Appellant from its responsibility to demonstrate entitlement to the Medicaid payments under audit.

The OMIG audit sample findings

The audit disallowances are organized into six finding categories and listed in exhibits attached to the final audit report. The findings remaining at issue are:

1. Missing/Invalid Signature on Medical Evaluation.

OMIG withdrawals at the hearing left 56 claims disallowed in this finding category on the grounds that the resident record did not contain a valid physician's signature on a medical evaluation or interim assessment covering the date of the claim.[2] The OMIG's post hearing brief then dropped without explanation two more claims (samples 115 and 139) from its list of disallowances still at issue. (OMIG brief, page 5.)

A medical evaluation (form DSS 3122 or an approved substitute) that includes a physical examination by a physician is required for admission to an adult home. 18 NYCRR 487.4(d-f) [now (f-h)]. Reassessments of ALP residents, which use a different form, are also required to be completed no less frequently than once every six months. 18 NYCRR 494.4(h). OMIG auditors found during the audit that medical evaluations and six-month interim assessments, all purportedly signed by Dr. Owen Golden, appeared to have been signed in several different hands.

[2] Samples 2, 4, 29, 32, 34, 40, 45, 49, 53, 56, 59, 66, 67, 73, 78, 82, 84, 87, 91, 93, 95, 97, 102, 111, 113, 115, 116, 118, 124, 134, 138, 139, 145, 152, 154, 156, 166, 167, 168, 169, 172, 173, 174, 175, 176, 177, 178, 179, 180, 184, 185, 186, 187, 188, 189, 198.

Upon further inquiry at Goldencare, it was determined that none of these documents had been signed by Dr. Golden, who also denied seeing any of the residents. (Exhibit 14b.) Many had been signed by other physicians in his practice, who saw Bronxwood residents and signed evaluations with his name rather than their own. (Transcript, pages 118-122.) The revised draft audit report disallowed 133 claims on the grounds that evaluation and assessment documents were signed with Dr. Golden's name but the residents were not seen by him nor did he sign the documents. (Exhibit 6, page 62.)

The OMIG subsequently withdrew disallowances where another physician at Goldencare acknowledged signing Dr. Golden's name. (Transcript, pages 122, 139, 181, 257.) The 84 disallowances in the final audit report were of claims for which no physician at Goldencare acknowledged, when interviewed, signing the medical evaluation or assessment covering the claim service date. (Transcript, pages 182-184.)

At the hearing, the OMIG then withdrew an additional 28 disallowances because it accepted that the signatures, although not explicitly acknowledged by a physician in Dr. Golden's office, were "close" to and "kind of looked like" signatures it had allowed for other sampled claims. (Transcript, pages 188-189.) The remaining 56 disallowances, then, are because the signature on the relevant form was not perceived by OMIG to be "close" to or "kind of" look like a signature that it accepted as having been signed by another physician at Goldencare.

As late as the second day of and even after this hearing, the OMIG was still wavering on the question what signatures it would accept as valid. On the second hearing day it withdrew the disallowance of sample 33 on the basis of documentation that the Appellant had submitted in 2016 with its response to the revised draft audit report. (Transcript, pages 343-346; Exhibit B attachment 11.) The 2016 response to the revised draft audit report also produced a signed medical evaluation that covered the service dates

in samples 115 and 139, which involved the same resident. Mr. Greco, the OMIG audit supervisor, acknowledged upon being shown the evaluation: "I couldn't argue that is an error." (Transcript, pages 348-351; Exhibit B, attachment 14.) Even so, the OMIG said it would "reserve decision" on withdrawing these disallowances with which its own audit supervisor testified he disagreed. (Transcript, page 349.) Its post hearing brief then simply dropped, without explanation, samples 115 and 139 from its list of disallowances. (OMIG brief, page 5.)

The OMIG auditors had reason to question these signatures. They are in several different hands and many are clumsily executed. Many were dated several weeks or more after the date the patient was ostensibly examined.[3] Dr. Maniego, one of the Goldencare physicians, told OMIG auditors that "Bronxwood would have the Medical Evaluations ready for him based upon previous visits and he would sign the forms for the people he had seen." (Exhibit 14e.) The auditors had reason to refer their initial audit findings to the OMIG Division of Medicaid Investigation (DMI), which then investigated and eventually issued notices of agency action charging unacceptable practices by four physicians at Goldencare. (Exhibit 6a, page 82; Exhibit 8, page 90; Exhibits X-BB.)

What is missing from either the OMIG audit or the DMI investigation and notice of agency action against this Appellant, however, is evidence that Bronxwood knew or was complicit in the execution of invalid physician evaluations and assessments issued by Dr. Golden's office. In its 2010 response to the draft audit report, the Appellant flatly stated:

> Bronxwood has no knowledge of and is not aware of any medical evaluation forms falsely reporting that a physician examined a Bronxwood resident... Bronxwood was not aware whether the residents were being seen by Dr. Golden or other physicians in his group practice... The Goldencare Doctors' practice of signing the

[3] For example, Sample 49, Exhibit L page 811, Transcript page 314; Sample 66, Exhibit OO page 676, Transcript pages 317, 380; Sample 156, Exhibit 13 page 1188, Exhibit B attachment 20; Sample 118, Exhibit B attachment 15; Transcript page 380.

> medical evaluations on behalf of Dr. Golden was done without Bronxwood's knowledge or consent. (Exhibit A, pages 12, 18-19.)

The OMIG's June 3, 2010 review of that response (Exhibit J) simply did not address this contention, nor has the OMIG addressed it in this hearing.

