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HTH's Comments and OSC's Responses

HTH's Counsel submitted a response to the Draft Audit Report that took issue with OSC's sampling and extrapolation methodology as well as the audit findings. HTH, however, did not provide OSC with a Corrective Action Plan (CAP) indicating the steps HTH will take to correct the deficiencies identified in the report nor did HTH address whether it would repay the identified overpayment. Set forth below are OSC's responses to each of HTH's objections. Upon review of HTH's objections, OSC did not find any basis to revise its extrapolation or audit results.

I.   Extrapolation

HTH's Comments: Poor Degree of Precision

"Estimation methodologies using statistical sampling require analysts to weigh the estimate's uncertainty to determine whether the conclusions are useful for their desired purpose.[1] Several measures are useful when evaluating a study's uncertainty. *Precision* reflects the range of accuracy related to an estimated amount, while *confidence* is the degree of certainty that the sample correctly depicts the population. Together, confidence and precision yield the *confidence interval*, a range of values within which the true population value is estimated to fall.

"In healthcare overpayment matters, precision levels from 5 to 10 percent are generally sought. However, the precision of MFD's analysis in this matter is significantly worse: 35 percent.[2] In addition to its overall precision, MFD also achieved extremely poor precision in each and every stratum. This is particularly problematic considering MFD's own stated objectives for achieving high precision in its sampling plan:

> *Used the 95% confidence, 5% precision (95/5) level or better in selecting sample sizes based on the examined values. Note: Selecting sample sizes at the 95/5 level does not guarantee each strata will achieve 5% precision. However, it does ensure the overall sample precision will be approximately 5% when estimating the total dollars in the universe.[3]*

"Instead of achieving its own goal, the actual precision of MFD's analysis in this case was dramatically higher than 5%, yielding distinctly imprecise conclusions. This imprecision

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[1] United States, Internal Revenue Service, Bulletin 2007-23, Sampling Plan Standards, 2007.

[2] MFD Spreadsheet, Data Provider Copy.xlsx, Recovery Summary tab.

[3] MFD Spreadsheet, Data Provider Copy.xlsx, Sampling Plan tab. Emphasis added.

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is highlighted by MFD's extremely large confidence interval (i.e., estimated range of overpayments) ranging from $1.5 to $3.3 million:

> *Using extrapolation, MFD can reasonably assert, <u>with 90% confidence,</u> that the <u>true overpayment in the universe falls between $1,506,618 and $3,261,647</u> with the most likely overpayment amount (i.e. error point estimate) as $2,384,132.55.*[4]

"In contrast to MFD's precision in this matter, most healthcare post-payment audits seek significantly lower (i.e., better) precision levels ranging from 5 to 10 percent, and RAT-STATS software (which MFD purportedly used) prepopulates with desired precision levels from 1 to 15 percent. Even guidance for OIG Corporate Integrity Agreements prescribes a maximum precision level of 25 percent.[5] The poor degree of precision in this case indicates a lack of technical rigor applied by MFD and a high degree of variability in MFD's analysis. It also indicates the inadequacy of the sample size chosen by MFD in this matter, since increasing sample size is generally the most effective technique for improving precision."

OSC's Response

HTH claims that precision levels between 5-10% generally are sought in healthcare overpayment matters, but does not provide any context or cite any source for this assertion. Moreover, HTH confuses the aim of seeking a precision level with the outcome of obtaining a precision level, which are two different elements. Finally, HTH does not address the central issue involving precision, which is what precision level is required to support an overpayment demand.

First, contrary to HTH's claim, there is no "industry standard" or statistical rule that establishes a 5-10% precision rate that would require OSC to alter the methodology utilized in this matter.

Second, HTH's claim that OSC did not meet its own stated objectives in the sampling plan is incorrect because HTH appears to confuse standard terminology in the audit industry. The Variable Appraisal Table below confirms that OSC met its stated objective, which was to "ensure the overall sample precision will be approximately 5% when estimating the total dollars in the universe." The total dollars in the universe is $16,092,741.69. By extrapolating the selected stratified random sample, OSC can reasonably assert, with 95% confidence that the total dollars in the universe falls between $15,252,392 and $16,313,067 (3.36% precision). Since OSC already knows the universe dollars, one can

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[4] MFD Spreadsheet, Data Provider Copy.xlsx, Recovery Summary tab. Emphasis added.

