Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Saadite A. Green
Docket No. A-19-43
Decision No. 2940
May 3, 2019

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Saadite A. Green (Petitioner) appeals the December 11, 2018 decision of an Administrative Law Judge (ALJ) concluding that the Inspector General (I.G.) properly excluded Petitioner from participating in Medicare, Medicaid, and other federal health care programs and that the ten-year exclusion falls within a reasonable range, *Saadite A. Green*, DAB CR5223 (2018) (ALJ Decision). The I.G. excluded Petitioner under section 1128(a)(1) of the Social Security Act (Act)[1] due to his conviction in state court for insurance fraud, which the I.G. stated was "a criminal offense related to the delivery of an item or service under the Medicare or a State health care program." I.G. Exhibit (Ex.) 1, at 1. Petitioner asserts in his appeal that the ALJ erred in "finding a logical nexus between the delivery of a healthcare item or service and [Petitioner's] criminal conviction." Notice of Appeal and Supporting Brief (NA) at 9 (bold and capitalization removed). For the reasons explained below, we affirm the ALJ Decision.

Legal Background

Section 1128(a)(1) of the Act provides that the Secretary of Health and Human Services "shall exclude" from participation in federal health care programs "[a]ny individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under title XVIII [Medicare] or under any State health care program."

Section 1128(c)(3)(B) prescribes a "minimum period of exclusion . . . [of] not less than five years" for an exclusion imposed pursuant to section 1128(a). That mandatory minimum period of exclusion may be extended based on the application of the

[1] The current version of the Act can be found at https://www.ssa.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at https://www.ssa.gov/OP_Home/comp2/G-APP-H.html.

aggravating factors listed at 42 C.F.R. § 1001.102(b), including the following factors that the I.G. found applicable in this case:

> (1) The acts resulting in the conviction . . . caused, or were intended to cause, financial loss to a government agency or program or to one or more other entities of $50,000 or more . . . ;
>
> (2) The acts that resulted in the conviction . . . were committed over a period of one year or more; [and]
>
> ***
>
> (9) The individual or entity has been the subject of any other adverse action by any Federal, State or local government agency or board if the adverse action is based on the same set of circumstances that serves as the basis for the imposition of the exclusion.

Only if the I.G. extends the minimum period of exclusion based on the application of any of the regulatory aggravating factors may the I.G. consider any of the mitigating factors specified in section 1001.102(c) to reduce the period of exclusion to no less than the five-year mandatory minimum period. 42 C.F.R. § 1001.102(c).

An excluded individual may request a hearing before an ALJ. *Id.* §§ 1001.2007(a), 1005.2(a). The only issues before the ALJ on review are whether the I.G. had a basis for the exclusion and whether an exclusion longer than the mandatory minimum period is unreasonable in light of any of the regulatory aggravating and mitigating factors established in the case. *Id.* § 1001.2007(a). A party dissatisfied with the ALJ's decision may appeal to the Board. *Id.* § 1005.21.

Case Background[2]

Petitioner owned a company, We Are Family, Inc. (WAF), that provided in-home care and services to people with developmental disabilities through a contract with the California Department of Developmental Services (CDDS). ALJ Decision at 1. On June 29, 2016, a felony complaint in support of an arrest warrant for Petitioner was filed in Superior Court in Los Angeles County alleging two separate counts: (1) presenting false

[2] We draw the factual information in this background section from the ALJ Decision and the record to provide context for the discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact.

Medi-Cal[3] claims; and (2) insurance fraud. *Id*. at 4; I.G. Ex. 2, at 1-2. On November 10, 2016, Petitioner pleaded guilty to Count 2, insurance fraud, and the court found that there was a factual basis for and accepted Petitioner's plea. ALJ Decision at 4; I.G. Ex. 3, at 4. The felony complaint, under Count 2, alleged that, "[f]rom on or about January 1, 2010, through September 30, 2012, in the County of Los Angeles, State of California, [Petitioner], knowingly made or caused to be made a false or fraudulent claim for payment of a health care benefit, in violation of section 550(a)(6) of the Penal Code, a felony." I.G. Ex. 2, at 2.

