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NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

August 16, 2022

CERTIFIED MAIL/RETURN RECEIPT

Marvin Neiman, Esq.
Theodore T. Mairanz, Esq.
Neiman and Mairanz, P.C.
39 Broadway, 25th Floor
New York, New York 10006

Philip Hoffman, Esq.
Office of the Medicaid Inspector General
90 Church Street, 14th Floor
New York, New York 10007

RE: In the Matter of Brooklyn Center Rehab & Residential Healthcare

Dear Parties:

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

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

Sincerely,

Sean D. O'Brien

Sean D. O'Brien
Acting Chief Administrative Law Judge
Bureau of Adjudication

SDO: cmg
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

COPY

In the Matter of the Appeal of **Brooklyn Center Rehab & Residential Healthcare** Medicaid ID #00312547; Audit #14-4088, Appellant, from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments.	**Decision After Hearing**

Before: Ann Gayle
Administrative Law Judge

Hearing Dates: March 16, 2021
March 25, 2021
Record closed November 8, 2021

Held at: New York State Department of Health
Remotely via Cisco Webex

Parties: New York State Office of the Medicaid Inspector General
90 Church Street, 14th Floor
New York, New York 10007
By:. Philip Hoffman, Esq.

Brooklyn Center Rehab & Residential Healthcare
170 Buffalo Avenue
Brooklyn, New York 11213
By: Neiman & Mairanz P.C.
39 Broadway, 25th floor
New York, New York 10006
Marvin Neiman, Esq., Of Counsel
Theodore T. Mairanz, Esq., Of Counsel

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 Brooklyn Center Rehab & Residential Healthcare (Appellant). Appellant requested a hearing pursuant to SSL 145-a, 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 1-279) of the hearing was made, and exhibits (Ex) were offered into evidence.

OMIG witness:	Kevin Banach
OMIG exhibits in evidence:	1-18
OMIG exhibits for ID:	None
Appellant witnesses:	[redacted]
Appellant exhibits in evidence:	B-C, E-I
Appellant exhibits for ID:	A and D (remained with Appellant)

The parties submitted post hearing briefs (OMIG brief; App brief) and reply briefs (OMIG reply; App reply). The record closed on November 8, 2021.

SUMMARY OF FACTS

1. Appellant Brooklyn Center Rehab & Residential Healthcare (Brooklyn Center) is a 281-bed residential health care facility (RHCF), or nursing home, in

Brooklyn, 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 3)

2. By letter dated August 31, 2011, OMIG initiated a review of Appellant's reimbursement for Medicaid recipients who resided at Brooklyn Center during the period March 1, 2007 through February 28, 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). There was ongoing communication and letter and document exchange between Appellant and HMS from August 2011 until the final documentation was provided to Appellant in January 2013. (Exhibits 1 through 6; T 82-96)

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 room and board or other services covered either partially or in full by other payor sources including Medicare, commercial insurers, and other private payors;

Incorrect Rate Code – Medicaid reimbursements billed at the incorrect rate based on the recipient's Medicare eligibility;

Post Resident Discharge – Medicaid reimbursements billed at for dates of service beyond the date of resident death or discharge.

OMIG issued a draft audit report (draft) on July 21, 2014. The draft sought reimbursement of the auditors' identified Medicaid Program overpayments to Brooklyn Center in the total amount of $147,569.95, inclusive of interest. Audit findings were made in three categories: Finding 1–NAMI ($65,451.98 + interest); Finding 2–Other Payor Sources ($30,121.91 + interest); and Finding 3–Duplicate Room & Board Services

($32,439.73 + interest). The accrued interest for these overpayments totaled $19,556.33. (Ex 2; Ex 7)

4. Appellant's response to the draft (response) consisted of a letter dated September 16, 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 NAMI's (sic) in the amount of $187,531.00, that [Appellant] has suffered and for which [Appellant] seeks offset or repayment." (Ex 16). The response consisted of legal arguments. The response did not challenge any of the specific overpayments identified in the draft, and no documentation challenging the identified overpayments was submitted. (Ex 16)

5. On October 16, 2014, OMIG issued a final audit report (FAR). On November 4, 2014, Appellant informed OMIG that: Appellant objected to the audit adjustments in the FAR; the FAR did not afford Appellant any right to a hearing; and averred that the interest charges are illegal per 18 NYCRR 518.4(e). (Ex B)

6. On August 12, 2015, OMIG rescinded the FAR and issued a Revised Final Audit Report (final). 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 $147,569.95, inclusive of interest ($128,013.62 + 19,556.33). The findings and overpayments were unchanged from the draft. (Ex 9; T 59)

