Audit of Heart to Heart Health Care Services, LLC, (D/B/A Heart to Heart Home Care) Medicaid Billing Practices

Medicaid Fraud Division Report

Issued September 16, 2021

For the period August 1, 2014 through July 31, 2019

NEW JERSEY
OFFICE OF THE STATE
COMPTROLLER

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ACTING STATE COMPTROLLER

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I. Introduction

As part of its oversight of the New Jersey Medicaid program (Medicaid), the Office of the State Comptroller, Medicaid Fraud Division (OSC) conducted an audit of Heart to Heart Health Care Services, LLC, d/b/a Heart to Heart Home Care (HTH), a Personal Care Services (PCS) provider, to determine whether HTH appropriately billed Medicaid for PCS services in accordance with applicable state and federal laws and regulations. OSC's audit was for the period from August 1, 2014 through July 31, 2019 (audit period).

OSC conducted an audit of Medicaid claims submitted by and paid to HTH to determine whether HTH billed for home-based PCS in accordance with applicable state and federal laws and regulations. Specifically, OSC reviewed HTH's PCS claims billed under the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System (HCPCS) code T1019. From its audit of 118 statistically selected claims, totaling $7,177.46 in Medicaid funds paid to HTH, OSC determined that 19 of the 118 claims, totaling $929.68 paid to HTH, failed to comply with state regulations. Apart from the sample claims, OSC also found that HTH improperly billed for 46 claims, totaling $2,155.42 paid to HTH that overlapped with hospital claims on the same dates for the same beneficiaries.

For audit testing purposes, OSC first identified HTH PCS claims coinciding with hospital claims for the same beneficiaries for overlapping periods. From a universe of 296,420 PCS claims, totaling $16,094,897 paid to HTH under HCPCS code T1019, OSC identified 46 claims, totaling $2,155.42 for which HTH was paid for PCS provided to beneficiaries in their homes while these beneficiaries had inpatient status in a hospital setting. HTH should not have billed for these PCS claims because the beneficiaries for whom HTH purportedly provided at home services were in a hospital. To perform a more comprehensive review of the remainder of HTH's PCS claims, OSC removed these 46 improperly billed and paid claims from the universe of 296,420 claims, leaving a net universe of 296,374 claims, totaling $16,092,741.69 paid to HTH. OSC then selected and reviewed a statistically valid sample of 118 claims, totaling $7,177.46 in Medicaid reimbursement.

OSC determined that 19 of the 118 sampled claims, totaling $929.68 in reimbursement, failed to comply with state regulations. Specifically, OSC found that HTH failed to: a) verify that a homemaker-home health aide (HHA) was certified, thus allowing an uncertified HHA to provide PCS for 1 claim; b) conduct supervisory evaluation of the Plan of Care (POC) and HHA once every 60 days or less for 14 claims; c) substantiate services billed for 3 claims; and d) complete a POC prior to initiating services for 1 claim.

In sum, OSC determined that HTH improperly billed 19 of the 118 sample claims, for which HTH received total payment of $929.68. For purposes of ascertaining a final recovery amount, OSC extrapolated the dollars in error for these 19 failed claims to the total dollars in the population of claims from which the sample claims was drawn, which in this case was 296,374 claims with a total payment amount of $16,092,741.69. After extrapolating the sample dollars in error over the entire universe of claims, OSC calculated that HTH received an overpayment of $2,384,132.55. Additionally, OSC determined that HTH improperly billed and received payment for 46 claims, totaling $2,155.42, which overlapped with hospital claims for the same beneficiary and for the same date of service. In total, OSC determined that HTH received an overpayment of $2,386,287.97 ($2,384,132.55 plus $2,155.42) that it must repay to the Medicaid program.

II. Background

The Division of Medical Assistance and Health Services (DMAHS), within the New Jersey Department of Human Services (DHS), administers New Jersey's Medicaid program. Medicaid is a program through which individuals with disabilities and/or low incomes receive health care services. DMAHS contracts with five managed care organizations (MCOs) to administer certain health care services to Medicaid beneficiaries. PCS are provided to Medicaid beneficiaries who experience functional impairments and need assistance with activities of daily living, such as dressing, bathing, toileting, or feeding, or with instrumental activities of daily living, such as meal preparation and grocery shopping. These services enable Medicaid beneficiaries to remain in their homes and minimize reliance on institutionalized settings, such as nursing facilities.

HTH has locations in New Jersey (Paterson, Hackensack, East Orange, Lakewood, and Vineland) and New York (Brooklyn, Flushing, and Bronx). HTH has participated as a home care provider in the New Jersey Medicaid program since July 2008.

III. Audit Objective, Scope and Methodology

The objective of this audit was to evaluate claims billed by and paid to HTH to determine whether these claims complied with applicable state and federal laws and regulations.

The scope of the audit was August 1, 2014 through July 31, 2019. The audit was conducted under the authority of the Office of the State Comptroller as set forth in *N.J.S.A.*52:15C- 23 and the Medicaid Program Integrity and Protection Act, *N.J.S.A.*30:4D-53 et seq.

To accomplish this objective, OSC reviewed the universe of 296,420 claims, totaling $16,094,897 billed under HCPCS code T1019, and identified 46 claims in which services were provided to beneficiaries while these beneficiaries had inpatient status in a hospital setting. OSC then removed those 46 claims from the universe and selected a statistically valid random sample comprised of 118 claims, totaling $7,177.46 paid to HTH, from a net universe of 296,374 claims, totaling $16,092,741.69 billed by and paid to HTH under HCPCS code T1019.