An Investigative Auditor (Auditor) employed by the California Department of Justice, Bureau of Medi-Cal Fraud and Elder Abuse prepared and signed a declaration supporting the arrest warrant (Audit Declaration). I.G. Ex. 4. The Auditor declared that, based on his investigation, Petitioner "received an excess remuneration of $455,194.58 from the Medi-Cal program between January 1, 2010 [and] September 30, 2012." I.G. Ex. 4, at 1. He averred that Petitioner "overbilled hours and up-cod[ed] the rates of the services his instructors provided to adults with developmental disabilities." *Id.* The Auditor explained that the Home and Community-Based Services (HCBS) waiver provides an "alternative to care provided in institutions . . . by allow[ing] states to use Medicaid funding to provide services and support to persons living in their homes or in . . . other community-based settings." *Id*. at 2. Under the HCBS waiver program, beneficiaries receive a certain amount of service hours in their homes. *Id*. Vendors provide these service hours through private, non-profit, and regional centers that contract with CDDS. *Id*. at 3. Invoices for services are submitted to regional centers and, upon the regional center's approval, are paid for with Medi-Cal funds. *Id*. Vendors execute the "Regional Center Provider Electronic Billing Agreement Form," certifying, among other things, that the vendor "understands that payment of these claims will be from federal and/or state funds." *Id*. at 12. The audit of WAF demonstrated that Petitioner had billed for services that either had not been provided or had been up-coded, resulting in an excess of $455,194.58 paid to him from January 1, 2010 through September 30, 2012. *Id*. at 10-11.

By letter dated April 30, 2018, the I.G. informed Petitioner that he was "being excluded from participation in any capacity in the Medicare, Medicaid, and all Federal health care programs . . . for a minimum period of 10 years." I.G. Ex. 1, at 1 (bold and underlining omitted); *see also* ALJ Decision at 1. The letter stated that the exclusion pursuant to section 1128(a)(1) of the Act was due to Petitioner's conviction "of a criminal offense related to the delivery of an item or service under the Medicare or a State health care program, including the performance of management or administrative services relating to the delivery of items or services, under any such program." I.G. Ex. 1, at 1. The I.G.'s letter further explained that the period of exclusion was longer than the five-year

[3] Medi-Cal is the Medicaid program in the State of California. ALJ Decision at 2; I.G. Ex. 4, at 2.

minimum because: (1) the sentencing court ordered Petitioner to pay restitution of approximately $447,700; (2) the acts which resulted in the conviction were committed from January 2010 through September 2012; and (3) the California Department of Health Care Services suspended Petitioner from participating in the Medi-Cal program. *Id*. at 2.

Petitioner requested an ALJ hearing, arguing that the regional centers provide services to individuals pursuant to California's Lanterman Act (codified at CAL. WELF. & INST. CODE §§ 4500-4885) and that not all individuals eligible for services under the Lanterman Act are eligible for services under the HCBS Medicaid waiver program. Petitioner's Request for Hearing at 2-3. Moreover, Petitioner asserted, his "record of conviction relating to providing such services [under the Lanterman Act] does not necessarily mean any funds from a federal or state healthcare program were used to pay for the services." *Id*. at 3. Petitioner also asserted that the 10-year period of exclusion was unreasonable because his "conviction is based on a plea of no contest rather than a final adjudication," he "accepted all of the auditor's recommendations and has made full restitution of any billing found to be inadequately supported during the audit," and "since implementing the auditor's recommendations and best practices in 2011, [Petitioner] has suffered no further adverse actions or billing issues from the State entities responsible for administering the program." *Id*. at 3-4.

The ALJ issued a decision based on the written record before her. *See* ALJ Decision at 3 ("The IG indicates that an in-person hearing is not necessary . . . [and] Petitioner lists no witnesses, offers no witness testimony, and does not suggest that an in-person hearing is necessary."). Petitioner had argued that because prosecutors withdrew Count 1 of his indictment – presenting false Medi-Cal claims – his conviction was not related to the delivery of an item or service under a state health care program. *Id*. at 4. The ALJ rejected this argument, citing Board precedent holding that exclusion authority under section 1128 is not limited "to the bare elements of the offense on which the individual was convicted." *Id*. at 4 (citing *Narendra M. Patel, M.D.*, DAB No. 1736, at 7 (2000), *aff'd, Patel v. Thompson*, 319 F.3d 1317 (11th Cir. 2003); *Timothy Wayne Hensley*, DAB No. 2044 (2006); *Scott D. Augustine*, DAB No. 2043 (2006); *Lyle Kai, R.Ph.*, DAB No. 1979, at 5 (2005), *aff'd, Kai v. Leavitt*, No. 1:05-cv-00514 (D. Haw. July 17, 2006); *Berton Siegel, D.O.*, DAB No. 1467, at 5 (1994); *Carolyn Westin*, DAB No. 1381 (1993), *aff'd, Westin v. Shalala*, 845 F. Supp. 1446 (D. Kan. 1994)). The ALJ concluded that "the IG has come forward with compelling evidence – which Petitioner did not rebut – that Petitioner's crime was related to the Medi-Cal program." *Id*. at 5. The ALJ explained that the I.G.'s evidence demonstrated that companies, like Petitioner's, that were not enrolled in Medicaid "could nevertheless bill Medicaid for its services" and that, here, the Auditor had reviewed Petitioner's documentation and had obtained the claims Petitioner submitted to the regional centers to determine that Petitioner's company had overbilled. *Id*. The ALJ found that Petitioner did not rebut any of this evidence. *Id*.