[5] U.S. Department of Health and Human Services, Office of the Inspector General, Corporate Integrity Agreement FAQs, CIA Claim Reviews. Available at https://bit.ly/2MertiD

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clearly see that it falls within the predicted range, thus, confirming that OSC's sample dollars are representative of the universe dollars, which was OSC's purpose as articulated in the Sampling Plan.

Third, although HTH discusses pre-populated precision levels in RAT-STATS, it fails to note that RAT-STATS offers the option to enter any desired precision level in conjunction with the standard 1-15% levels. Moreover, HTH's references to guidance from the Office of Inspector General (OIG) is outdated. The OIG's current frequently asked question (FAQ) section of its website does not include any precision level requirements for extrapolation. In fact, there is no statistically valid reason to establish an arbitrary precision level that must be exceeded prior to making a recovery.

Fourth, HTH maintains that OSC's process lacks "technical rigor" and that OSC chose an "inadequate sample size." OSC followed its well established and independently validated Sampling and Extrapolation process, which OSC developed through input from various sources, including an independent outside expert, subject matter experts from the Centers for Medicare and Medicaid Services (CMS), OIG, U.S. Government Accountability Office (GAO), and other State Medicaid Fraud Divisions. OSC is confident that its approach is robust, reliable, and reproducible.

Finally, with respect to HTH's claim that a larger sample size would increase precision, it is important to note that while that is accurate, it is also true that using a larger sample size would just as likely increase the identified overpayment and would translate into additional time and effort on the part of the provider and audit team. After weighing these factors, OSC has established a practical sampling approach that fairly and properly balances these factors.

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Variable Appraisal Table

OVERALL	POINT ESTIMATE / UNIVERSE	15,782,730	296,374
	STANDARD ERROR	270,585	
		CONFIDENCE LIMITS	
		80% CONFIDENCE LEVEL	
	LOWER LIMIT	15,435,961	
	UPPER LIMIT	16,129,498	
	PRECISION AMOUNT	346,769	
	PRECISION PERCENT	2.20%	
	Z-VALUE USED	1.281551565545	
		90% CONFIDENCE LEVEL	
	LOWER LIMIT	15,337,657	
	UPPER LIMIT	16,227,803	
	PRECISION AMOUNT	445,073	
	PRECISION PERCENT	2.82%	
	Z-VALUE USED	1.644853626951	
		95% CONFIDENCE LEVEL	
	LOWER LIMIT	15,252,392	
	UPPER LIMIT	16,313,067	
	PRECISION AMOUNT	530,337	
	PRECISION PERCENT	3.36%	
	Z-VALUE USED	1.959963984540	

HTH's Comments: Improper Use of Point-Estimate

"In reaching its conclusions regarding Heart to Heart's extrapolated overpayment amount, MFD based its overpayment demand on the point-estimate, stating the following:

> *Using extrapolation, MFD can reasonably assert, with 90% confidence, that the true overpayment in the universe falls between $1,506,618 and $3,261,647* <u>*with the most likely overpayment amount (i.e. error point estimate) as $2,384,132.55.*</u>[6]

"Here, MFD incorrectly contends that the point estimate is the most likely amount of overpayment. This characterization is untrue, and it suggests a limited understanding of probability theory. Selecting the point-estimate (or any value in a confidence interval) is not a probabilistic statement, and no value that lies within the confidence interval is *more*

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[6] MFD June 15, 2021, Draft Audit Report.

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likely than another to be the *true* overpayment value. The point-estimate is simply the convenient midpoint of the confidence interval and is therefore anticipated to over-assess the disallowance almost half of the time. This distinction becomes more significant as the level of imprecision in a particular analysis grows, since the confidence interval grows wider with increased imprecision and over-assessments may be even greater.

