STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of	:	
Suffolk Center for Rehabilitation and Nursing	:	**Decision**
Medicaid ID #00314690; Audit #14-4118,	:	**After**
Appellant,	:	**Hearing**
from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments.	:	

Before: Ann H. Gayle
Administrative Law Judge

Held at: New York State Department of Health
90 Church Street
New York, New York 10007

Hearing Dates: November 27, 2018, March 13 and 14, and June 25, 2019
Record closed February 10, 2020

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

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

OMIG determined to seek restitution of payments made under the Medicaid Program to Suffolk Center for Rehabilitation and Nursing (Appellant). Appellant requested a hearing pursuant to SSL 22 and the former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the determination.

HEARING RECORD

Witnesses testified, a transcript (T) (pages 1-527) of the hearing was made, and exhibits (Ex) were offered into evidence.

OMIG witness:	Kevin Banach
OMIG exhibits in evidence:	1-9, 12-20
OMIG exhibits for ID:	10 and 11 (remained with OMIG)
Appellant witnesses:	[redacted] and [redacted]
Appellant exhibits in evidence:	A-G, I, N, Q-V
Appellant exhibits for ID:	H, J-M, O-P (remained with Appellant)

The parties submitted post hearing briefs (OMIG brief; App brief) and reply briefs (OMIG reply; App reply). The record closed on February 10, 2020.

SUMMARY OF FACTS

1. Appellant Suffolk Center for Rehabilitation and Nursing (Suffolk) is a 120-bed residential health care facility (RHCF), or nursing home, in Patchogue, New

York. It is licensed under PHL Article 28 and enrolled as a provider in the Medicaid Program. (App brief, p 7; OMIG brief, p 7)

2. In 2011, OMIG initiated a review of Appellant's reimbursement for Medicaid recipients who resided at Suffolk during the period February 1, 2007 through January 31, 2011. The review of Appellant's Medicaid claims and resident Medicaid eligibility information during this audit period was conducted by OMIG's contracted agent, Health Management Systems, Inc. (HMS). OMIG provided to Appellant final exit documentation dated February 15, 2012. (Ex 17; T 63-65, 68-69, 71-76)

3. OMIG's review included:

> NAMI – Medicaid reimbursements paid without being reduced by partial or full net available monthly income (NAMI);
>
> Other Payor Sources – Medicaid reimbursements paid for services covered either partially or in full by other payor sources including Medicare, commercial insurers, and other private payors;
>
> Bed Reservations – Medicaid reimbursements paid for bed reservations on behalf of recipients who have not established residency or on days when the facility had a vacancy rate in excess of 5%;
>
> Incorrect Rate Code – Medicaid reimbursements billed at the incorrect rate code based on the recipient's Medicare eligibility.

OMIG issued a draft audit report (draft) on July 22, 2014. The draft sought reimbursement of the auditors' identified Medicaid Program overpayments to Suffolk in the total amount of $135,529.53 for: Finding 1–NAMI; Finding 2–Other Payor Sources; Finding 3–Bed Reservations; and Finding 4–Incorrect Rate Code. (Ex 1; T 66-68, 76-77)

4. Appellant's response to the draft (response) consisted of a letter dated August 25, 2014, which "incorporate[ed] by reference" an attached letter dated December 15, 2011, and an attached "copy of an analysis of the amounts of uncollected NAMIs in

the amount of $345,680.12, that [Appellant] has suffered and for which [Appellant] seeks offset or repayment." (Ex 2; Ex B). The response consisted of legal arguments and reference to a declaratory action counsel commenced in another matter in Kings County, Index No. 68/2014. The response did not challenge any of the specific overpayments identified in the draft, and no documentation challenging the identified overpayments was submitted. (Ex 2; Ex B; T 78-79, 124-125, 131, 153, 261)