While the documentation may be questionable, and Bronxwood obviously had an interest in having residents readily certified as eligible for Medicaid claims for its services, there is no direct evidence that Bronxwood knew about or colluded with Dr. Golden's office in the issuance of invalidly authorized medical reports. Consequently, the OMIG offered no good, evidence-based reason to conclude that the Appellant knew or should have known that any of these documents received from Goldencare did not comply with regulatory requirements for ALP admission and retention. 18 NYCRR 487.4(f) [now (h)].

The only regulation relied on by the OMIG for this finding that was applicable during the audit period requires: "Each medical evaluation... shall be a written and signed report from a physician." 18 NYCRR 487.4(f) [now (h)]. The regulation does not say the signature, name signed, and evaluation must all be by the same person, and does not specifically say it must be signed by the physician who did the evaluation and not by another physician or someone on that physician's behalf.

Other authorities cited and relied on in the final audit report are inapplicable to this audit. The 18 NYCRR 488.4 requirement that a medical evaluation must be "written and signed by a physician," applies to Part 488 enriched housing programs, not Part 494 ALPs. Department "Dear Administrator Letter" DAL 14-10, stating "the resident's physician... will sign the physician certification," and DAL 14-12, stating the medical evaluation "must continue to be signed by a physician," were issued in 2014, seven years after the audit period ended.

The OMIG itself eventually withdrew its proposed disallowances for reports that other physicians acknowledged having signed with Dr. Golden's rather than their own names, and even ultimately withdrew disallowances of signatures that looked "close enough" even though no physician or anyone else in Dr. Golden's office acknowledged them. In its post hearing brief, the OMIG then returned to arguing the inconsistent position that none of the 133 claims disallowed in the revised draft audit report was entitled to payment, including the 79 disallowances for evaluations admittedly not signed by Dr. Golden but nevertheless subsequently withdrawn by the OMIG:

> Since there are multiple signatures for Dr. Golden that were signed by different physicians, the Appellant's medical evaluations and interim assessments did not contain information that its "true". By failing its duty to provide "true" information, that Appellant was not therefore entitled to receive payments for these claims. (OMIG brief, page 8.)

As the Appellant points out, laws and regulations can be quite clear and specific when their intent is to require that a physician's authorization be evidenced by a personally affixed signature. (Appellant brief, page 20.) The OMIG did not meet its burden of establishing the existence of a law, regulation, or generally accepted medical practice that was violated by the Appellant's reliance on these evaluations. 18 NYCRR 519.18(d).

The OMIG repeatedly interviewed all five physicians in Dr. Golden's practice, inspected his charts, and reviewed his Medicare and Medicaid billings. (Exhibits 14a-f; Exhibits Q, R; Exhibit 13, for example pages 541, 582.) The OMIG was unable to confirm from these records that some residents in the sample had been seen by Goldencare or billed to Medicare or Medicaid on the dates of purported evaluations. This alone does not justify the disallowances in this audit, because it was the Appellant, not Goldencare, that was under audit. Goldencare's alleged failure to keep records or bill for patients is not the Appellant's responsibility. If Goldencare issued evaluations of patients who had not been properly examined that is also not chargeable to the Appellant unless there is some reason

to believe it knew or should have known of it. As Mr. Greco repeatedly said: "We weren't doing an audit of Dr. Golden... We were not auditing Dr. Golden. We were auditing Bronxwood." (Transcript, pages 284, 374.)

Nowhere in any of the information gathered by the OMIG from Dr. Golden's office and presented at this hearing is there an indication that anyone from that office disavowed Goldencare as the source of the signed evaluations relied on by the Appellant. Nowhere does Dr. Golden's office or anyone else accuse the Appellant of having concocted or signed evaluations or allege that the evaluations it relies on were not provided to it by Goldencare.

Three physicians at Goldencare, Dr. Bressner, Dr. Chang and Dr. Maniego, told OMIG auditors that they did examine Bronxwood residents and sign evaluations with Dr. Golden's name. (Exhibits 14c-14e; Exhibits Q, R.) Under threat of a three-year exclusion from the Medicaid Program, they entered into settlements with the OMIG in which they admitted signing Dr. Golden's name without his knowledge or instruction. In return, the proposed exclusions were reduced to a censure for Chang and Maniego, and no sanction was imposed on Bressner. (Exhibits Z, AA, BB.) None of them alleged, nor did Dr. Golden or Dr. Escobar, a fifth physician associated in the practice, allege that Bronxwood, not Goldencare, was responsible for the execution of the evaluations and assessments or that Bronxwood personnel signed them.

What is missing from the OMIG investigation is evidence that the OMIG even looked for, let alone obtained any evidence that Bronxwood, as distinguished from Dr. Golden's office, knew or should have known that evaluations might be invalid. The OMIG presented no evidence that during the audit, or during the six years between issuance of the draft audit report and issuance of the revised draft audit report and, for the first time, a proposed notice of agency action charging unacceptable practices, it investigated Bronxwood personnel to determine whether anyone at Bronxwood knew of, should have

known of, or colluded in the production or execution of the questioned evaluations. It presented no evidence of any attempts to identify any of the Appellant's staff who might have known how these evaluations were created and transmitted to the Appellant.[4]

The OMIG presented no evidence, furthermore, of any inquiry into the residents who were the subjects of these evaluations to determine whether there were any discrepancies between the evaluations and the residents' actual conditions that might suggest they were not properly evaluated or were otherwise ineligible for ALP placement.