"In cases of poor precision such as this, the point-estimate is not the preferred estimate. Instead, the lower-limit of the 90 percent confidence interval is preferred in cases where adequate precision is not achieved. For example, CMS prefers the use of the lower-limit "in most cases" in post-payment audits since it "allows a reasonable recovery without requiring the tight precision that might be needed to support a demand for the point-estimate."[7] Similarly, the OIG's Statistical Sampling Toolkit for MFCUs states 'When the precision is poor, the uncertainty in the sample can often be managed through the use of alternate estimates such as the lower limit of a confidence interval.'[8]

"In this matter, the lower-limit of the 90% confidence interval is $1,506,618 using MFDs own calculations and without considering any of Heart to Heart's other arguments.[9]"

OSC's Response

HTH has taken OSC's use of the phrase "most likely overpayment amount" out of context and, using that improper context, tries to argue that OSC's extrapolation approach was flawed. OSC's use of this term is taken directly from the American Institute of Certified Public Accountants Audit Guide *Audit Sampling* (AAG-SAM). The AAG-SAM defines the point estimate as the most likely amount of the population characteristic based on the extrapolation of the sample results. It is also known as the likely misstatement or best estimate amount.

While there is no confidence in the point estimate itself, the calculation of this figure is derived from the average (i.e. mean) of the overpayment amounts. The mean is perhaps the most common and widely used measure of central tendency. The measure of central tendency gives a single number that is most representative of all of the data points. Therefore, when discussing the point estimate (an expansion of the average or mean overpayment amount) it is reasonable to say that the point estimate is OSC's most likely or best estimate of the total overpayment in the universe.

The provider incorrectly asserts that the probability of the point estimate over-assessing the total overpayment amount increases as the level of imprecision grows because the

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[7] Medicare Program Integrity Manual, 8.4.5.1.

[8] U.S. Department of Health and Human Services, Office of the Inspector General, Statistical Sampling: A Toolkit for MFCUs, September 2018.

[9] MFD Spreadsheet, Data Provider Copy.xlsx, Recovery Summary tab.

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probability never changes. The point estimate is always the mid-point, and therefore, is always just as likely to understate the overpayment amount as it is to overstate it.

The use of the lower bound is by no means an industry standard or a statistical requirement. Additionally, OSC is not bound by the CMS Medicare Program Integrity Manual (MPIM) or the OIG Sampling Toolkit. Both of these policies simply state their preferences regarding the use of the lower bound. Moreover, the OIG Sampling Toolkit states, in footnote 6, that "there is no bright-line statistical rule for how precise a sample needs to be to reasonably rely on the point estimate."

HTH's Comments: Lack of Scientific Rigor in Sample Size Determination

"MFD's sample size of 118 claims was determined without sufficient scientific rigor and RAT-STATS, a statistical sampling software, was used improperly leading to a non-representative sample selection and insufficient levels of statistical precision. In accordance with the CMS' MPIM, one of the 'major' steps of statistical sampling involves 'Performing the appropriate assessment(s) to determine whether the sample size is appropriate for the statistical analyses used.'[10]

"Despite the well-known risk of selecting a sample size that is too small to achieve valid results, MFD adopted a sample size of only 118 claims to estimate overpayments for a population totaling 296,374 claims (i.e., a sample of less than 0.040 percent). Had they carefully considered an appropriate sample size; they would have concluded that a much larger sample would be required to reach sufficiently precise conclusions in this matter.

"MFD's stated reason for choosing a sample size of 118 was reliance on RAT-STATS and its stratified sample size calculation module. MFD demonstrated that the calculation of sample size is determined using three variables: (1) desired confidence, (2) desired precision, and (3) standard deviation (i.e., variance). However, in its own analysis, MFD misapplied these variables. MFD calculated sample size using the standard deviation of the irrelevant claim payment amounts, as opposed to the more-appropriate standard deviation of the overpayment amounts (i.e., the actual variable of interest). MFD had relevant overpayment data from its probe sample, however seemingly failed to consider their own analysis and instead relied on less relevant payment data.

"In fact, MFD's probe sample provides meaningful data that should have been used in MFD's sample size calculations. Failing to do so ignores a basic purpose of probe samples – collecting initial data to make better-informed decisions about the sample design (including sample size). OIG and CMS specifically address the role of probe samples in developing sampling analysis and determining sample size. Also, RAT-STATS'

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[10] Medicare Program Integrity Manual, 8.4.1.3 (5).

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Unrestricted Sample Size module, which MFD failed to use, specifically utilizes the probe sample when determining sample size.