5. OMIG issued a final audit report (final) dated August 13, 2015. The final listed and set forth reasons for each disallowed payment and notified Appellant that OMIG had determined to seek restitution of Medicaid Program overpayments in the total amount of $99,137.60; this included interest in the amount of $12,620.61. The findings and overpayments were for: Finding 1–NAMI in the amount of $39,333.32; Finding 2–Other Payor Sources in the amount of $14,757.44; and Finding 3–Incorrect Rate Code in the amount of $32,426.23. (Ex 3; T 80-93)

6. On September 3, 2015, Appellant requested an administrative hearing to challenge OMIG's determination. The hearing commenced on November 27, 2018, and continued on March 13 and 14, 2019. On April 12, 2019, Appellant requested consolidation of this hearing with fifteen others. Appellant's request, opposed by OMIG, was denied on May 14, 2019. The hearing concluded on June 25, 2019. (Ex D)

7. At the hearing, Appellant withdrew its challenge of Findings 2 and 3, but contests the interest charged in all three findings. OMIG rescinded 41 claims (for "Retroactive NAMI") from Finding 1 totaling $1,917.15 plus the interest thereon of $347.89. OMIG's reply reads, "As such, the revised overpayment … in this administrative hearing includes the remaining claims in Finding 1 resulting in

overpayment of $37,415.37. The [total] overpayment being sought [by OMIG] at this hearing is $97,219.65 plus the calculated interest of $12,272.72" (OMIG reply, p 10). (T 443-449)

ISSUES

Was OMIG's determination to recover Medicaid Program overpayments from Appellant Suffolk Center for Rehabilitation and Nursing correct?

Was OMIG's determination to recover interest from the date of the overpayments correct?

APPLICABLE LAW

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

When the Department has determined that claims for medical services have been submitted for which payment should not have been made, it may require repayment of the amount determined to have been overpaid. 18 NYCRR 518.1(b). An overpayment includes any amount not authorized to be paid under the Medicaid Program, whether paid

as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake. 18 NYCRR 518.1(c).

Interest may be collected upon any overpayments determined to have been made. 18 NYCRR 518.4(a). Interest will accrue from the date of the overpayment. 18 NYCRR 518.4(b)&(c). No interest will be imposed on an inpatient facility established under PHL Article 28 as a result of an audit of its costs for any period prior to the issuance of a notice of determination. 18 NYCRR 518.4(e).

A person is entitled to a hearing to have the Department's determination reviewed if the Department requires repayment of an overpayment. 18 NYCRR 519.4. At the hearing, Appellant has the burden of showing that the determination of the Department was incorrect and that all claims submitted and denied were due and payable under the Medicaid Program. 18 NYCRR 519.18(d).

Computer generated documents prepared by the Department or its fiscal agent to show the nature and amount of payments made under the Medicaid Program will be presumed, in the absence of direct evidence to the contrary, to constitute an accurate itemization of the payments made to a provider. 18 NYCRR 519.18(f).

A nursing home's costs for Medicaid eligible patient care are reimbursed by means of a per diem rate set by the Department on the basis of data reported by the facility. PHL 2808; 10 NYCRR 86-2.10. The nursing home's Medicaid rate is the daily amount that it may charge for the care of a Medicaid eligible resident.

A nursing home is not, however, always entitled to charge its full Medicaid rate to the Medicaid program for each Medicaid eligible resident. Medicaid recipients in nursing home care are required to contribute toward the cost of their care if they have available

income. A Medicaid recipient's local social services district, which determines Medicaid eligibility, calculates the recipient's NAMI which represents income that the recipient is required to contribute for the cost of nursing home care while Medicaid covers the balance. The local district issues a budget letter for each recipient that establishes the recipient's NAMI amount. SSL 366; 18 NYCRR 360-4.6, 4.9.

The nursing home's monthly Medicaid rate charges to the Medicaid Program for the resident's care must be reduced by the resident's NAMI. The nursing home's Medicaid claims for the resident's monthly care must reflect the resident's NAMI amount and be adjusted accordingly. 42 CFR 435.725; Residential Health Care UB-04 Billing Guidelines, Version 2007 - 1 (01/09/07), Version 2008 - 3 (06/04/08); Ex 12; Ex 13.