There may be reason to suspect that invalidly signed medical documentation issued by Dr. Golden's office was being created by someone. The issue is whether the evidence indicates the Appellant participated in, knew of, or should have known of this. The Appellant's obligation was to create and maintain its own records to support its Medicaid claims. Dr. Golden's office was a separate entity from Bronxwood, with separate Medicaid provider status and documentation obligations, that simply leased space there. (Transcript, page 120; Exhibit W.) The OMIG has not established or even suggested that either Dr. Golden or Goldencare was an affiliate of Bronxwood within the meaning of 18 NYCRR 504.1(d)(1).

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[4] In a 2019 administrative hearing decision reviewing charges that Dr. Golden engaged in unacceptable practices, the ALJ noted that Drs. Chang, Maniego and Bressner all "reported to OMIG auditors and investigators that Bronxwood personnel, particularly a receptionist named '[redacted] and/or a nurse named '[redacted]' gave them the forms and/or instructed them to sign Dr. Golden's names on the forms, yet it appears that OMIG did not follow up on this *[citations omitted].*" Owen Golden, MD and Owen Golden, MD PC (08-F-3711, DOH hearing decision issued September 12, 2019, pages 10-11). The OMIG's evidence at this hearing did not even include this allegation, let alone evidence that it was investigated. Instead, the OMIG's post hearing brief quoted the earlier decision but left out the words "yet it appears that OMIG did not follow up on this." (OMIG brief, page 20.)

It is also noted, however, that this previous administrative hearing decision plainly has not, as the Appellant would have it, "dealt a devastating blow to OMIG's position by reversing OMIG's attempt to exclude Dr. Golden." (Exhibit KK, page 7.) A finding that Dr. Golden did not engage in unacceptable practices in no way precludes a finding that the Appellant engaged in unacceptable practices. (Exhibit KK, page 16; Appellant reply brief, pages 12-13.) If anything, it throws suspicion back on the Appellant, a conclusion which the prior hearing decision (page 11) suggests.

According to the OMIG: "Since Bronxwood had no knowledge of who signed the forms or who the residents were being seen by, the Appellant failed to prove that the disallowed samples had a valid signature." (OMIG brief, page 8.) The Appellant has the burden of proving entitlement to its Medicaid billings, but this burden does not reasonably include proving it investigated and verified every signed evaluation it received from a physician's office, which appeared to be valid, and proving a negative - that it was not invalid; or later proving another negative – that the ALP did not know it was invalid.

The Appellant received the evaluations and assessments at issue in this finding category from Goldencare, and the Appellant maintained and produced them for audit. The OMIG presented no evidence upon which it can be concluded that Dr. Golden's office was not responsible for the documents it provided to the Appellant, nor did Dr. Golden's office deny that it was responsible for them. It is unreasonable to hold the Appellant responsible in the absence of some reason to conclude that it knew or should have known it was not entitled to rely on the documentation provided by that physician's office.

It is noted that the OMIG moved from a proposed three-year exclusion in 2016, which would likely be appropriate for an ALP that was fabricating or colluding in the creation of invalid medical evaluations, to a censure in 2019, to the dropping at this hearing in 2025 of any sanction for unacceptable practices. This trajectory is hardly consistent with an OMIG determination that the Appellant participated in or knew about the production of invalid medical evaluations and assessments. It is consistent, instead, with absence of any evidence-based reason to conclude the Appellant did know about or participate in it.

For the sample claims disallowed in this finding category, the Appellant produced for audit the evaluations and assessments it was required to maintain. The OMIG has failed to explain how or why it should be concluded that Bronxwood knew or should have known

these documents, provided by an unaffiliated physician's office, were invalid. The disallowances in this finding category are reversed.

2. Missing Plan of Care.

ALP services must be provided in accordance with a written plan of care in effect for the date on which the services were provided. SSL 461-l(2); 10 NYCRR 766.3; 18 NYCRR 494.4(c). In 13 instances pertaining to five residents, the Appellant's record did not include a plan of care in effect for the claimed date of service. (Samples 8, 12, 74, 75, 76, 77, 79, 80, 81, 88, 89, 149, 186.) The Appellant did not dispute these disallowances and they are affirmed. (Transcript, pages 210-212.)

3. Missing Medical Evaluation.

The OMIG disallowed samples 3 and 13 on the grounds that required medical evaluations covering the dates of service were not produced. (Exhibit 13, pages 565-572, 635-640; Transcript, pages 215, 217-221.)

Regarding sample 13, a six-month interim assessment covering the date of service was documented, but the OMIG rejected it on the grounds that an annual medical evaluation, for which a different form is used, did not also cover the date of service. (Exhibit 13, page 642; Transcript, pages 303-305.) The audit report cited 18 NYCRR 487.4(d-f) [now (f-h)] and 488.4(e)(1) [now (f)(1)] for this requirement.

18 NYCRR Part 487, which applies to adult homes, and Part 494, which applies to assisted living programs, require a medical evaluation be conducted as a condition of admission. 18 NYCRR 487.4(d-f) [now (f-h)], 494.4(g). Neither regulation, however, explicitly requires annual medical evaluations. Section 487.4(f) [now (h)] mentions "required annual evaluations," not "annual evaluations are required," leaving unspecified when they are required. 18 NYCRR 494.4(h) and 505.35(h)(4), which specifically apply to assisted living programs, require "reassessment" at least once every six months but do

not mention an additional requirement of a separate annual medical evaluation. Section 494.4(c) also requires "periodic assessments," not annual evaluations.

In its post hearing brief (page 11), the OMIG relied entirely on 18 NYCRR 488.4(e)(1) [now (f)(1)]. This regulation does require a yearly medical assessment, but it was not shown to be applicable to this Appellant. As the audit report states:

> An Assisted Living Program ("ALP") is an entity approved to operate, pursuant to 18 NYCRR Section 485.6(n), in adult homes and enriched housing programs. (Exhibit 8, page 102.)