"Notwithstanding MFD's failure to consider its own probe sample, Heart to Heart recalculated an appropriate sample size by properly using RAT-STATS. Using MFD's own determinations for its probe sample of 46 claims, its own stratification criteria, and its own stated criteria for determining sample size (i.e., 95% confidence and 5% precision) **an appropriate stratified sample size would require a random selection of over 8,839 claims** (i.e., approximately 3 percent of the total universe).[11] Even when using the most aggressive values of confidence and precision available in RAT-STATS (i.e., 80% confidence and 15% precision) the calculated sample size for Heart to Heart's universe would be a **minimum sample size of 435 claims**.[12] Had MFD chosen an adequately sized sample, many of the issues described in this document (i.e. representativeness, precision, etc.) would have likely been avoided."

OSC's Response

HTH assails OSC's sample size, claiming it was too small. Contrary to HTH's unsupported position, it is firmly established that the size of the universe has little impact on the sample size, unless the universe is very small. Simply put, HTH's suggestion that the sample size used in this matter was too small because the universe is large is incorrect.

HTH also claims that OSC used the incorrect values to determine the sample size. This claim is baseless, as it is common industry practice to use the claim payment amounts (i.e. examined values) in the absence of the overpayment amounts (*See* AAG-SAM 4.28, p 59).

For this audit, the probe and full sample were selected simultaneously. The purpose of distinguishing the claims was to allow OSC to assess early in the process whether a review was necessary. Although it is possible to reassess the sample size based on the results of the probe sample, and then select additional claims (i.e. the full sample), it is not necessary to do so. Although HTH asserts that OIG and CMS do this with probe samples, OSC recently discussed the use of probe samples with CMS and CMS contractor statisticians and can confirm that CMS does not select probe samples.

The suggestion that OSC should have used the RAT-STATS Unrestricted Sample Size Module to re-calculate the sample size is misguided. "Unrestricted" refers to a simple random sample, when OSC selected a stratified probe sample.

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[11] Heart to Heart Re-Calculation of Stratified Sample Size with RAT-STATS.pdf.

[12] Heart to Heart Re-Calculation of Stratified Sample Size with RAT-STATS.pdf.

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The attempt to calculate alternate sample sizes in the provider's letter are exaggerated. As explained above, it is incorrect that OSC's desired confidence and precision is 95% and 5%, respectively.

In sum, there is no minimum sample size requirement in statistics or in this industry. The size of OSC's sample does not in any way invalidate OSC's findings.

HTH's Comments: Lack of Sample Representativeness

"This dramatic difference in sample size is not merely a theoretical issue. In a universe with high variability (i.e., heterogeneity) small samples risk failing to adequately capture subsets or characteristics of the universe, thereby misrepresenting an extrapolated estimate. In fact, that is precisely what occurred in this case. Even if MFD's limited sample size was determined to be technically sound, the sample of claims that was actually selected is not adequately representative of the universe from which it was chosen. Since characteristics of a sample will be used to infer characteristics of the broader population, a sample must be reasonably representative of the population to permit a valid extrapolation. If the sample chosen is not representative of the population, inferences about the population may be irreparably biased and invalid. Although selecting a sample randomly is anticipated to lead to a representative sample, it is not guaranteed, particularly when small samples are selected (such as this case).

"Nonetheless, MFD provided no evidence that it adequately addressed the representativeness of its own sample in this matter. More importantly, a diligent review of MFD's chosen sample instead suggests it is not representative of the population of claims at issue, and therefore insufficient for the purposes of making inferences (i.e., extrapolation) about the distinctly heterogeneous population. Had MFD properly selected a larger sample, it likely would have selected and examined many more of these ignored claims leading to a more representative and reliable sample."

OSC's Response

HTH states that OSC's sample is not representative, but fails to support its claim. To select a representative sample, the focus must be on the variable of interest. In OSC's case, the variable of interest is ultimately the overpayment amount. However, since that value cannot be determined until after the sample is selected, the claim payment amounts are a suitable substitute. Since the universe only consists of one procedure code, T1019, the primary variability comes from the entity that paid the claim and how many units were billed. OSC controlled for this variability by stratifying the dollars. Effectively, this grouped patients into three buckets: low, medium, and high volume of personal care services. Prior to requesting records, OSC used the variable appraisal module in RAT-STATS to ensure the selected sample accurately represented the dollars in the universe (*see* OSC's Response to Improper Use of Point-Estimate above).