OSC reviewed HTH's records related to these 118 claims to determine whether the documentation provided complied with the requirements of 42 *CFR* § 440.167(a)(1), *N.J.A.C.* 10:49-9.8(a), *N.J.A.C.* 10:49-9.8(b)(1), *N.J.A.C.* 10:49-5.5(a)(11), *N.J.A.C.* 10:49-5.5(a)(18), *N.J.A.C.* 10:49-11.1, *N.J.A.C.* 10:60-1.2(3),-(1), *N.J.A.C.* 10:60-3.5(a)(1), *N.J.A.C.* 10:60-3.5(a)(2), *N.J.A.C.* 10:60-3.8(a), *N.J.A.C.* 13:37-14.3, *N.J.A.C.* 13:45B-14.4(a),-(c), *N.J.A.C.* 13:45B-14.9(a), and *N.J.A.C.* 13:45B- 14.9(g).

IV. Discussion of Auditee Comments

The release of this Final Audit Report concludes a process during which OSC afforded HTH multiple opportunities to provide input regarding OSC's findings. Specifically, OSC provided HTH a Summary of Findings (SOF) and offered HTH an opportunity to discuss the SOF at an exit conference. OSC and HTH, represented by counsel, held an exit conference during which the parties discussed OSC's findings in the SOF. After the exit conference, HTH provided OSC comments and additional records. After considering HTH's submission, OSC provided HTH with a Draft Audit Report (DAR). HTH provided a formal response to the DAR, which is attached as Appendix C, entitled "HTH's Response to Draft Audit Report."

In its response to the DAR, HTH objected to OSC's sampling and extrapolation methodology as well as the audit findings. HTH, however, not only failed to address any of OSC's recommendations or submit a corrective action plan (CAP), it also failed to indicate whether it intended to repay the identified overpayment. OSC addresses each argument raised by HTH in Appendix D, entitled "HTH's Comments and OSC's Responses."

OSC notes that HTH's response to the audit, specifically its failure to provide a CAP, substantively address the recommendations, and state whether it intends to repay the identified overpayment, 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.

V. Audit Findings

A. HTH Failed to Verify the Professional Certification of an HHA Prior to Rendering Services

Pursuant to state regulations, HHAs must be certified prior to performing PCS and PCS providers, including HTH, must ensure that HHAs who perform PCS on their behalf possess the required certification before allowing such personnel to perform these services.

OSC found that for 1 of the 118 sample claims, totaling $44.40 paid to HTH, HTH failed to ensure that the HHA was properly certified, thus allowing an uncertified individual to perform services. In this instance, the HHA provided PCS on December 30, 2015, however, the HHA's temporary HHA permit had expired on June 30, 2015. By failing to verify that this HHA was certified and thereby allowing the HHA to perform services six months after the individual's temporary work permit had expired, HTH violated *N.J.A.C.* 10:60-1.2 (definition of "[h]omemaker-home health aide") and *N.J.A.C.* 13:45B-14.4 (a) and (c). *See* Appendix A for claim detail.

Pursuant to *N.J.A.C.* 10:60-1.2, "'Homemaker-home health aide' means a person who: Successfully completes a training program in personal care assistant services and is certified by the New Jersey State Department of Law and Public Safety, Board of Nursing, as a homemaker-home health aide." That definition further provides that "[a] copy of the certificate issued by the New Jersey Department of Law and Public Safety, Board of Nursing or other documentation acceptable to the Division [must be] retained in the agency's personnel file."

Pursuant to *N.J.A.C.* 13:45B-14.4(a), "When licensure to perform a health care service or function is required by law, an agency shall refer or place only those health care practitioners who are currently licensed or certified and in good standing with their respective New Jersey licensing or registration boards." *N.J.A.C.* 13:45B-14.4(c) further provides that "[t]he agency shall, through its health care practitioner supervisor or other designated individual, verify the license status of each individual to be placed or referred prior to the referral or placement. Licensure shall be verified by obtaining a document, which verifies licensure from the Board or Committee that registers or licenses the individual and, within 45 days of obtaining the verification, by personally inspecting the current biennial registration or license or a copy of the current biennial registration or license."

B. HTH Failed to Perform Timely In-Home Evaluations of the HHA and POC

Medicaid PCS providers must perform an in-home evaluation of the HHA and the beneficiary's POC not less than once during each 60-day period. Timely completion of the in-home evaluation is required to evaluate the HHA's performance and to determine whether the services called for in the POC meet the needs of the beneficiary and, if not, to make any necessary changes thereto. Since a beneficiary's needs can change, the POC must be updated to account for such changes in a beneficiary's health and wellbeing.

OSC reviewed the documentation to determine whether HTH completed the in-home evaluation of the HHA and the POC at least once every 60 days. OSC found that for 14 of the 118 sample claims, totaling $689.06 paid to HTH, HTH did not perform the in-home evaluation of the HHA and the POC once every 60 days. For example, for services rendered by HTH to a beneficiary on February 28, 2018, HTH last completed the in-home evaluation of the beneficiary's HHA and POC on October 27, 2017, 124 days before the date of service. HTH did not complete any subsequent in-home evaluations for this beneficiary. See Exhibit I. In another instance, HTH billed for PCS services rendered on August 30, 2014, but the two in-home evaluation visits for that beneficiary took place on May 23, 2014 and November 13, 2014, resulting in a 174-day span between the two in-home evaluations. *See* Exhibit II. For these claims, HTH violated *N.J.A.C.* 10:49-9.8(a), *N.J.A.C.* 10:60-3.5(a)(2), and *N.J.A.C.* 13:45B-14.9(g) by not performing in-home evaluations of the POC within the required timeframe. See Appendix A for claim detail.

Pursuant to *N.J.A.C.* 10:49-9.8(a), "all providers shall certify that the information furnished on the claim is true, accurate, and complete."