Section 485.6(n)(1)(i) requires an assisted living program to possess or be eligible for an adult care facility operating certificate. Section 485.6(n)(5)(i) goes on to require that an assisted living program must have "documentation of existing certification or application for certification as either an adult home or enriched housing program." An assisted living program, then, is operated by an adult care facility but not necessarily by an enriched housing program. The OMIG offered no evidence that the Appellant had certification as a Part 488 enriched housing program rather than a Part 487 adult home, yet the audit report cites and the OMIG's brief relies for the disallowance of sample 13 on 18 NYCRR 488.4, a regulation that applies to enriched housing programs.

A November 2, 2005 six-month interim assessment covered the February 23, 2006 sample 13 date of service. (Exhibit 13, page 642.) The regulations cited by the OMIG do not state a separate ALP requirement that an annual "medical evaluation," in addition to this "periodic assessment" also cover the date of service. ALP Provider Manual Policy Guidelines also simply require ALPs to reassess residents every six months without mentioning separate annual medical evaluations. (Exhibit 15.)

Regarding sample 3, the Appellant did not produce any medical evaluation or six-month assessment covering the date of service. (Transcript, pages 217-218.) 18 NYCRR

494.4(h), as well as the Provider Manual Policy Guidelines, require assisted living programs to conduct a reassessment at least once every six months.

The disallowance of sample 13 is reversed. The disallowance of sample 3 is affirmed. The OMIG withdrew its disallowance of sample 132 at the hearing. (Transcript, pages 14, 216.)

4. Missing Service Documentation.

In two instances (samples 11, 153), the Appellant did not produce any documentation that ALP services were provided to the resident on the date claimed. (Transcript, pages 223-24, 229.) The OMIG withdrew its disallowance of sample 110 (also withdrawn in finding category 1) at the hearing. (Transcript, pages 252-253.) The disallowances of samples 11 and 153 are affirmed.

5. No Service Rendered.

In two instances pertaining to two residents (samples 37, 38), the Appellant's aide activity sheets for the claim date did not document that home care services identified as required on the resident's plan of care were provided. (Transcript, pages 230-232, 237; Exhibit 13, pages 711, 722.) The Appellant argues that in order to justify these disallowances it was incumbent upon the OMIG to produce the plans of care in question to prove what services were required and not provided on the date of service. (Appellant brief, pages 34-35.) The OMIG met its responsibility by presenting the audit file and explaining its findings. 18 NYCRR 519.17. The burden was on the Appellant to maintain and produce documentation to support its claims. 18 NYCRR 517.3(b), 519.18(d). It has failed to either produce the plans of care to confirm that all required services were provided or identify where those plans can be found in the audit file. The disallowances are affirmed.

6. Invalid/False Service Documentation.

In one instance (sample 100), service documentation entries for toileting were made by an employee who was not at the facility on [redacted], 2007, the date for which a per diem claim was submitted. Appellant timesheets document the employee was absent that day. (Exhibit 13, pages 1012-1015; Transcript, pages 124-126.) The disallowance is affirmed.

False documentation created and maintained to support a claim is an unacceptable practice in the Medicaid Program. 18 NYCRR 515.2(b)(2). The Appellant's suggestion (reply brief, pages 13-14) that it is entitled to payment because it unknowingly relied on false documentation created by its own employee is meritless. The Appellant submitted the claim and received the payment from the Medicaid Program. It is difficult to imagine how a Medicaid provider could ever be held responsible for overpayments based on improperly documented claims as long as it asserts: "It wasn't my fault, one of my employees did it." The disallowance of the full amount of a claim for which false documentation was created, maintained, and produced for audit is appropriate.

The Appellant suggested that at least a partial rather than full disallowance of a per diem claim should have been considered if some services were provided on the date in question. (Transcript, page 156; Exhibit A, pages 32-33; Exhibit B, page 27; Appellant brief, page 35.) Each claim reviewed in this audit was one indivisible per diem claim, separately billed and paid for the services required under a plan of care for that date. Disallowance of the full amount of each per diem claim for which the Appellant failed to demonstrate its entitlement to payment is a reasonable and appropriate method of determining the overpayments.

Unacceptable Practices

The Appellant failed to maintain and make available for audit records necessary to fully disclose the medical necessity for and the nature and extent of medical care, services and supplies provided. It presented a false statement in support of a claim. It failed to document care for which it submitted claims and failed to document required plans of care and medical evaluations. These constitute unacceptable practices as defined at 18 NYCRR 515.2(b)(2)&(6).

The OMIG seeks restitution of overpayments that are attributable to these unacceptable practices but has withdrawn the imposition of any Medicaid Program sanction, such as the exclusion subsequently reduced to censure set forth in the proposed and final notices of agency action. The Appellant's claim that "OMIG completely abandoned the NOAA" by withdrawing the censure is, however, false. (Appellant brief, page 35.) The OMIG did not withdraw or "abandon" the notice of agency action (NOAA) simply because it dropped the sanction. Part 515 regulations clearly provide that restitution is not a sanction, but rather an additional remedy available to the Department when overpayments are identified as having been made as a result of unacceptable practices. 18 NYCRR 515.3(b), 515.9. As no 18 NYCRR 515.3(a) sanction is sought, the six 18 NYCRR 515.4 guidelines to be considered in the imposition of a sanction are irrelevant to this hearing, but recovery of overpayments made as a result of the unacceptable practices remains appropriate. A finding of unacceptable practices with no recommendation of a sanction is also entirely appropriate. In any event, the OMIG is also entitled to recover these same overpayments pursuant to its Part 517 final audit report, to which Part 515 is inapplicable.