The ALJ noted that, although Petitioner had conceded that he "understood that 'payment of [his] claims [would] be from federal and/or state funds,'" he maintained that the federal or state funds were not necessarily from a health care program. *Id*. at 6 (quoting Petitioner's Prehearing Brief at 7) (first alteration in ALJ Decision). The ALJ reasoned that the federal or state funds were related to a health care program because Petitioner was convicted of making "fraudulent claims 'for payment of a *health care* benefit.'" *Id*. (quoting I.G. Ex. 2, at 2) (ALJ's alteration and emphasis). Therefore, the ALJ concluded that Petitioner had overbilled Medi-Cal, his crime was related to the delivery of services under a state health care program, and he was properly excluded under section 1128(a)(1) of the Act. *Id*. The ALJ also determined that the ten-year exclusion was reasonable based on the existence of the three aggravating factors the I.G. had cited as well as the absence of any mitigating factors. *Id*. at 6-8.

Petitioner submitted a timely request for an extension to file his notice of appeal with the Board. *See* Petitioner's Request for 10-day Extension to File Opening Brief. The Board granted Petitioner's request for an extension, and Petitioner subsequently filed a notice of appeal within the extended deadline.[4] *See* NA.

Standard of Review

Pursuant to 42 C.F.R. § 1005.21(h), "[t]he standard of review on a disputed issue of fact is whether the initial decision is supported by substantial evidence on the whole record. The standard of review on a disputed issue of law is whether the initial decision is erroneous."

Analysis

The scope of this appeal is limited. Petitioner's appeal challenges only the ALJ's conclusion that the I.G. lawfully excluded him under section 1128(a)(1). *See* NA at 2 (stating grounds for appeal as ALJ's alleged error in findings of "a logical nexus between the delivery of a healthcare item or service and [Petitioner's] criminal conviction" and

[4] Petitioner filed with his Notice of Appeal an addendum entitled "The HCBS Waiver Primer and Policy Manual" and a 103-page document he titled "Appellant's Excerpts of Record In Support of Appeal" (Record Excerpts). The Presiding Board Member informed Petitioner that 42 C.F.R. § 1005.21(f) precludes filing before the Board evidence not filed during the ALJ hearing unless the "party demonstrates to the satisfaction of the [Board] that additional evidence not presented at such hearing is relevant and material and that there were reasonable grounds for the failure to adduce such evidence at such hearing," in which case the Board would remand the case to the ALJ for consideration of the new evidence. Acknowledgment and Order to Address Submissions Filed with Appeal of ALJ Decision (Jan. 23, 2019). Petitioner filed no response to this order. Accordingly, we do not remand this case to the ALJ or admit the addendum or the Record Excerpts to the record for our decision. We note that the Record Excerpts merely duplicate some, but not all, of the documents in the record before the ALJ, and we review all record documents.

"that [Petitioner] billed Medicaid for services [he] provided to Medicaid recipients" and ALJ's alleged "fail[ure] to consider material evidence and relevant state laws when reaching [her] decision"). Since Petitioner does not challenge the ALJ's conclusion that the length of his exclusion was reasonable, we affirm that conclusion without further discussion and address only Petitioner's challenge to the legal basis for the exclusion. For the reasons stated below, we uphold the ALJ's conclusion that the exclusion was lawful.

I. The ALJ correctly concluded that the I.G. lawfully excluded Petitioner based on his conviction – health benefits insurance fraud – that was related to the delivery of an item or service under a state health care program.

A. The nexus between Petitioner's conviction and the delivery of an item or service under a state health care program is evidenced by the criminal offense itself and the undisputed facts underlying that conviction, including Petitioner's concessions.