Pursuant to *N.J.A.C.* 10:60-3.5(a)(2), "Direct supervision of the personal care assistant shall be provided by a registered nurse at a minimum of one visit every 60 days, initiated within 48 hours of the start of service, at the beneficiary's place of residence during the personal care assistant's assigned time. The purpose of the supervision is to evaluate the personal care assistant's performance, to determine that the plan of care has been properly implemented, and to document that hands-on personal care is being provided. At this time, appropriate revisions to the plan of care shall be made as needed . . . ."

Pursuant to *N.J.A.C.* 13:45B-14.9(g), "The health care practitioner supervisor shall make an on-site, in home evaluation of the plan of care not less than once during each 60 day period during which the agency has placed or referred a health care practitioner in the home care setting."

C. HTH Billed for Unsubstantiated Services

Medicaid PCS providers must maintain records that are true, accurate and complete. Further, the records must document fully the extent of services provided. OSC reviewed HTH's timesheets to determine whether HTH maintained proper documentation for its Medicaid-billed services. OSC found that for 3 of the 118 sample claims, totaling $166.62 paid to HTH, HTH billed for services that were not supported by documentation. Specifically, OSC found that HTH billed for PCS for 2 of the 3 claims, totaling $69.90, for which HTH did not provide a timesheet to support the PCS. Further, OSC found for 1 of the 3 claims, totaling $96.72, the timesheet was incomplete as the services performed were not documented. For these claims, HTH violated *N.J.A.C.* 10:49-9.8(a), and *N.J.A.C.* 10:49-9.8(b)(1) by failing to maintain appropriate records. *See* Appendix A for claim detail.

Pursuant to *N.J.A.C.* 10:49-9.8(a), "all providers shall certify that the information furnished on the claim is true, accurate, and complete." Moreover, pursuant to *N.J.A.C.* 10:49-9.8(b)(1), providers are required "to keep such records as are necessary to disclose fully the extent of services provided."

D. HTH Failed to Prepare a POC Prior to Initiating Service

Medicaid PCS providers must evaluate the beneficiaries' needs and establish a written POC prior to initiating service. This requirement ensures that PCS providers identify the HHA tasks and hours of service needed before sending an HHA to provide services. It also ensures that the HHA knows the beneficiary's needs before providing services to the beneficiary. OSC found that HTH billed for PCS for

1 of the 118 sample claims, totaling $29.60 paid to HTH, without first having completed a POC before rendering services. For this claim, HTH violated *N.J.A.C.* 10:49-9.8(a) and *N.J.A.C.* 13:45B-14.9(a) by not preparing the POC prior to rendering services. *See* Appendix A for claim detail.

Pursuant to *N.J.A.C.* 10:49-9.8(a), "all providers shall certify that the information furnished on the claim is true, accurate, and complete."

Pursuant to *N.J.A.C.* 13:45B-14.9(a), "Prior to referring or placing a health care practitioner in a home care setting, an agency shall assure that an appropriately licensed person evaluates the patient's needs and establishes, in writing, a plan of care. The health care practitioner preparing the plan of care shall sign it and indicate thereon his or her license designation."

E. HTH Improperly Billed PCS while Beneficiaries Were Inpatient in a Hospital

Apart from the review of the sampled claims, OSC also reviewed HTH's home-based PCS claims billed under the HCPCS code T1019 to determine whether such claims overlapped with dates when beneficiaries were in a hospital. OSC found that HTH submitted 46 claims, totaling $2,155.42 paid to HTH, for services purportedly provided to beneficiaries in a home setting while these beneficiaries had inpatient status in a hospital. Pursuant to Medicaid regulations, a beneficiary cannot receive PCS, Private Duty Nursing, or In-Home-Nursing services, while Medicaid is paying a hospital for room and board services for the same beneficiary. Therefore, these 46 claims constitute overpayments that HTH must repay to the Medicaid program. For these claims, HTH violated *N.J.A.C.* 10:49-9.8(a) and *N.J.A.C.* 10:60-3.8(a) by improperly billing for PCS while a beneficiary has inpatient status in a hospital. *See* Appendix B for claim detail.

Pursuant to *N.J.A.C.* 10-49-9.8(a), "providers shall certify that the information furnished on the claim is true, accurate, and complete."

Pursuant to *N.J.A.C.* 10:60-3.8(a)(1)-(3) and (8), "Medicaid/NJFamilyCare reimbursement shall not be made for personal care assistant services provided to Medicaid or NJ FamilyCare –Plan A beneficiaries in the following settings: A residential health care facility; A Class C boarding home; A hospital; . . . Adult Family Care, Assisted Living Program, and Assisted Living Residence."

F. Summary of Medicaid Overpayment

OSC determined that HTH improperly billed and received payment for 19 of the 118 sample claims, totaling $929.68 paid to HTH. *See* Appendix A for Summary. For purposes of ascertaining a recovery amount, OSC extrapolated the dollars in error for these 19 claims to the total population of 296,374 claims from which the sample claims was drawn, totaling $16,092,741.69 paid to HTH. By extrapolating the sample of deficient claims to this universe of claims/reimbursement amount, OSC calculated that HTH received an overpayment of $2,384,132.55 that it must repay to the Medicaid program.[1] Additionally, OSC determined that HTH improperly billed and received payment for 46 claims, totaling $2,155.42, for services provided to beneficiaries while these beneficiaries had inpatient status in a hospital setting. In total, OSC determined that HTH received an overpayment of $2,386,287.97 ($2,384,132.55 plus $2,155.42) that it must repay to the Medicaid program.

1 OSC can reasonably assert with 90% confidence that the overpayment in the universe falls between $1,506,618 and $3,261,647 with the error point estimate as $2,384,132.55.