Medicaid Program overpayments

The 200 claim audit sample was selected from an audit frame of 107,608 claims that the Department's computer billing and payment records show were paid by the Medicaid Program during the two-year audit period. The Appellant did not challenge or offer any evidence to rebut the presumption of accuracy to which these records are entitled. 18 NYCRR 519.19(f).

The Medicaid Program employs a pay first and audit later process which ensures providers receive prompt payment of their claims. In return, providers are required to produce proof of their entitlement to payment when requested on a subsequent audit. The provider's obligation to fully and properly document its entitlement to payment and to produce that documentation for audit goes to the heart of the Department's ability to oversee expenditures in this government funded program. It is entirely reasonable and appropriate to hold providers to that obligation, and Department regulations specifically authorize the recovery of payments not supported by adequate documentation. The OMIG is entitled to recover the identified overpayments. As the Appellant's response to the notice of proposed agency action (Exhibit C) did not raise any issue regarding the determination to impose interest on the overpayments pursuant to 18 NYCRR 518.4, that issue is not reviewable in this hearing. 18 NYCRR 519.18(a).

Statistical sampling and extrapolation

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 certification was submitted in the form of written statements from its statistical consultant, Dr. Karl Heiner and from Krysta Bryk, the OMIG employee who verified the assembly of the Department's computer billing and payment records to

produce the audit frame and sample in accordance with Dr. Heiner's sampling plan. (Exhibits 11, 12.) The revised draft and final audit reports set forth the manner in which the extrapolation was made and identified the disallowed claims and audit frame to which they were extrapolated. Statistical sampling and extrapolation is authorized by the Department's regulations and its use has consistently been upheld by the courts, including the New York Court of Appeals. Mercy Hospital v NYS DSS, 79 NY2d 197, 581 NYS2d 628 (1992); West Midtown Management Group v NY, 31 NY3d 533, 81 NYS3d 343 (2018); Yorktown Medical Laboratory v Perales, 948 F2d 84 (2nd Cir 1991).[5]

The Appellant presented Dr. Warren Bilker to testify about the extrapolation method used in this audit, and Dr. Heiner then testified in rebuttal. The OMIG used a stratified sample, in which the audit frame was divided into nonoverlapping subpopulations, or 'strata,' and an independently drawn sample was taken from each. Dr. Bilker did not criticize the overall sample size of 200 claims. (Transcript, page 42.) His criticism concerned the OMIG's allocation of the 200 claims to eight strata. His opinion was "the allocation to the strata is – I don't think it's appropriate... It is the allocation to different strata that I think produces an invalid audit." (Transcript, pages 41-42.)

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[5] Additional reported decisions affirming the 18 NYCRR 519.18(g) extrapolation methodology include: Harry's Nurses Registry, 236 AD3d 1338, 229 NYS3d 735 (4th Dept 2025); David Wegman d/b/a Angels in Your Home v DOH, 229 AD3d 862, 215 NYS3d 562 (3rd Dept 2024); Beth Israel Medical Center v OMIG, 221 AD3d 446, 198 NYS3d 64 (1st Dept 2023); Sarfo v Glass, 243 AD2d 824, 663 NYS2d 894 (3rd Dept 1997); Tsakonas v Dowling, 227 AD2d 729, 642 NYS 2d 342 (3rd Dept 1996); Lala v Dowling, 226 AD2d 933, 640 NYS2d 933 (3rd Dept 1996); Piasecki v DSS, 225 AD2d 310, 639 NYS2d 319 (1st Dept 1996); Polanco v DSS, 212 AD2d 443, 622 NYS2d 932 (1st Dept 1995); Kuchment v DSS, 222 AD2d 806, 634 NYS2d 849 (3rd Dept 1995); Enaw v Dowling, 220 AD2d 942, 632 NYS2d 715 (3rd Dept 1995); Lock v DSS, 220 AD2d 825, 632 NYS2d 300 (3rd Dept 1995); Enrico v Bane, 213 AD2d 784, 623 NYS2d 25 (3rd Dept 1995); Ghosal v Bane, 204 AD2d 215, 612 NYS2d 399 (1st Dept 1994), *lv denied* 84 NY2d 805, 618 NYS2d 6; Ogunkoya v DSS, 204 AD2d 122, 612 NYS2d 7 (1st Dept 1994); Newman v Dowling, 210 AD2d 552, 619 NYS2d 794 (3rd Dept 1994); State v Khan, 206 AD2d 732, 615 NYS2d 771 (3rd Dept 1994); Roggeman v Bane, 206 AD2d 622, 614 NYS2d 593 (3rd Dept 1994), *lv denied* 84 NY2d 809, 621 NYS2d 518; Adrien v Kaladjian, 199 AD2d 57, 605 NYS2d 33 (1st Dept 1993); Lalani v Bane, 199 AD2d 80, 605 NYS2d 48 (1st Dept 1993); Clin Path v DSS, 193 AD2d 1034, 598 NYS2d 583 (3rd Dept 1993); Metzies Shoe Brooklyn NY v DSS, 151 AD2d 675, 542 NYS2d 731 (2nd Dept 1989).

Dr. Heiner designed a stratified sampling plan for this audit because the OMIG asked him to do so:

> A. I do – I do stratified random sampling for them, when they feel that they have a case where the – or the pay claim amounts are – are very dispersed, very – very – very varied. And – and they would like to do stratified sampling to increase precision and then – and thus narrow the width of the confidence interval. Otherwise, they will – they will do simple random sampling using a program that I wrote for them. (Transcript, page 393.)