The I.G. excluded Petitioner under section 1128(a)(1) of the Act, which requires the Secretary to exclude from participation in the Medicare program and any state health care program "[a]ny individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under title XVIII or under any State health care program." As the ALJ noted, the Board has broadly construed the "related to" element. ALJ Decision at 4-5. Under that construction, an offense is "related to" the delivery of an item or service under Medicare or a state health care program if there is "a common sense connection or nexus" between the conduct giving rise to the offense and the delivery of the item or service under a covered program. *E.g., Kimbrell Colburn*, DAB No. 2683, at 5 (2016) (quoting *James O. Boothe*, DAB No. 2530, at 3 (2013)); *Kai*, DAB No. 1979, at 5. The Board has also held that the nature of the criminal offense may establish the required nexus and that an ALJ may look to the facts underlying the conviction when determining whether the nexus exists. *E.g*., *Craig Richard Wilder*, DAB No. 2416, at 6 (2011); *Siegel*, DAB No. 1467, at 6-7. While Petitioner argues that the ALJ "erred in finding a logical nexus[5] between the delivery of a healthcare item or service and Mr. Green's criminal conviction[,]" NA at 9, Petitioner does not argue that the ALJ wrongly applied this precedent nor does he even discuss it. (Bold and capitalization omitted.) We conclude that the ALJ did not err in finding a common sense nexus.

Petitioner concedes that the I.G. excluded him based on his undisputed guilty plea and conviction for the criminal offense of insurance fraud in a California state court. NA at 4, 5. The count describing that criminal offense specifically states that Petitioner

[5] We note Petitioner's substitution of "logical" for "common sense," but have no problem upholding the ALJ's finding of the required nexus using either term.

"knowingly made or caused to be made a false or fraudulent claim for payment of a *health care benefit*." I.G. Ex. 2, at 2; *see* ALJ Decision at 6. Petitioner also concedes that he made the fraudulent claims for services WAF delivered to developmentally disabled individuals and that he "understood that 'payment of [his] claims will be from federal and/or state funds.'" ALJ Decision at 6; *see also* NA at 7; I.G. Ex. 4, at 12. Thus, Petitioner has effectively conceded the nexus required to support exclusion under section 1128(a)(1), that is, that his criminal fraud offense was related to the delivery of an item or service under either a state or federal health care program. Furthermore, "false billing for items or services has been repeatedly held to be an offense related to the delivery of an item or service within the meaning of section 1128(a)(1)." *Wilder*, DAB No. 2416, at 6 (citations omitted). Petitioner was convicted of submitting false or fraudulent claims for payment of health care benefits and has conceded that payment for those claims came from federal and/or state funds.

For the reasons stated, we affirm the ALJ's finding that there was a common sense nexus between Petitioner's conviction and the delivery of an item or service under a state health care program.

B. Petitioner's other arguments are not supported by the record and are irrelevant in any event.

Despite asserting that the ALJ erred in finding a common sense nexus, an assertion we have rejected, Petitioner's notice of appeal does not directly challenge any of the ALJ's material findings or point to any record evidence that might provide a basis for questioning those findings. Instead, Petitioner argues that there is no evidence that: "WAF billed Medicaid or Medi-Cal directly"; "the invoices WAF submitted to the regional centers were for . . . covered healthcare items or services"; "[CDDS] received funds from a Federal or State healthcare program to pay WAF for the services it billed"; or "WAF provided or billed for services or items in connection with a participant in the HCBS waiver program." NA at 9. These arguments are not supported by the record and are irrelevant in any event.

Petitioner's "no direct billing" argument rests on the fact, which is not disputed, that WAF submitted invoices for the services it provided and for which it was overpaid to a regional center that had contracted with CDDS to secure qualified vendors of services, not directly to Medi-Cal. NA at 10. Whether WAF billed Medi-Cal directly is irrelevant as a matter of law. Section 1128(a)(1) requires only that the conviction be related to the delivery of an item or service under a federal or state health care program. That criterion, as discussed above, is met in this case. How an individual or entity bills for the item or service is not a criterion for finding a basis to exclude under that section.

Petitioner's remaining three arguments involve variations on a similar theme: the alleged lack of evidence that WAF billed for services covered by the HCBS waiver program or any federal or state healthcare program. NA at 10-14. Petitioner argues that "the ALJ erroneously presumed that all vendors hired by the regional centers [to provide services to disabled persons] are paid through funds under the HCBS waiver program." NA at 10. Petitioner also asserts that "the record is devoid of any information indicating that any of the services WAF billed for were even covered by a state or federal healthcare program" and that "there is no evidence to suggest that any of WAF's customers were Medi-Cal beneficiaries, a prerequisite to being able to have non-healthcare related services nevertheless paid for by a federal or state healthcare program." NA at 12.