VI. Recommendations

1. HTH shall reimburse Medicaid the overpayment amount of $2,386,287.97.

2. HTH must adhere to state and federal regulations for Medicaid services provided by HTH and its health care professionals.

3. HTH must verify licensures and/or certifications before HHAs are assigned case referrals, and maintain documentation that ensures compliance with the state regulations.

4. HTH must ensure that HTH and its health care professionals receive training to foster compliance with applicable state and federal regulations.

5. HTH must provide OSC with a CAP indicating the steps HTH will take to implement procedures to correct the deficiencies identified herein.

Exhibit I

HEART TO HEART HOME CARE

let our family service your family's needs

[redacted] 60 Day RN Revisit Assessment and Nursing Note

Patient's Name [redacted]	Date: 10/27/17	Time Arrived: 9AM	Time Left:	Visit Total:
Address: [redacted]	DOB [redacted]	Location: Home		

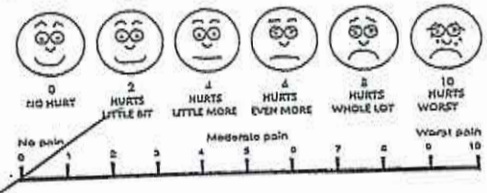
Reason for Visit: ✓ 60 Day Supervision ___ PRN ___ Supervise New Hire ___ Other _____

Other Objective/Subjective Data _____

Vital Signs: BP 150/80 AP 93 RP 60 Resp 18 Temp 98.2 Weight 109 lbs. ☐ Actual ☐ Stated Height _____

98% 99%

Pain Assessment:



Describe: location, character, frequency, and pain relief measures Denies any pain. Lost wt. 20 lb CA; lost of appetite before.

Emergency Plan/ Patient has: ✓ Emergency Contact _____ ☐ Alternate Housing in a Disaster

✓ Plan to obtain food, supplies, medication, DME ✓ Comments Adequate medication

Functional Assessment:

___ Change ✓ No Change in Upper Body dressing

___ Change ✓ No Change in Lower Body dressing

___ Change ✓ No Change in Toileting and Transfer

Assist = ADL

___ Change ✓ No Change in assistance needed for food and meal preparation

___ Change ✓ No Change in Medication management

Future schedule for possible Chemo therapy

Fall Risk and Safety Assessment reviewed:

✓ No changes and no additional interventions ☐ Change- describe and actions taken: _____

Plan of Care reviewed with: ✓ Patient ☐ Family ✓ CHHA ☐ LPN ☐ Other _____

Plan of Care meets Patient's needs ✓ Yes ☐ No – Explain _____

Name of CHHA/Staff Present [redacted] Skills observed _____

Review of Systems

Cardiovascular	☐ WNL Circle any that apply: Chest pain, Dyspnea, Cyanosis, Palpitations, Pulses present, Pulses Absent, Irregular pulse, History MI, History CHF Other Comments weak
Respiratory	☐ WNL Circle any that apply: Lungs clear to auscultation, SOB on exertion, SOB at Rest, Orthopnea, Cough, Wheezing, Rhonchi, Rales Oxygen at ____ L/Min Comments Med SOB on Exertion
Head/ Neck	☑ WNL Circle any that apply: Masses, Tenderness, Swollen Glands, History Thyroid disease Other Comments
Neurological	☐ WNL Circle any that apply: Headache, History CVA, Tumor, Alzheimers, Dementia, Parkinsons, Syncope, Spinal disc, Mental Status changes, History of seizure disorder, Other Comments
GI	☐ WNL Circle any that apply: Nausea, Vomiting, Acid reflux; Constipation, Diarrhea, history of cancer, appetite loss, tenderness, distention, abnormal bowel sounds Other Comments Sluggish
GU	☐ WNL Circle any that apply: Active UTI, History UTI, Foley catheter (size___, balloon___ cc), burning, painful urination, change in color ___, cloudiness, history of BPH, Urostomy Other Comments Anuria 2° to HD
Musculo- Skeletal	☐ WNL Circle any that apply: Arthritis, Broken bone, History of fractures, History of Sprain, History Joint Replacements Other Comments Swollen ankle 2+
Integumentary	☐ WNL Circle any that apply: Color Pale, Color flushed, Color jaundiced, bruising ____, Wound(s) describe ____ Other Comments
Psychosocial	☑ WNL Coping Ability fair Lives with family Environment suitable for therapy ☐ Yes ☐ No Circle any that apply: Depression, Anxiety, Schizophrenia, Psychosis Other Comments
Other	☐ None ☐ Anemia ☐ Autoimmune Disease ____ ☐ Genetic Disorder ____ Comments

Nutritional: ☑ Oral ☐ Enteral ☐ TPN ☐ Other ____

Current Diet Renal ↓ Cholesterol Nutritional Screen done ☐ Yes ☐ No, not needed on this visit

Pump Type ____ ☐ Intermittent ☐ Continuous – Rate and other ____

Patient compliant with Treatment, Therapy ☐ Yes ☐ No

Patient Teaching Comply / Continue present regimen

Referrals Made: ☐ No ☐ Yes ____

General Assessment comments and comments on Plan of Care meeting patient's needs

Patient ongoing CHHC; Home Care Follow-up
Needs future assessment for Chemo Therapy.
At present Comfortable & no Reported discomfort

RN Signature: [redacted] Date: 10/27/17

HEART TO HEART HOME CARE

PARAPROFESSIONAL SUPERVISORY FORM

EMPLOYEE NAME: [redacted] DATE: 10/27/17

SKILL LEVEL CHHA CONTRACT: _____ PATIENT ID: [redacted]