> A. ... the only time I do stratification for the OMIG was when the OMIG decides that -- that if they just use simple random samples that the paid claim amounts and subsequent disallowance amounts are so varied that the confidence intervals would be large. If you just did simple random samples. And so they would -- they would ask me to do stratified samples.
> Q. And that wasn't the case here. The -- the -- the claim amounts are pretty similar in -- in dollar, right?
> A. Yeah. So it's sort of strange that they would have wanted to do stratified estimates here. (Transcript, page 453.)

Dr. Heiner said the audit plan and program he prepared on the OMIG's request used "optimal allocation" rather than "proportional allocation" (Transcript, page 415) to devise a 200 claim stratified sample. The paid claim amounts ranged from $69 to $114, and his program originally came up with a plan for four strata divided into roughly $10 payment increments. Sample claims were then independently selected from each of the four strata. (Transcript, pages 403, 473, 499.)

It was only after Dr. Heiner created his sampling plan with four strata that he was instructed by OMIG, for reasons he was unable to explain, to further divide those four strata into eight:

> So – so – but so -- so I don't remember who – who then wanted to subdivide these four strata into cases that had no documentation and physical exams, and those who did. So the four became eight... The only difference is that the – the pay claims in strata 1 through 5 *[sic]* are what OMIG or some auditor OMIG thought didn't – didn't contain any record of physical exam. (Transcript, page 402.)

> THE HEARING OFFICER: So are you saying, Doctor, that when you originally divided this up into strata, you divided it up into four strata?
> THE WITNESS: Yes.

> THE HEARING OFFICER: And then OMIG came back to you and said we want to divide those into two sections?
> THE WITNESS: Yeah... They didn't indicate that they want -- they wanted to -- to -- to now redo the stratification, but they -- they wanted to separately look at these -- these two parts. And I don't know how they come up with the -- the indication of no physical exam doesn't have anything to do with anything I do. Somehow they know that or think they know that... The separating it into no physical exam indicated and -- and those that did was done after that... (Transcript, pages 403-404, 406.)
>
> A. The stratification really gave you the four strata. And then somebody, for some reason, I don't even remember this happening. They gave this – this other information about each of the cases. So some of the cases in strata 1 that remained in strata 1, and other ones got moved to strata 5, just based on –
> Q. And you did not perform a second – you didn't go back to scratch and start over with the stratification. When you now had eight variables, you just took the four, and you divided them, right?
> A. Yes. (Transcript, page 464.)

Dr. Heiner did not know what the "No Indication of Phys. Exam" variable meant, and so was unable to say how stratification by "No Indication of Phys. Exam" might matter for the purposes of identifying overpayments or extrapolating them to all paid claims:

> Well, I certainly don't know why they eventually wanted to separate out the – what they thought were cases where there was no evidence of physical exam. (Transcript, page 454.)
>
> Yeah, I was directed to separate out those. I don't know why. (Transcript, page 462.)

Dr. Heiner and Dr. Bilker agreed that stratification by amount paid can be an appropriate method in an audit seeking to identify overpayments. The revised draft audit report described payment amount as providing a "useful basis for the stratification of the universe as it is believed that the payment amount is correlated with the error amount." (Exhibit 6, page 70.) This audit report account of the OMIG stratified sampling methodology, however, did not even mention let alone explain the additional basis for stratification, "No Indication of Phys. Exam," which doubled the four strata based on payment amount to eight for an entirely different reason.

Simply doubling the strata from four to eight in this manner, according to Dr. Bilker, resulted in an inadequate allocation of claims in some strata. Dr. Bilker used the audit frame to calculate allocations for a 200 claim audit sample with eight strata based on both "optimum allocation" and "proportional allocation" methods. (Exhibit HH; Transcript, page 417.) The "optimum allocation" used a "Cochran formula," identified with the very statistical sampling authority cited and relied on by Dr. Heiner. (Exhibit 11; Transcript, pages 422, 448.) Dr. Bilker's two allocations were far more alike than either was to the very different allocation devised by the OMIG. (Exhibit HH; Transcript, page 93.)

Dr. Bilker pointed out that the OMIG's stratum five contained 34% of the claims in the audit frame (37,173 of 107,608 claims) but was represented by only 2.5% of the sample (5 of 200 sampled claims). Conversely in the OMIG's stratum four, 30% of the sampled clams (60 of 200 sampled claims) represented 8% of the frame (8,676 of 107,608 claims). Dr. Bilker's two allocation methods assigned 87 (43%) or 70 (35%) of the sample claims to stratum five, which represented 34% of the audit frame, and 6 (3%) or 17 (8.5%) of the claims to stratum four, which represented 8% of the audit frame. Several of the other strata in Dr. Bilker's two allocations among eight strata ended up with an insufficient number of claims (as low as 1 or 2) to be statistically reliable. (Exhibit HH.)

Dr. Heiner said the difference between his optimal allocation and Dr. Bilker's was that Dr. Bilker made the allocation on the amounts paid for each claim, which was known, while Dr. Heiner made his allocation on estimated error, or disallowance amounts, which are not known before the audit is conducted. (Transcript, pages 418-425, 455-456, 488.)

> Now, the – the trouble is, you don't know what those are ahead of time. So you – you have to, you know, you – you have to kind of – you have to kind of guess or estimate or something that will give you – that will give you zeros in – in the different strata, so you can get more reasonable estimates of the standard deviation. So – so what I did when I did this procedure that I described at first was to – was

> to guess that the Bronxwood would have approximately eighty percent correct cases, so that there'd be that many zeros and twenty percent not. (Transcript, pages 420-421.)