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In regards to all other attributes and variables in the universe, the random selection of claims, a key factor of probability samples, is what accounts for their representation. Without controlling for these attributes/variables, the natural proportion that exists in the Universe should be similar to what is in the sample. This does not mean that everything will be exactly the same, nor is that required for a valid sample.

HTH's Comments: Extrapolation is Likely Impermissible

"In its audit letter, MFD evaluated a sample of 118 claims and identified a Claim Error Rate (i.e., the percentage of claims with any measurable deficiency) to be 16.1 percent. More meaningfully, MFD identified a Net Financial Error Rate in the sample (i.e., the percentage of payment amounts found in error) to be 12.95 percent.[13] Even if Heart to Heart's arguments disputing these identified errors were ignored, MFD's calculated error rates are insufficient to allow extrapolation in similar matters.

"Specifically, CMS authorities have ruled that error rates must exceed 50% in order to permit extrapolation, and extrapolations based on smaller error rates have been excluded in CMS administrative hearings citing 'the Provider error rate is below the threshold of 50% required to justify extrapolation.'[14] In fact, CMS states in its Medicare Program Integrity Manual ('MPIM') guidance on statistical sampling that 'For purposes of extrapolation, a sustained or high level of payment error shall be determined to exist through a variety of means, including, but not limited to: high error rate determinations by the contractor or by other medical reviews (i.e., <u>greater than or equal to 50 percent</u> from a previous pre- or post-payment review).'[15]

"In this matter, MFD has presented no evidence that Heart to Heart's error rate was sustained over any period of time, and based upon similar CMS decisions, Heart to Heart's error rate is also not "high" as contemplated by CMS. Consequently, extrapolation is likely impermissible for the purpose to estimating overpayments in this matter."

OSC's Response

HTH argues that extrapolation is not permissible because the error rate is below 50%, which HTH cites as the CMS "threshold" for extrapolation. OSC is not bound by the guidelines set forth in the CMS MPIM. Additionally, CMS's decision to apply a 50% error rate threshold is not an industry standard and, in fact, only applies to Medicare audits, which means that it is not relevant to this Medicaid audit. There is no basis, in statistics or in the audit industry, to require a 50% error rate in order to extrapolate.

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[13] MFD Draft Audit Report, dated June 15, 2021, page 1.

[14] QIC redetermination decision, dated June 1, 2017.

[15] Medicare Program Integrity Manual, 8.4.1.4.

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II.   <u>Audit Findings</u>

<div align="center"><u>HTH's Comments: Audit Finding A</u>
<u>HTH Failed to Verify the Professional Certification of an HHA</u></div>

"In the sample of 118, MFD found that one instance where an HHA did not have a current certification, because the HHA's temporary certification had expired. By extrapolation, MFD is stating that 1 out of 118 claims, or 0.85% of all claims by HTH involved an expired temporary certification. Said another way, MFD is claiming there were 2,512 instances within the pool of 296,374 claims where the claim was invalid due to an HHA's temporary certification being expired. It is doubtful that HTH employed any individuals with an expired temporary license, other than this particular HHA, so it is not appropriate to expand this single unusual occurrence into a pattern or trend."

<div align="center"><u>OSC's Response</u></div>

HTH's claim that "it is not appropriate to expand this single unusual occurrence into a pattern or trend" is misguided. First, HTH did not provide any additional documentation to support its claim that, other than the person OSC identified, it was "doubtful that HTH employed any individuals with an expired temporary license…." As such, HTH did not provide any factual basis for OSC to modify this finding. Second, it is extremely unlikely statistically that OSC found the only instance of an HHA who did not have a current certification from its review of 118 claims out of a universe of 296,374. For OSC to test HTH's belief that there are no other HHA's who did not have current certifications, OSC would have to review the remaining 296,256 claims. To do so would not only defeat the entire well-supported purpose of using statistically valid sampling and extrapolation protocols, but also require HTH to produce all of the necessary documentation regarding every PCA who worked for HTH and OSC to link that information to every claim in the net universe of claims. OSC would then have to review each such claim and perform the same analysis for license verification that it performed on the 118 sampled claims. The amount of time and effort that HTH and OSC would have to expend to complete such a process would overwhelm both parties. The only valid basis that HTH could put forward to revise this extrapolation result would be evidence demonstrating that OSC's finding was incorrect, which HTH did not provide. As such, OSC will not modify this finding.