Regulations of the former DSS most pertinent to this hearing decision are at 18 NYCRR Parts 517 (provider audits), 518 (recovery and withholding of payments or overpayments) and 519 (provider hearings).

The New York State Medicaid Program issues Medicaid Program UB-04 Billing Guidelines, January 2007, June 2008, etc. (Ex 13) and Medicaid Management Information Systems (MMIS) provider manuals, which are available to all providers and include, among other things, billing policies, procedures, codes and instructions (www.emedny.org). The Department of Health also issues "Dear Administrator" letters (DAL), including DAL October 26, 2001 (Ex 14) and Administrative Directives (ADM), including ADM-6 dated July 17, 2000 (Ex 18). Providers are obligated to comply with these official directives. 18 NYCRR 504.3(i); Lock v. NYS Department of Social Services, 220 A.D.2d 825, 632 N.Y.S.2d 300 (3rd Dept. 1995); PSSNY v. Pataki, 58 A.D.3d 924, 870 N.Y.S.2d 633 (3rd Dept. 2009).

DISCUSSION

The final audit report incorporated OMIG's conclusions after review of Appellant's response to its July 22, 2014 draft audit report, in accordance with audit procedures set forth at 18 NYCRR 517.5 and 517.6. Reasons for the overpayments were set forth in three categories/Findings. OMIG rescinded 41 claims (for "Retroactive NAMI") from Finding 1, and except for the interest charged on the overpayments in all three categories, Appellant withdrew its challenge of Findings 2 and 3. As such, only interest and the first category remain at issue for this hearing decision.

Category/Finding 1: Medicaid reimbursements paid without being reduced by partial or full NAMI

Auditors reviewed Medicaid eligibility information on Appellant's residents during the audit period to determine whether Appellant's claims for their care were reduced to accurately reflect the residents' NAMI obligations. In many instances the auditors found that Appellant did not reduce its monthly claims to reflect the residents' NAMI amounts[1].

UB-04 Billing Guidelines, a Medicaid directive, instructs providers to accurately report a resident's NAMI amount when submitting claims for payment. In the event that a NAMI is not yet determined by the local district for a newly admitted resident, the nursing home "should not bill Medicaid until [the nursing home] receive[s] a copy of the budget letter … indicating the NAMI amount and effective date of the NAMI." DAL October 26, 2001 (Ex 14)

[1] *As stated at pages 6-7 of Appellant's reply brief, Appellant did reduce some of its billings by the NAMIs when first submitting them; these overpayments were due to retroactive changes to the NAMIs, but these types of disallowances were rescinded by OMIG at the hearing and therefore not addressed in this decision.*

A resident's monthly NAMI obligation is between the resident and the facility, and it is the facility's responsibility to collect it. The facility is not entitled to turn to the Medicaid Program to make good its loss if the resident does not pay. "This reading of the statute is plainly supported by the federal regulations, which make clear that state Medicaid agencies may not pay institutions any amounts that are the patient's responsibility." Florence Nightingale Nursing Home v. Perales, 782 F.2d 26 (2nd Cir. 1986.)

Appellant argues it is entitled to Medicaid reimbursement for "bad debts" it experiences from uncollected NAMIs of the residents. Appellant proffers that "bad debt," once "good faith efforts" to collect it have been made, is an item that can properly be included in a facility's cost report and subsequent calculation of its Medicaid reimbursement. From this assertion about what, generally, may be reportable costs for the calculation of a Medicaid rate, Appellant then shifts to the entirely different proposition that it is entitled to simply apply "bad debt" loss, dollar for dollar, to offset overpayments identified in this audit of its Medicaid claims. Appellant's theory that "uncollected NAMIs in the amount of $345,680.12, that [Appellant] has suffered and for which [Appellant] seeks offset or repayment" (Ex 2; Ex B) should be applied to the overpayments identified in this audit relies on erroneous reasoning, is inconsistent with Medicaid reimbursement methodology and regulations, and even on its own terms is not supported by evidence.