Dr. Heiner was not certain, however, that 80% was the actual error rate he used in this case. He did not retain any records, saying he had been directed by OMIG not to keep them:

> Q. Going back to 2008, do you know whether that version in 2008 included that baked in eighty percent correct?
> A. I would say it probably did. Okay. I don't have any documentation to show that, though... I used to keep all of the – all of the programs and all the results and all. But I'm not supposed to keep any of that stuff anymore. (Transcript, page 457-459.)

Upon Dr. Heiner's assumption as a "kind of guess" that 80% of claims were correctly paid, his "judgmental allocation of the total sample size of 200 resulted in stratum sample sizes of 20, 40, 60 and 80." (OMIG brief, page 32.)[6]

Dr. Heiner did not explain the method used or account for the subsequent reallocation of claims from four strata (20, 40, 60, 80 claims each) into eight (15, 30, 45, 60, 5, 10, 15, 20 claims each) in a way that consistently assigned three times as many sample claims to "No Indication of Phys. Exam" strata one through four (52,546 claims), than to the comparably sized strata five through eight (55,062) claims. He said "that wasn't part of the original stratification. And I would have to think about how to do it. Because you couldn't do it the way that I did it." (Transcript, page 467.)

Dr. Bilker testified, regarding the allocation of only 5 claims to stratum five "I have no idea how that [stratum five] arrived at 5... I tried to figure it out." (Transcript, page 55.) He could not, however, meaningfully review the allocation without "the output from

[6] Interestingly, Dr. Heiner's "judgmental allocation" using a 20% disallowance rate turned out to be nowhere near to any of the actual disallowance rates the OMIG determined at any time on audit: 137 of 200 sample claims (68.5%) were disallowed at the exit conference; 195 of 200 (97.5%) in the draft audit report; 174 of 200 (87%) in the revised draft; and 104 of 200 (52%) in the final audit report. (Exhibit 3, page 9; Exhibit 4, page 21; Exhibit 6, page 54; Exhibit 8, page 108.)

whatever program was used to determine the allocation." (Transcript, pages 41, 79.) In its March 2016 response to the revised draft audit report, the Appellant had requested:

> ... sufficient information to enable Bronxwood to reproduce the same extrapolation analysis... Bronxwood must, at least, have access to the spreadsheets and formulas that OMIG utilized so they can be tested for reliability. (Exhibit B, page 5.)

Dr. Heiner testified, however:

> Q. And what about the output that you're – you know, generated from your program for the allocation, would you have kept that?
> A. No, I would have just transmitted. I transmitted the outcome into the letters. (Transcript, page 457.)

The OMIG's reply brief, in addition to inaccurately quoting Dr. Heiner's testimony, misrepresents it to claim "the Appellant received the 'Output' data." (OMIG reply brief, page 6.) Dr. Heiner testified that his letters transmitted "the outcome," not "the output data," and the letters to which he referred are consistent with this testimony. They provide the formulae used to calculate overpayment point and interval estimates from the stratified sample and the resulting extrapolated overpayment, not "output data" and information about the program used to select and allocate the strata to begin with. (Exhibits F, G, H.)

Dr. Heiner acknowledged Dr. Bilker's point regarding the impact of an allocation of only 5 sample claims to stratum five, saying "well, it's valid, but they're right about the – the cases in the first and fifth strata being influential." (Transcript, page 503.) As a result of this allocation, 3 of 104 disallowed claims – all at the low end of the frame's $69-$114 payment range - were "influential" enough to account for $1,569,518.41, over one-third of the final audit report's $4,423,684 overpayment estimate. (Exhibit 8, page 118.)

Dr. Heiner himself, when he first devised his four strata sampling plan with sample sizes of 20, 40, 60 and 80 claims, had moved some claims from his original stratum two into stratum one because "I didn't – I didn't think below – I didn't think below twenty was enough." (Transcript, page 487.) When "[s]ubsequently, OMIG chose to separately

consider paid claims with no indication of a physical exam from those with an indication of physical exam" (OMIG brief, page 32) and directed Dr. Heiner to divide his four strata into eight, the result was not only to reduce stratum one to 15 claims but to also create strata with only 5 and 10 claims.

Dr. Bilker agreed that if there was a large variability within a stratum it might make sense to select a relatively large sample size for a relatively small stratum; or if the total payments in the stratum were small it might be appropriate to select a smaller sample size for that stratum. (Transcript, pages 60-61.) Neither of these scenarios fits the allocation scheme in this audit: Each stratum had a payment range of $10, a variance of roughly 10% with no "outliers," and the smallest sample sizes (7.5% & 2.5%) were allocated to the strata (one & five) with the largest total payments (32% & 30%). Stratum one had $2.7 million in payments for 38,754 claims and stratum seven had $42,000 in payments for 454 claims, but each had 15 sample claims allocated to it. (Exhibit HH.)[7]

Nowhere did Dr. Heiner or the OMIG explain how or why the OMIG chose to separately consider paid claims with "No Indication of Phys. Exam" and subdivide Dr. Heiner's four strata determined by payment amount into eight strata. (Exhibit 12b-2.) The OMIG did not offer any explanation of what "No Indication of Phys. Exam" even meant, how it was able to divide the frame in this manner, or why it mattered. As the Appellant pointed out (Transcript, pages 463-464), Bronxwood was not reimbursed for performing physical examinations, and it obtained its medical evaluations from outside physicians.