<div align="center"><u>HTH's Comments: Audit Finding B</u>
<u>HTH Failed to Perform Timely In-Home Evaluations</u></div>

"MFD alleged 14 instances where a claim fell outside a range within 60-days of an in-home evaluation. MFD is alleging violations of *N.J.A.C.* 10:60-3.5(a)(2) and *N.J.A.C.* 13:45B-14.9(g), which require periodic in-home evaluations to be sure the POC (plan of care) is correct. MFD is not alleging that the POC should have been revised in those 14

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instances, or that the care provided to the patient was deficient in some way, or that at in-home evaluation would have resulted in different services or a different POC. In those 14 cases, the patients in question received the same care before and after the 60-day in-home evaluation was performed, albeit later than required. As MFD is aware, in-home evaluations are sometimes scheduled but canceled by the patient or the patient's guardian, thereby making 60-day visits not as timely as would be preferred. But it is important to note that tardiness of the 60-day evaluations did not change the POC. Appropriate services were provided, and the services were properly paid. However, assuming the claims should not have been paid because they fell outside the 60-day period, it is not appropriate to suggest that 11.9% (14/118) of all 296,374 claims fall outside the 60-day period. A more accurate methodology would have been to determine how many claims in the sample of 118 fall outside the 60-day period (in this case 14), and of those claims, how many days were not in compliance for each patient. For the 14 instance identified by MFD, HTH looked at how many days were billed before a subsequent 60-day evaluation occurred. The results are below:

███████████	114
█████████████	188
██████	58
█████████████	196
████████	178
████████████	64
███████	26
███████████████	10
█████████████	186
████████████	76
██████████	42
██████████	245
█████████████	3
█████████	55

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"The total of days in the above chart is 1,441. As noted by MFD, the remaining 104 claims reviewed by MFD did not fall outside the 60-day window. Roughly speaking, MFD's sample of 118 claims represents 118 patients, or 43,070 days of service in one year (365 x 118). Within these there were 1,441 days outside the 60-day period. The ratio of 1,441/43,070 is 3.3%. In other words, only 3.3% of the total days of service related to the representative sample in one year fell outside the 60-day evaluation period. Moreover, at the time of the <u>audit</u>, the total number of days outside of the 60-day period was even less, only 564 days, resulting in an extrapolated rate of 1.3%. Although HTH is not conceding that extrapolation is appropriat [sic], HTH would offer either 1.3% or 3.3% as more accurate than the methodology used by MFD. MFD's methodology erroneously fails to consider the number of days outside compliance, but rather focuses on instances of non-compliance, which give a skewed number.

"To further illustrate the inaccuracies of MFD's extrapolation in connection with the 60-day evaluations, we looked closer at the 14 instances identified by MFD. In the Draft Audit Report, MFD claims that 11.9% of all claims are outside the 60-day evaluation period. However, even the 14 instances identified by OSC were only 564 days out of compliance at the time of audit. Out of 5,114 possible days for the 14 patients (365 x 14), 564 were not in compliance, resulting in a percentage of 11.0%. In other words, even ignoring the 104 *good* claims, the 14 *bad* claims themselves have a lower error rate (11.0%) than the extrapolated rate (11.9%)! Clearly, this demonstrates that MFD's extrapolation methodology is flawed."

OSC's Response

In its response, HTH does not dispute that it failed to perform In-Home Evaluations within the legally required 60-day period. Despite conceding that, HTH maintains that OSC's finding is not valid because HTH did not adjust the POCs in these cases. HTH's argument ignores the existence of the relevant regulations that require in-home evaluations every 60 days, *N.J.A.C.* 10:60-3.5(a)(2) and *N.J.A.C.* 13:45B-14.9(g), and the intent behind these requirements. These regulations require PCS providers to perform in-home evaluations to ensure that their HHA's are performing their duties properly and that the services called for in the POC continue to meet the needs of the beneficiary and, if not, to make any necessary changes thereto. The fact that it was not necessary to modify the POC in these instances is irrelevant. By failing to adhere to these requirements, HTH violated these regulations and placed Medicaid beneficiaries at risk. As such, OSC will not modify these findings.