Appellant has not explained how it made "good faith efforts" to obtain payment before charging the Medicaid Program for these resident NAMI contributions. For example, Appellant has not explained (other than the statements by its witnesses (T 380,

423, 453-456) of how, generally, they bill and try to collect) what those "good faith efforts" were with regard to the residents involved in this audit. Appellant has not come forward with evidence of residents (let alone those who were identified in this audit) who, initially not paying the NAMI, were pursued in a "good faith effort" to collect it.

It is further noted that Appellant offered no testimony that it reimbursed the Medicaid Program for NAMI amounts it had billed to Medicaid that it eventually, by “good faith” efforts, recovered from a resident, particularly with regard to the residents involved in this audit. Appellant made a practice of billing Medicaid for these NAMIs before they became "bad debts." "Good faith efforts" did not come into it. Even if Appellant had provided such evidence, a resident’s monthly NAMI obligation is between the resident and the facility, and it is the facility’s responsibility to collect it. The facility is not entitled to turn to the Medicaid Program to make good its loss if the resident does not pay.

None of the authorities cited by Appellant support the assertion that unpaid NAMI is always, necessarily, or indeed ever, "bad debt" that may be applied, dollar for dollar, to set off overpayments identified in an audit of fee-for-service claims. Appellant cites (and misrepresents the holding in) Eden Park Health Services v. Axelrod, 114 A.D.2nd 721; 494 N.Y.S.2nd 524 (3rd Dept. 1985). Eden Park involves an appeal regarding a facility’s Medicaid rate, and whether bad debt expenses may be reported as allowable costs in determining a rate. Eden Park recognizes that bad debts are an item that can be looked at in connection with reported costs used to determine a facility's rate, and under some circumstances might be allowable in the calculation of the rate. The court did not find an

entitlement to reimbursement of bad debts in any fashion other than by consideration of it in connection with a determination of a facility's rates.

Appellant seeks payment in this fee-for-service audit for what it claims is a reportable "bad debt" cost, without providing evidence that it reported that cost by including it on a cost report for inclusion in its rate. By confusing Medicaid cost-based reimbursement 18 NYCRR 517.3(a) with fee-for-services reimbursement 18 NYCRR 517.3(b), Appellant is attempting to hold the Medicaid Program responsible for charges for which it has specifically determined it is not responsible: "Medicaid agencies may not pay institutions any amounts that are the patient's responsibility." Florence Nightingale, *supra*.

Appellant's objections to the audit findings attempt to raise issues about cost reporting and rate setting processes that resulted in the setting of its per diem Medicaid reimbursement rates. These matters are irrelevant to this hearing which is about an audit of specific fee-for-service claims submitted for services to individual Medicaid recipients. Appellant's per diem Medicaid rate for these services was not reviewed in this audit and it is not reviewable in this hearing. 18 NYCRR 519.18(a).

At issue in this hearing are entirely different Medicaid determinations that were made by the social services districts for Appellant's nursing home residents. 42 USC 1396p(h); SSL 366.5. Those determinations established the Medicaid Program would NOT be responsible for a portion of the facility's per diem rate because the residents had the resources with which to pay it. 42 CFR 435.725. A failure by these residents to pay their NAMIs is between the residents and the facility and is not chargeable to Medicaid. That is the entire point of a NAMI.