The ALJ did not make the presumption Petitioner suggests. The ALJ relied on "compelling evidence – which Petitioner did not rebut – that Petitioner's crime was related to the Medi-Cal program." ALJ Decision at 5. That evidence includes the Audit Declaration which Petitioner himself concedes provided "the primary factual basis" for his indictment. *Id*.; NA at 6. The ALJ noted that the Audit Declaration "includes, in some detail, the links between Petitioner's billing and the Medi-Cal program," including, the ALJ noted, the statement that "[o]nce the invoice is approved by the regional center, the claim is paid with Medi-Cal funds." ALJ Decision at 3 (citing I.G. Ex. 4, at 3). She also noted that the Auditor who prepared the Audit Declaration "is . . . well-qualified to address that process, and would be expected to know whether the Medi-Cal program was billed for specific services." *Id*.

Petitioner does not challenge the Audit Declaration or the ALJ's reliance on it, and that exhibit provides the very evidence Petitioner claims is lacking. The Audit Declaration expressly states, "Saadite Green, the sole owner of [WAF] received an excess remuneration of $455,194.58 from the Medi-Cal program between January 1, 2010 to September 30, 2012 . . . by filing false claims with overbilled hours and up-coding the rates of the services his instructors provided to adults with developmental disabilities." I.G. Ex. 4, at 1.[6] Petitioner does challenge the ALJ's purported "reliance upon the bare assertions by the prosecutor in the Criminal Case that WAF billing was paid by Medi-Cal Funds . . . ." NA at 12. Petitioner asserts that the "prosecutor's statements lack foundation." *Id*. (bold and capitalization omitted). We note that the only statements by the prosecutor in the record are in a declaration by the prosecutor submitted in the ALJ proceeding. ALJ Decision at 2; I.G. Ex. 5. Petitioner raised his "lack of foundation"

[6] We note that the Audit Declaration describes the Regional Center Provider Electronic Billing Agreement Form that all vendors of services, including WAF, were required to sign. That billing agreement states, in part: "The provider understands that payment of these claims will be from federal and/or state funds . . .; The Provider agrees that no invoice shall be submitted until the required source documentation is completed and made readily retrievable **in accordance with Medi-Cal statutes and regulations**." I.G. Ex. 4, at 12 (emphasis added).

argument regarding the prosecutor's declaration in the ALJ proceeding, but the ALJ overruled the objection. ALJ Decision at 2. After noting that the prosecutor filed the felony complaint in support of the arrest warrant, the ALJ stated that --

> [h]e would know whether Petitioner's company provided services to Medi-Cal beneficiaries because, in drafting the complaint – which also alleged that Petitioner submitted false claims to the Medi-Cal program – he would have seen the results of the state audits, as well as Petitioner's underlying billing statement and other documents.

Id. (citing I.G. Ex. 4, at 5-8 (describing the Bureau of Medi-Cal Fraud and Elder Abuse's search warrant and witness interviews)).

The ALJ found both the Audit Declaration and the prosecutor's declaration "relevant and material," stating that "they directly address the question of whether Petitioner's crime was program-related" and that "[i]n both cases, the IG laid a proper foundation to establish their reliability." ALJ Decision at 2. Petitioner, as the ALJ noted, "has rebutted none of this evidence." *Id.* at 5. Nor, as she further noted, has Petitioner "suggest[ed] that he submitted claims to any insurer other than the Medicaid program, and the record includes no references to any other insurer." *Id*. In short, Petitioner's arguments on appeal that there is no evidence connecting WAF's delivery of services to the HCBS waiver program or WAF's billing and payment for those services to the Medicaid program are not supported by an unchallenged evidentiary record.[7] Moreover, these arguments are essentially collateral attacks on Petitioner's conviction, which are not allowed in exclusion proceedings. 42 C.F.R. § 1001.2007(d); *see also Richard E. Bohner*, DAB No. 2638, at 14 (2015) (finding the petitioner's attempt to downplay facts in his indictment to be a prohibited collateral attack on his conviction), *aff'd*, *Bohner v. Burwell*, No. 2:15-cv-4088 (E.D. Pa. Dec. 2, 2016), *subsequent appeal dismissed*, No. 17-1235 (3d Cir. Mar. 9, 2017); *Kai*, DAB No. 1979, at 9 (holding that petitioner's claim of innocence in pharmacy recycling scheme for which he was convicted after pleading "no contest" was an impermissible collateral attack).