Further, HTH's theory of extrapolation for this finding is not statistically supportable. The only valid basis to revise extrapolation results here would be if there were evidence that the reviewed claims were not in error. Claims are evaluated on an individual basis and can be disqualified (i.e. in Error) for any number of reasons. The number of claims associated with a particular Error Reason has nothing to do with the validity of the extrapolation. From a statistical perspective, the relevant objective is to project the error

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dollars found in a sample back to the universe to determine the total overpayment amount.

HTH's claim that one would be unlikely to find certain Error Reasons at the same rate in the Universe as OSC found in the Sample is a flawed argument. The only way one could know with 100% accuracy whether this were the case would be to individually review all of the claims in the Universe, which would defeat the purpose of sampling and extrapolation. In addition, any given claim could be disqualified for multiple reasons, thus it is possible that by expanding the review, additional Error Reasons could appear.

HTH's Comments: Audit Finding C
HTH Billed for Unsubstantiated Service

 "In the sample of 118, [OSC] found three (3) instances where HTH could not find a time-sheet. There is no allegation that the claim is otherwise improper or that the service was not performed. HTH believes its claims are valid, even if a timesheet was not located at the time of audit. Three (3) is too few to form the basis of a trend or pattern from which an extrapolation can be made."

OSC's Response

OSC does not agree with HTH's position. Pursuant to *N.J.A.C.* 10:49-9.8(a) and *N.J.A.C.* 10:49-9.8(b)(1), all providers "shall certify that the information furnished on the claim is true, accurate, and complete," and "to keep such records as are necessary to disclose fully the extent of services provided." HTH failed to provide any additional documentation relating to the claims in question. Moreover, as explained previously, HTH's position demonstrates a failure to understand fully the propriety of OSC's extrapolation process. As such, OSC will not modify these findings.

HTH's Comments: Audit Finding D
HTH Failed to Prepare a POC Prior to Initiating Service

"In the sample of 118, [OSC] found that an instance where HTH failed to prepare a POC prior to initiating service. By extrapolation, [OSC] is stating that 1 out of 118 claims, or 0.85% of all claims by HTH involved a failure to prepare a POC prior to service. Said another way, [OSC] is claiming there were 2,512 instances within the pool of 296,374 claims where a POC was not prepared prior to service. HTH would respectfully submit that a single occurrence cannot form the basis of a trend or pattern from which an extrapolation can be made."

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OSC's Response

OSC again disagrees with HTH's contention that a relatively small number of deficient claims should not be extrapolated. As stated above, the only valid means that HTH can change the results of the extrapolation would be to provide evidence that the deficient claims were not, in fact, in error. Moreover, claims are evaluated on an individual basis and can be disqualified (i.e. in Error) for any number of reasons. The number of claims associated with a particular Error Reason has nothing to do with the validity of the extrapolation.

HTH's Comments: Audit Finding E
HTH Improperly Billed PCS while Beneficiaries were Inpatient in a Hospital

"HTH reserves its rights in connection with challenging this allegation upon additional investigation. HTH does not presently concede that the applicable hospital records, as opposed to records of HTH, are more reliable."

OSC's Response

Throughout the audit, HTH did not provide any documentation regarding services provided while patients had in-patient status at a hospital. As such, OSC will not modify this finding.

HTH's Comments: CONCLUSION

"HTH disputes the findings in the Draft Audit Report. Nonetheless, HTH recognizes that billing mistakes can, and do, occur."

OSC's Response

HTH has not put forth any valid arguments that would cause OSC to adjust its audit findings. By simply stating that "billing mistakes can, and do, occur," HTH fails to address the core Medicaid program requirement that applies to all providers – the requirement to submit true, accurate and complete claims, and maintain records as are necessary to disclose fully the extent of services provided. As such, OSC will not modify any of its findings.

Finally, HTH did not provide a CAP or otherwise address any of OSC's recommendations, including the identified overpayment. This audit is designed to identify whether HTH complied with Medicaid laws, rules, and guidance and, from that review, assess vulnerabilities and compliance elements that HTH should address. HTH's failure to

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provide any meaningful response to OSC's findings and recommendations demonstrate its unwillingness to address the requirements and deficiencies that OSC identified in the audit. Should HTH fail to modify its behavior to adhere to the identified requirements, its actions would increase the level of risk for Medicaid beneficiaries served by HTH as well as the Medicaid funds associated with these services.