Florence Nightingale could not be more explicit in rejecting Appellant's position in this hearing:

> It is arguable that NAMI payments remaining uncollected despite reasonable collection efforts are an overhead cost reimbursable like all other costs of providing covered services. But the Secretary's view, expressed in an amicus brief, that uncollected NAMI is not reimbursable is the more reasonable interpretation and is entitled to "particular deference." DeJesus v. Perales 770 F.2d 316, 327 (2d Cir. 1985).
>
> This reading of the statute is plainly supported by the federal regulations, which make clear that state Medicaid agencies may not pay institutions any amounts that are the patient's responsibility. The regulations state that "[t]he agency must reduce its payment to an institution, for services provided to an individual . . ., by the amount that remains after deducting the amounts specified in paragraph (c) of this section [*i.e*., the individual's allowance], from the individual's income." 42 C.F.R. §§ 435.725, 435.832 (1984). The regulations are consistent with the statutory plan that Medicaid funds not be paid to reimburse those costs that patients with resources of their own can afford.
>
> The regulatory scheme is not altered by 42 C.F.R. § 447.15. According to section 447.15, "[a] State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency. . . ." The District Court construed this to mean that states rather than providers should be the guarantors of payment. 570 F.Supp. at 288. This interpretation is inconsistent with both the statute and the other regulations…
>
> Nor does *Seneca Nursing Home, supra,* cited by the District Court, aid the appellee. In that case, the Tenth Circuit held that a Kansas statute required the state agency to reimburse medical providers for uncollected patient contributions. 604 F.2d at 1314-15. As we have stated, 42 U.S.C. § 1396a(a)(13)(E) required payment by the state only of the cost of services covered by Medicaid. The statute was silent on the consequences of a state's decision voluntarily to reimburse providers for costs not covered by Medicaid, such as patients' NAMI. However, nothing in *Seneca Nursing Home* permits a state that makes such voluntary reimbursement to receive federal reimbursement for such payments. In any event there is no New York statute analogous to the Kansas statute in *Seneca Nursing Home*.
>
> Both the statute and the regulations make clear that the financial responsibility for patient NAMI is not borne by the Medicaid program. The burden of uncollectible NAMI does not fall on the city, state, or federal government but rather on the institutional provider. (Florence Nightingale)

Without disputing the holding in Florence Nightingale that federal regulations do not permit state Medicaid agencies to pay patient NAMI obligations, Appellant turns to a claim that Eden Park establishes that New York Medicaid must reimburse providers for "bad debt" (App reply, p 11-12.). Eden Park involved a challenge to a rate setting determination of whether bad debts must be considered in a determination of a facility's reimbursement rate. It is not about directly reimbursing any specific fee-for-service charges at that rate. Eden Park ordered the provider:

> … be given a hearing with regard to such bad debts, the origin of which is unclear. At that hearing, in order to have their claim allowed on this item, petitioners must show, *inter alia*, that the bad debts in question were related to covered services and derived from deductible and coinsurance amounts and that reasonable collection efforts had been made (10 NYCRR 86-2.17 [a]; 42 C.F.R. § 405.420 [d], [e]).

There is no suggestion in Eden Park that the alleged bad debt in that case, "the origin of which is unclear," could simply be applied to offset Medicaid claim overpayments.

Nor does Eden Park suggest that New York has in any way decided "voluntarily to reimburse providers for costs not covered by Medicaid, such as patients' NAMI." Florence Nightingale, *supra*. In fact, Florence Nightingale specifically noted that there is no such requirement in New York. *id*. The Appellant's suggestion (App brief, p 15-17) that the 10 NYCRR 86.2.17(a) reference to Medicare principles of reimbursement that allegedly recognize unpaid NAMI as "bad debt" override specific New York and federal Medicaid law to the contrary, is explicitly contradicted by 86-2.17(a) itself and is without merit.

Appellant commenced an action in 2012 (Index 305755/12) arguing the issues it seeks to raise in this hearing. That action was dismissed in its entirety. Concourse

Rehabilitation & Nursing Center, Inc. v. Shah, (A.D. 1st Dept. May 29, 2018) (Ex F).