ACTIVITY	PLEASE BOX [redacted]
FOLLOWS PLAN OF CARE	
COMPLETES TASKS AS DIRECTED	
MAINTAINS PATIENT'S LIVING AREA/ENVIRONMENT NEAT AND CLEAN	
DEVELOPS RELATIONSHIPS WITH PATIENTS AND/OR FAMILY	
UNIFORM/I.D. BADGE WORN	
VERBALIZES UNDERSTANDING OF OBSERVING CHANGES IN THE PATENT'S CONDITION AND MEANS OF REPORTING CHANGES	
VERBALIZES UNDERSTANDING OF STANDARD/UNIVERSAL PRECAUTIONS AND PROCEDURES	

[redacted]

OTHER (SPECIFY): _____

ON THE JOB TRAINING AND/OR OTHER SUPERVISORY OBSERVATIONS: _____

RN SIGNATURE: [redacted] **DATE:** 10/27/17

LPN SIGNATURE: _____ **DATE:** _____

COORDINATOR SIGNATURE: [redacted] **DATE:** 10/27/17
***By phone**

EMPLOYEE SIGNATURE: [redacted] **DATE:** 10/27/17

CHECK ONE:

- ☐ CARE PLAN ORIENTED TO NEW EMPLOYEE
- ☑ CARE PLAN REVIEWED WITH PREVIOUSLY ORIENTED EMPLOYEE
  - ☐ IN HOME ☐ IN OFFICE ☐ BY PHONE

Exhibit II

HEART TO HEART

"Family Service For Your Family"

Patient Name: [redacted]	Date: 5/23/14	Visit Time: 10-4PR	Time Arrived: 11 Am	Time Left: 11:45	Total:
Address: [redacted]	DOB: [redacted]	Location: Home			

Reason for visit: Twitts Symptoms
Subjective Data: C/O pain both knees
Objective Data: in no distress, clo. + lying down in bed
Vital Signs: BP 118/71 AP 78 RP 18 Resp 18 Temp ___ Weight ___ ▫Actual ▫Stated Height ___

Pain Assessment

No 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Location: Knees
Character: hurts
Exacerbation: just Here
Pain Releif Measures: medicate
Teaching Provided: diversional therapy
Follow Up: ___

Frequency: daily
Duration: varies

NEURO: ✓WNL ▫Headache ▫Vertigo
Other: ___

Oriented to: ▫Time ▫Place ▫Person
Comments: Confused

HEAD/NECK: ✓WNL ▫Masses ▫Tenderness
Comments: ___

RESPIRATORY: ✓WNL ▫Dyspnea ▫Cyanosis
SOB: ▫At Rest ▫On exertion ▫Orthopne ▫Cough
Oxygen at: ___ L/min via ___
Breath Sounds: lungs Clear bil

CARDIOVASCULAR: ▫WNL ▫Dyspnea ▫Cyanosis
▫Palpatations Peripheral Pulses ▫Present ▫Absent
Breath Sounds: ▫Regular ▫Irregular
Comments: ___

GU: ✓WNL
Problems: incontinent
Comments: uses diaper

GI: ▫WNL ▫Nausea ▫Vomiting ▫Diarrhea
▫Constipation ▫Abn, Bowel Sounds ▫Distention
▫Tenderness ▫Anorexia ▫Weight Loss
Comments: Abd. Soft, +) BS x 4 quad BM regularity

MUSCULO-SKELETAL: ▫WNL unsteady
Comments/Problems: uses, walker, W/C

PSYCHOSOCIAL/ENVIRONMENT:
Coping Ability: fair
Lives With: grand daughter
Environment suitable for therapy? ✓Yes ▫No
Comments: Home Safe

Review RN Care Plan with: ✓CHHA ▫LPN ▫Patient
Review 485 ▫ MAR ▫ RN Prog. Notes ✓
Med Sheet ▫ Support Services ▫ Referrals ▫
Chha/RN Name: [redacted] Present ✓Y ▫N
Supervisory/Skills Observed ✓Y ▫N

NUTRITIONAL: ▫ Enteral ▫ Oral ▫ TPN ▫ Upld s 20%/10%
NUTRITIONAL SCREEN: ▫Yes ✓No
Total Volume: ___ ▫ Cyclic ▫Continuous ▫Intermittent
days/week: ___

Pump Type: ___
Rate: ___ cc/hr ___ hours/day ___
Comments: ___

INTEGUMENTARY: ✓WNL Color ▫ Pale ▫ Pink ✓Norm ▫ Turgor Poor
Comments: Skin intact

PT Cpmplaint w/Treatment/Therapy: ✓Yes ▫ No

CARE PLAN REVISED: ▫ Yes ✓No
TEACHING REINFORCED: ✓Yes ▫No

COMMENT/PATIENT RESPONSE/PLAN/INSTRUCTIONS: +) response to teach re/ to pains

PLAN OF CARE MEETS PATIENT'S NEEDS/PROGRESS NOTE: CHHA follows POC stable, no changes required

RN SIGNATURE: [redacted] **DATE:** 5/23/14

[redacted]

HEART TO HEART HOME CARE

PARAPROFESSIONAL SUPERVISORY FORM

EMPLOYEE NAME: [redacted] DATE: 5/23/14

SKILL LEVEL 01 02 CONTRACT: _____ PATIENT ID: [redacted]

[redacted] PLEASE BOX

ACTIVITY	[redacted]
FOLLOWS PLAN OF CARE	
COMPLETES TASKS AS DIRECTED	
MAINTAINS PATIENT'S LIVING AREA/ENVIRONMENT NEAT AND CLEAN	
DEVELOPS RELATIONSHIPS WITH PATIENTS AND/OR FAMILY	
UNIFORM/I.D. BADGE WORN	
VERBALIZES UNDERSTANDING OF OBSERVING CHANGES IN THE PATENT'S CONDITION AND MEANS OF REPORTING CHANGES	
VERBALIZES UNDERSTANDING OF STANDARD/UNIVERSAL PRECAUTIONS AND PROCEDURES	