Mr. Greco, the OMIG audit supervisor who prepared the draft, revised draft, and final audit reports (Transcript, pages 164, 166-67, 171) and signed the revised draft and

[7] The OMIG's invocation of the hearing decision underlying David Wegman/Angels in Your Home v. DOH, *supra,* is inapplicable to this issue, as the OMIG's brief confuses and conflates a small number of claims in a disallowance finding category with a small number of claims in a stratum. (OMIG brief, page 28.)

final audit reports, testified "I have no idea" how the OMIG determined "No Indication of Phys. Exam" was the case in strata one through four or why it mattered. (Transcript, pages 375-376.) Mr. Greco testified that the use of a stratified sample was "not something I was involved in at the time" and that he did not have anything to do with the selection or allocation of the sample, which was "all done before I came in." The auditors' role was to compile the errors in the sample. (Transcript, pages 162, 241-242.) The OMIG did not explain who, given it was neither the auditors nor Dr. Heiner, decided to introduce "No Indication of Phys. Exam" and divide the audit frame into eight strata, or why.

Indeed, the completely unexplained category "No Indication of Phys. Exam" makes little apparent sense in relation to the audit findings: Physical examinations are a required component of medical evaluations. 18 NYCRR 487.4(f)(4) [now (h)(4)]. Yet in the final audit report, finding category 1, "Missing/Invalid Signature on Medical Evaluation," disallowed 56 claims in strata to which the audit plan gave the description "No Indication of Phys. Exam," while finding category 3, "Missing Medical Evaluation," contained only three disallowances among the 150 claims stratified under the description "No Indication of Phys. Exam." (Exhibit 8, pages 109-111; Exhibit 12b-2; Exhibit 20.)

Dr. Heiner testified he would not have designed the stratified sampling plan in the same manner if he knew OMIG would divide his four strata into eight by introducing the "No Indication of Phys. Exam" category "because Cochran would say that there's no point in doing more than five or six strata because its precision doesn't increase. So – so I would typically do four, and the fifth one... for large outliers." (Transcript, page 455.) "But there weren't any of those [large outliers] in this case." (Transcript, page 400.) Cochran, the authority both Dr. Heiner and Dr. Bilker invoked, reflects this view. William Cochran, Sampling Techniques (3rd ed. 1977), Chapter 5A.8 (Exhibit I.)

Dr. Heiner testified that instead of creating eight strata, as the OMIG instructed him to do after he designed a plan with four strata, he would have recommended a simple random sample because the variable of interest, the amount of each paid claim, was not wide enough to be of great concern given the size of the audit frame. All 107,608 claims were between $69.62 and $113.45, with no outliers:

> A. Are they -- should -- they should have just taken a random sample, or asked me to take a random sample, not a stratified sample. Because there's no -- the only – the only advantage for doing stratified sample is it tightens up the confidence intervals. But in this particular case, the confidence intervals for a random sample wouldn't have been much wider than the confidence intervals for stratified samples. (Transcript, pages 461-462.)

For an appropriate use of the "No Indication of Phys. Exam" variable, Dr. Heiner said:

> A. I've never done any -- any stratifications with these -- with these categorical -- categories provided by the auditor. So -- so what -- so what I would have done if, you know, if that's what they were interested in doing, is to take -- is to divide the population into these two different sorts of things. And then -- and then do the stratification on each one, maybe 100 cases, maybe 150 cases in each. (Transcript, page 468.)

Dr. Heiner's testimony did not fully support his written certification of the validity of the OMIG's statistical sampling method because he did not recommend, endorse or approve of the OMIG's allocation of the sample into eight strata. His endorsement of the final overpayment estimate was also equivocal. He said, "the estimates are not invalid. Well, the total estimate is not invalid. There -- there shouldn't be any estimates for each strata" (Transcript, page 413), yet estimates for each of the eight strata ($ disallowance in stratum ÷ stratum sample size × total number of claims in stratum), which he preferred to call "contributions," are precisely what are separately reported in the final audit report and in his own certification, and then added up to yield the total overpayment estimate for the audit frame. (Exhibit 8, page 118; Exhibit 11, page 152; Transcript, pages 435-440.)

The particular circumstances of this case present an unexplained stratification decision imposed on the OMIG's own statistical consultant that appears to be inconsistent

with his recommendations at the hearing; inconsistent with the very nature of the care under review; and which produces an allocation significantly at odds with the proportions in the audit frame. If there is some sound statistical basis for the OMIG's division of four strata into eight, the OMIG made no attempt to explain it and Dr. Heiner, whose certification OMIG relied on, explicitly denied understanding its purpose. The 18 NYCRR 519.18(g) presumption of accuracy in the overpayment determination has been overcome in this case by the evidence regarding these unexplained peculiarities in the stratification.

The amount paid for each sampled claim is set forth in the exhibits attached to the final audit report. (Exhibit 8, attachment C.) In accordance with the foregoing, 19 disallowances (samples 3, 8, 11, 12, 37, 38, 74, 75, 76, 77, 79, 80, 81, 88, 89, 100, 149, 153, 186) in the total amount of $1,650.89, are affirmed. All other disallowances, and the extrapolation, are reversed. A restitution claim in the amount of $1,650.89 is authorized under 18 NYCRR 518.1 & 518.3.

DECISION: The OMIG's determinations that the Appellant engaged in unacceptable practices and received Medicaid Program overpayments are affirmed.

The OMIG's determination to recover Medicaid Program overpayments from the Appellant is affirmed. The overpayment is in the total amount of $1,650.89.

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

DATED: Rochester, New York
January 27, 2026

John Harris Terepka
Bureau of Adjudication