Appellant misrepresents the Concourse decision by claiming:

> The Appellate Division ruled, in *Concourse*, that the issues raised in the Concourse appeal have to be raised via administrative review, and directed that it be done. (App reply, p 2)

Appellant further misrepresents the Concourse decision by claiming:

> The Appellate Division has made plain that the bad debts issue as related to Eden Park had to be heard in the administrative hearing process and it directed these cases to proceed to hearing on this issue.
> …and that
> The Appellant Division decision is the reason for these hearings being scheduled by OMIG. (App reply, p 6)

The Appellate Division did not hold or "make plain" that the "bad debts issue as related to Eden Park … have to" be raised in an administrative review or anywhere else, nor did it "direct these cases to proceed to hearing on this issue." The Appellate Division did not direct the "bad debt" claim to be addressed in any audit, and it did not direct any administrative review. The reason for this hearing being scheduled is that OMIG issued a final audit report and Appellant then requested an administrative hearing.

The Appellant Division did not in any way address Appellant's ability to write-off bad debts related to a Medicaid recipient's NAMI or OMIG's treatment of its allegedly uncollectible NAMI debt. It simply dismissed Appellant's state court action seeking a declaratory judgment and seeking to annul the Concourse audit because:

> Plaintiff commenced the action prior to OMIG's issuance of its draft and final audit reports for the subject years and did not avail itself of the administrative remedies available after issuance of the report, including by issuing a statement detailing items of objection to the draft report and requesting a hearing. (Concourse)

The "bad debt" claim, nonetheless, has been addressed herein and it is found to be both without merit and irrelevant to the fee-for-service overpayments identified in this audit.

New York law is in accordance with Federal Medicaid law which -as was held in Florence Nightingale- is that the Medicaid Program is not responsible to reimburse providers for unpaid NAMIs.

The audit findings that Appellant submitted claims to the Medicaid Program that included NAMI amounts of more than $37,000 that were the responsibility of the residents are not disputed by Appellant. Appellant's response (Ex 2; Ex B), which did not address the specific disallowed payments, did not, pursuant to Concourse "detail items of objection to the draft report." Appellant's only witnesses, Usher Halberstam and Yaakov Bedziner, were not familiar with the final audit report (T 412-413, 422, 471-472, 495) and they did not give any testimony about the specific disallowed payments. As such, Appellant has failed to establish that OMIG's determination to recover Medicaid Program overpayments from Appellant was not correct and that all claims submitted and denied were due and payable under the Medicaid Program.

Interest

OMIG calculated interest from the date of the overpayments in accordance with 18 NYCRR 518.4(b)&(c). Appellant offered no evidence to rebut the presumption of accuracy in the Department's Medicaid payment records or to dispute the accuracy of its calculations of interest based on those records. 18 NYCRR 519.18(f). Appellant's witness suggested that there is a lag of up to 15 days from the date a claim is processed until a facility receives the payment (T 399) but Appellant did not present any evidence to support this allegation, to show when any of the payments in dispute were actually made, or to otherwise demonstrate that OMIG's interest calculations for any of the overpayments identified in this audit were inaccurate.

Appellant's argument that OMIG incorrectly imposed interest from the date of the overpayments pursuant to 18 NYCRR 518.4(b)&(c), instead of from the date of issuance of the audit report pursuant to 18 NYCRR 518.4(e), attempts to confuse audits of cost reports with fee-for-service audits (App brief, p 24; App reply, p 18). As this audit was not an audit of Appellant's costs, 18 NYCRR 518.4(e) is inapplicable. Interest was properly charged pursuant to 18 NYCRR 518.4(b)&(c).

DECISION

OMIG's determination to recover Medicaid Program overpayments is correct and is affirmed.

OMIG's determination to calculate interest on the overpayments in the manner it did is correct and is affirmed.

This decision is made by Ann H. Gayle, Bureau of Adjudication, who has been designated to make such decisions.

DATED: New York, New York
April 27, 2020

Ann H. Gayle
Administrative Law Judge

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