[redacted]

OTHER (SPECIFY): _____

ON THE JOB TRAINING AND/OR OTHER SUPERVISORY OBSERVATIONS: [redacted]

RN SIGNATURE: [redacted] **DATE:** 5/23/14

LPN SIGNATURE: _____ **DATE:** _____

COORDINATOR SIGNATURE: _____ **DATE:** _____
***By phone**

EMPLOYEE SIGNATURE [redacted] **DATE:** 5/23/14

CHECK ONE:

- ☐ CARE PLAN ORIENTED TO NEW EMPLOYEE
- ☐ CARE PLAN REVIEWED WITH PREVIOUSLY ORIENTED EMPLOYEE
- ☑ IN HOME ☐ IN OFFICE ☐ BY PHONE

HEART TO HEART HOME CARE

PARAPROFESSIONAL SUPERVISORY FORM

EMPLOYEE NAME: [redacted] DATE: 11/13/14

SKILL LEVEL CHHA CONTRACT: HOR PATIENT ID: [redacted]

ACTIVITY	PLEASE BOX
FOLLOWS PLAN OF CARE	
COMPLETES TASKS AS DIRECTED	
MAINTAINS PATIENT'S LIVING AREA/ENVIRONMENT NEAT AND CLEAN	
DEVELOPS RELATIONSHIPS WITH PATIENTS AND/OR FAMILY	
UNIFORM/I.D. BADGE WORN	
VERBALIZES UNDERSTANDING OF OBSERVING CHANGES IN THE PATENT'S CONDITION AND MEANS OF REPORTING CHANGES	
VERBALIZES UNDERSTANDING OF STANDARD/UNIVERSAL PRECAUTIONS AND PROCEDURES	

[redacted]

OTHER (SPECIFY): _____

ON THE JOB TRAINING AND/OR OTHER SUPERVISORY OBSERVATIONS: _____

RN SIGNATURE: [redacted] **DATE:** 11/13/14

LPN SIGNATURE: [redacted] **DATE:** _____

COORDINATOR SIGNATURE: _____ **DATE:** _____
***By phone**

EMPLOYEE SIGNATURE [redacted] **DATE:** 11/13/14

CHECK ONE:

- ☐ CARE PLAN ORIENTED TO NEW EMPLOYEE
- ☑ CARE PLAN REVIEWED WITH PREVIOUSLY ORIENTED EMPLOYEE
- ☑ IN HOME ☐ IN OFFICE ☐ BY PHONE

Heart to Heart Health Care Services, LLC
DBA: Heart to Heart Health Home Care
Period: 08/01/2014 - 07/31/2019
Detail and Summary of Overpayments

Appendix A

Source: Shared Data Warehouse (SDW)						Source: MFD Testing								
						Test A		Test B		Test C		Test D		Summary
Claim ICN Identification	Claim Recipient Full Name	Claim Recipient Birth Date	Claim Service Date	Claim Procedure Code	Claim Payment Amount	Services Provided by Licensed Professionals	Recoverable Claim Payment	Health Care Practitioner Supervisor Conducted on Site in Home Evaluation of Plan of Care Every 60 Days or Less	Recoverable Claim Payment	Timesheet Hours Match Hours Billed	Recoverable Claim Payment	Existence of Current Plan of Care (POC)	Recoverable Claim Payment	Overpayment Amount
[redacted]			8/30/2014	T1019	$ 44.40	IC	$ -	NIC	$ 44.40	IC	$ -	IC	$ -	$ 44.40
			1/5/2015	T1019	$ 59.20	IC	$ -	NIC	$ 59.20	IC	$ -	IC	$ -	$ 59.20
			2/26/2015	T1019	$ 27.60	IC	$ -	NIC	$ 27.60	IC	$ -	IC	$ -	$ 27.60
			3/9/2015	T1019	$ 44.40	IC	$ -	NIC	$ 44.40	IC	$ -	IC	$ -	$ 44.40
			3/23/2015	T1019	$ 74.00	IC	$ -	NIC	$ 74.00	IC	$ -	IC	$ -	$ 74.00
			5/5/2015	T1019	$ 44.40	IC	$ -	NIC	$ 44.40	IC	$ -	IC	$ -	$ 44.40
			6/20/2015	T1019	$ 34.50	IC	$ -	NIC	$ 34.50	IC	$ -	IC	$ -	$ 34.50
			7/17/2015	T1019	$ 29.60	IC	$ -	NIC	$ 29.60	IC	$ -	IC	$ -	$ 29.60
			12/30/2015	T1019	$ 44.40	NIC	$ 44.40	IC	$ -	IC	$ -	IC	$ -	$ 44.40
			9/9/2016	T1019	$ 29.60	IC	$ -	IC	$ -	IC	$ -	NIC	$ 29.60	$ 29.60
			11/6/2016	T1019	$ 29.60	IC	$ -	IC	$ -	NIC	$ 29.60	IC	$ -	$ 29.60
			1/11/2017	T1019	$ 29.60	IC	$ -	NIC	$ 29.60	IC	$ -	IC	$ -	$ 29.60
			4/10/2017	T1019	$ 27.60	IC	$ -	NIC	$ 27.60	IC	$ -	IC	$ -	$ 27.60
			10/13/2017	T1019	$ 55.20	IC	$ -	NIC	$ 55.20	IC	$ -	IC	$ -	$ 55.20
			2/28/2018	T1019	$ 59.20	IC	$ -	NIC	$ 59.20	IC	$ -	IC	$ -	$ 59.20
			4/24/2018	T1019	$ 111.00	IC	$ -	NIC	$ 111.00	IC	$ -	IC	$ -	$ 111.00
			10/26/2018	T1019	$ 40.30	IC	$ -	IC	$ -	NIC	$ 40.30	IC	$ -	$ 40.30
			2/27/2019	T1019	$ 96.72	IC	$ -	IC	$ -	NIC	$ 96.72	IC	$ -	$ 96.72
			6/28/2019	T1019	$ 48.36	IC	$ -	NIC	$ 48.36	IC	$ -	IC	$ -	$ 48.36