[7] Petitioner's Notice of Appeal contains multiple statements of alleged facts which Petitioner purports are supported by the Record Excerpts (Petitioner cites them as "ER") which we have not admitted into the record, *see* n.4, *supra*. *See* NA at 4-8. Since we have not admitted the Record Excerpts, we need not discuss these statements but note that, in large part, they simply involve arguments we have discussed elsewhere in our decision. For clarity's sake, we do address here Petitioner's statement that WAF was not enrolled as a provider in the Medicaid program. NA at 8. We note that the Record Excerpt Petitioner cites for this statement is actually a page in the ALJ Decision and that Petitioner gives an incomplete, out-of-context quotation of an ALJ statement on that page. The ALJ's full statement was "The I.G. explained how companies like Petitioner's – which were not enrolled in the Medicaid program – could nevertheless bill Medicaid for its services." ALJ Decision at 5. Thus, contrary to Petitioner's suggestion, the ALJ found that Petitioner's not being enrolled in Medicaid did not preclude his billing or being paid by Medi-Cal or undercut the evidence (the Prosecutor's Declaration and the Audit Declaration) that Petitioner did bill and receive payments from Medi-Cal.

Finally, we find no merit in Petitioner's argument that "the ALJ failed to consider material laws and facts." NA at 14 (bold and capitalization omitted). Presumably, Petitioner is referring to the two exhibits he submitted in the ALJ proceeding. *See* ALJ Decision at 2. The first exhibit is a document entitled "[CDDS] 2011-12 May Revision Highlights." P. Ex. 1. The ALJ Decision does not specifically discuss this document, other than to state its admission into the record. ALJ Decision at 3. However, we will not presume from that fact alone that the ALJ failed to consider it. Moreover, the Board has held that "[a]n ALJ is not required to discuss evidence that does not detract from the ALJ's findings." *Lake Park Nursing & Rehab. Ctr*., DAB No. 2035 at 18 (2006) (citing *Estes Nursing Facility Civic Center*, DAB No. 2000, at 5 (2005)); *see also Miss. Care Ctr. of Greenville*, DAB No. 2450 at 14 (2012) (While an ALJ must address evidence that conflicts with evidence supporting the ALJ's findings of fact, an ALJ is not required to discuss evidence that does not address relevant issues and, thus, does not conflict with the findings of fact on which the ALJ relied.), *aff'd*, *Miss. Care Ctr. of Greenville v. U.S. Dep't of Health & Human Servs.*, 517 F. App'x 209 (5th Cir. 2013). Nothing in the document in Petitioner Exhibit 1 tends to undercut the ALJ's findings of fact; nor is it relevant to her decision. Petitioner says that the document shows "that the HCBS waiver program only accounted for a small portion of its overall budget." NA at 14. Although Petitioner provides no explanation as to why this alleged fact is relevant, we suspect he offered this information to try to support his argument that there is no evidence WAF was paid from Medi-Cal funds as opposed to other CDDS funding. However, a generic breakdown of CDDS funding sources, in contrast to the Audit Declaration and the prosecutor's declaration on which the ALJ relied, says nothing about the billing by and payments to WAF for the services it delivered. Accordingly, Petitioner Exhibit 1 would be incapable of undercutting the ALJ's decision, which relied on the Audit Declaration and the prosecutor's declaration as providing direct, credible evidence that Petitioner was paid by Medi-Cal.

Petitioner Exhibit 2 is not evidence but, instead, a copy of the federal court decision *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005). The issues in *Sanchez* were whether developmentally disabled recipients of Medicaid and their services providers have a private right of action against California state officials to compel enforcement of a federal law governing state disbursement of Medicaid funds and whether California had unlawfully discriminated in the wages it paid community-based service providers. Although the court discussed the HCBS waiver program, that discussion, as the I.G. notes, "merely provided generic descriptions about how [CDDS] funding interacted with the HCBS waiver program." I.G. Response to Appeal at 11. Therefore, the *Sanchez* decision is not relevant and does not detract from the ALJ's findings and conclusion, and the ALJ was not required to address it in her decision.

Conclusion

For the reasons stated above, we affirm the ALJ Decision.

/s/
Constance B. Tobias

/s/
Susan S. Yim

/s/
Sheila Ann Hegy
Presiding Board Member