Legend:	
IC	In Compliance
NIC	Not In Compliance

TOTAL Recovery:				**$ 44.40**	**$ 689.06**		**$ 166.62**		**$ 29.60**	**$ 929.68**
TOTAL Number of Claims:				**1**	**14**		**3**		**1**	**19**

Heart to Heart Health Care Services, LLC
DBA: Heart to Heart Health Home Care
Period: 08/01/2014 - 07/31/2019
HTH Improperly Billed PCS while Beneficiaries were Inpatient in a Hospital

Appendix B

PCS Information	Recipient Information			PCS Information		Hospital Information						
HTH Claim ICN Identification Number	Claim Recipient Identification Number	Claim Recipient First Name	Claim Recipient Last Name	HTH Claim Recipient Patient Account Number	HTH Claim Service Date	Hospital Claim Service Date	Hospital Claim Service Thru Date	Hospital Claim Billing Provider Name	HTH Claim Procedure Code	HTH Claim Procedure Current Name with Modifiers	HTH Claim Payment Amount	Recoverable Claim Payment
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	07/07/2017	07/06/2017	07/09/2017	[redacted]	T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 44.40	$44.40
					10/20/2014	10/19/2014	10/22/2014		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 59.20	$59.20
					10/21/2014	10/19/2014	10/22/2014		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 59.20	$59.20
					06/13/2016	06/11/2016	06/20/2016		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 74.00	$74.00
					06/14/2016	06/11/2016	06/20/2016		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 74.00	$74.00
					07/03/2017	07/01/2017	07/12/2017		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 59.20	$59.20
					07/04/2017	07/01/2017	07/12/2017		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 59.20	$59.20
					07/05/2017	07/01/2017	07/12/2017		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 59.20	$59.20
					07/06/2017	07/01/2017	07/12/2017		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 29.60	$29.60
					07/08/2017	07/01/2017	07/12/2017		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 88.80	$88.80
					07/10/2017	07/01/2017	07/12/2017		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 59.20	$59.20
					07/11/2017	07/01/2017	07/12/2017		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 59.20	$59.20
					03/04/2019	03/03/2019	03/12/2019		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 80.60	$80.60
					03/05/2019	03/03/2019	03/12/2019		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 80.60	$80.60
					03/07/2019	03/03/2019	03/12/2019		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 64.48	$64.48
					11/02/2016	11/01/2016	11/06/2016		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 44.40	$44.40
					11/03/2016	11/01/2016	11/06/2016		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 59.20	$59.20
					11/04/2016	11/01/2016	11/06/2016		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 59.20	$59.20
					11/06/2018	11/05/2018	11/12/2018		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 48.36	$48.36
					03/21/2017	03/20/2017	03/23/2017		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 59.20	$59.20
					05/30/2015	05/29/2015	06/12/2015		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 29.60	$29.60

PCS Information	Recipient Information			PCS Information		Hospital Information						
HTH Claim ICN Identification Number	Claim Recipient Identification Number	Claim Recipient First Name	Claim Recipient Last Name	HTH Claim Recipient Patient Account Number	HTH Claim Service Date	Hospital Claim Service Date	Hospital Claim Service Thru Date	Hospital Claim Billing Provider Name	HTH Claim Procedure Code	HTH Claim Procedure Current Name with Modifiers	HTH Claim Payment Amount	Recoverable Claim Payment
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	06/01/2015	05/29/2015	06/12/2015	[redacted]	T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 59.20	$59.20
					10/23/2015	10/22/2015	10/26/2015		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 44.40	$44.40
					11/10/2015	11/09/2015	11/20/2015		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 44.40	$44.40
					11/11/2015	11/09/2015	11/20/2015		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 44.40	$44.40
					11/12/2015	11/09/2015	11/20/2015		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 44.40	$44.40
					11/13/2015	11/09/2015	11/20/2015		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 29.60	$29.60
					11/16/2015	11/09/2015	11/20/2015		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 44.40	$44.40
					11/17/2015	11/09/2015	11/20/2015		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 44.40	$44.40
					11/18/2015	11/09/2015	11/20/2015		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 44.40	$44.40
					11/19/2015	11/09/2015	11/20/2015		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 44.40	$44.40
					04/02/2018	04/01/2018	04/05/2018		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 59.20	$59.20
					04/03/2018	04/01/2018	04/05/2018		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 59.20	$59.20
					05/22/2015	05/21/2015	06/04/2015		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 44.40	$44.40
					05/25/2018	05/24/2018	05/29/2018		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 37.00	$37.00
					09/26/2016	09/24/2016	09/28/2016		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 29.60	$29.60
					09/27/2016	09/24/2016	09/28/2016		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 29.60	$29.60
					08/05/2014	08/04/2014	08/06/2014		S9122	HOME HEALTH AIDE OR CERTIFIED NURSE	$ 27.26	$27.26
					05/24/2017	05/23/2017	05/25/2017		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 11.24	$11.24
					05/24/2017	05/23/2017	05/25/2017		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 14.80	$14.80
					07/31/2017	07/29/2017	08/02/2017		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 11.24	$11.24
					07/31/2017	07/29/2017	08/02/2017		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 14.80	$14.80
					08/01/2017	07/29/2017	08/02/2017		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 11.24	$11.24
					08/01/2017	07/29/2017	08/02/2017		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 14.80	$14.80
					05/18/2018	05/15/2018	05/19/2018		T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 81.40	$81.40

PCS Information	Recipient Information			PCS Information		Hospital Information						
HTH Claim ICN Identification Number	Claim Recipient Identification Number	Claim Recipient First Name	Claim Recipient Last Name	HTH Claim Recipient Patient Account Number	HTH Claim Service Date	Hospital Claim Service Date	Hospital Claim Service Thru Date	Hospital Claim Billing Provider Name	HTH Claim Procedure Code	HTH Claim Procedure Current Name with Modifiers	HTH Claim Payment Amount	Recoverable Claim Payment
[redacted]					03/09/2018	03/08/2018	03/13/2018	[redacted]	T1019	PERSONAL CARE SERVICES, PER 15 MINUT	$ 14.80	$14.80

TOTAL Recovery:	**$2,155.42**
TOTAL Number of Claims:	**46**

Appendix C

BRACH | EICHLER LLC

Riza I. Dagli
Direct Dial: 973-403-3103
Direct Fax: 973-618-5503
E-mail: rdagli@bracheichler.com

July 2, 2021

VIA EMAIL

[redacted]
Audit Supervisor
Office of the State Comptroller
Medicaid Fraud Division
PO Box 025
Trenton,, NJ 08625-0025

Re: Heart to Heart Health Care Services, LLC, d/b/a Heart to Heart Home Care

Dear Mr. [redacted]:

Our firm represents Heart to Heart Health Care Services, LLC (HTH). We are in receipt of the Medicaid Fraud Division's (MFD) Draft Audit Report letter dated June 15, 2021, wherein your agency alleges certain improper payments made to HTH, and which also offers an extrapolation methodology as a basis for a calculation of an overpayment. This letter is in response to that letter. All rights are reserved.

As you are aware, HTH provides medical and personal care services to the New Jersey community, primarily serving the complex needs of New Jersey's vulnerable Medicaid population. Since its inception, Heart to Heart has devoted itself to the highest standards of professionalism and customer care and satisfaction. The notion that HTH erroneously billed Medicaid to the staggering extent suggested by the Draft Audit Report is troubling, but more importantly, unbelievable and contravened by HTH's business practices and its own review of its records. Certainly, errors can happen in any business, and, considering the large amount of transactions by HTH, it is possible that some billing mistakes were made, and HTH will reimburse Medicaid for any billing mistakes, including the ones identified in the Draft Audit Report.

However, as a preliminary point, prior to a discussion of the specific allegations and error types identified in the Draft Audit Report, HTH objects to the method by which extrapolation was used in this instance. Extrapolation is a useful tool when applied correctly to identify trends and patterns in large volumes of data. However, for extrapolation to be effective, the representative sample must represent the larger pool of data. In other words, the representative sample must

contain all the attributes of the population in the same proportion that they exist in the population. Only then can the representative sample be used to generalize from merely a sample to the larger population. For the reasons discussed below, the representative sample chosen in the Draft Audit Report does not represent the larger population.

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 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, with 90% confidence, that the true overpayment in the universe falls between $1,506,618 and $3,261,647 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

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

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.

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 with the most likely overpayment amount (i.e. error point estimate) as $2,384,132.55.*[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 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]

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[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

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

[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.

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]

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' 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.,

[9] MFD Spreadsheet, Data Provider Copy.xlsx, Recovery Summary tab.
[10] Medicare Program Integrity Manual, 8.4.1.3 (5).

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.

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.

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.

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

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., greater than or equal to 50 percent 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.

Error Theories:

A. HTH failed to verify the professional certification of an HHA.

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.

B. HTH Failed to perform timely in-home evaluations.

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 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

[14] QIC redetermination decision, dated June 1, 2017.
[15] Medicare Program Integrity Manual, 8.4.1.4.

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:

[redacted]	114
	188
	58
	196
	178
	64
	26
	10
	186
	76
	42
	245
	3
	55

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 audit, 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, 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.

C. HTH Billed for Unsubstantiated Service

In the sample of 118, MFD 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.

D. HTH Failed to Prepare a POC Prior to Initiating Service

In the sample of 118, MFD found that an instance where HTH failed to prepare a POC prior to initiating service. By extrapolation, MFD 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, MFD 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.

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.

CONCLUSION

HTH disputes the findings in the Draft Audit Report. Nonetheless, HTH recognizes that billing mistakes can, and do, occur. As always, HTH is willing to continue its discussions with MFD to achieve a resolution of MFD's concerns and resolve this matter.

Very truly yours,

Riza I. Dagli

RID:amp

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.

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, with 90% confidence, that the true overpayment in the universe falls between $1,506,618 and $3,261,647 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

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.

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 with the most likely overpayment amount (i.e. error point estimate) as $2,384,132.55.*[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*

6 MFD June 15, 2021, Draft Audit Report.

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.

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'

10 Medicare Program Integrity Manual, 8.4.1.3 (5).

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.

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).

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., greater than or equal to 50 percent 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.

II. Audit Findings

HTH's Comments: Audit Finding A
HTH Failed to Verify the Professional Certification of an HHA

"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."

OSC's Response

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.

HTH's Comments: Audit Finding B
HTH Failed to Perform Timely In-Home Evaluations

"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

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:

[redacted]	114
[redacted]	188
[redacted]	58
[redacted]	196
[redacted]	178
[redacted]	64
[redacted]	26
[redacted]	10
[redacted]	186
[redacted]	76
[redacted]	42
[redacted]	245
[redacted]	3
[redacted]	55

"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 audit, 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

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."

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

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.