7. In an October 14, 2015 letter, Appellant averred that the "notice" was defective because a copy was not provided to Appellant's counsel, and claimed that Appellant's counsel had "already requested a hearing ... in its November 4, 2014 letter"

(it had not). Appellant's "continue[d] request for a hearing" is deemed its request for the instant hearing. Similar to the draft response, Appellant's counsel wrote, "We are responding to preserve our client's rights and without waiver of any of our client's rights … it is our client's position that it is entitled to a complete accounting as to the details in its patient ledger accounts; rather than a partial one as propounded by your auditors, on your agency's behalf." Counsel added, "Since we believe that the issues in the audit related to issues of Medicaid rate methodology, which are beyond your office's purview, we have commenced a declaratory action in the Supreme Court, Kings County, under Index No. 68/2014. Furthermore, we object to the revised final audit on the grounds that it seeks to make an end run around the regulatory time frame within which a requested hearing is to commence." This hearing was noticed for January 11, 2016. Adjournments on consent were granted as Appellant's counsel pursued related matters in court. On April 12, 2019, Appellant requested consolidation of this hearing with an already commenced hearing, Matter of Suffolk Center, and sixteen others. Appellant's request, opposed by OMIG, was denied on May 14, 2019. This hearing was held on March 16 and March 25, 2021. (Ex 11; Ex 12)

8. Subsequent to the final and at or prior to the hearing, Appellant withdrew its challenge of Findings 2 and 3, but continues to contest the interest charged in all three findings. OMIG agreed to remove 69 retroactive NAMI claims in the amount of $11,259.20 ($9,727.43 + $1,531.77 interest) from Finding 1. This reduced Finding 1 from $74,805.75 to $63,546.55, and thereby reduced the total overpayment sought by OMIG from $147,569.95 to $136,310.75. Appellant concedes the $62,561.64 overpayment for Findings 2 and 3, but contests the associated $10,202.56 interest for those findings.

Appellant further contests the Finding 1 overpayment ($55,724.55) and interest ($7,822.00) totaling $63,546.55. The total amount contested is $73,749.11 (NAMI amount of $55,724.55 + interest for all three findings of $18,024.56). (Ex 9; Ex 15; Ex 18; T 59-60; OMIG brief, p 5-6; T 58-60, 105)

ISSUES

Was OMIG's determination to recover Medicaid Program overpayments from Appellant Brooklyn Center Rehab & Residential Healthcare 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) and (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) and (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).

The issues and documentation considered at the hearing are limited to issues directly relating to the final determination. An Appellant may not raise issues regarding the methodology used to determine any rate of payment or fee, nor raise any new matter not considered by the Department upon submission of objections to a draft audit report. 18 NYCRR 519.18(a).

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 on a cost report. PHL 2808; 10 NYCRR 86-2.10. The nursing home's Medicaid rate determines the daily amount that it may charge for the care of a Medicaid eligible resident. A nursing home may not charge a Medicaid eligible resident more than the facility's Medicaid rate. 10 NYCRR 415.3(i)(1)(i)(b). This does not mean, however, that a nursing home is always entitled to charge the Medicaid Program at its full Medicaid rate.

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 bills to the Medicaid Program for the resident's care must be reduced by the resident's NAMI. 42 CFR 435.725. The Medicaid Program will not pay any amounts that are the patient's responsibility. Florence Nightingale Nursing Home v. Perales, 782 F.2d 26 (2d Cir. 1986) (Ex 17).

The New York State Medicaid Program issues Medicaid Program UB-04 Billing Guidelines, 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, and

Administrative Directives (ADM), including ADM-6 dated July 17, 2000. (Ex 17.) 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).

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).

DISCUSSION

The revised final audit report incorporated OMIG's conclusions after review of Appellant's response to its July 21, 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 agreed to remove 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.

NAMI

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, *supra*.

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 $187,531.00 that [Appellant] has suffered and for which [Appellant] seeks offset or repayment" (Ex 16) 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's response to the draft audit report offered a bare assertion that it had $187,531.00 in uncollected resident NAMI during the audit period. It demanded "offset or repayment" of that amount in connection with this audit with the result that, according to Appellant, the Medicaid Program would owe it $48,334.84 (Ex 16, p 2279). In its brief (page 25-26) Appellant writes,

> Since Appellant is entitled to reimbursement for all of its NAMI bad debts, the amount the facility has written off as NAMI bad debt of $187,531.00 (Ex 16, p 2279) should be allowed in the final audit, as is required by §86-2.17(A) and thereafter netted out against the full principal amount currently being sought in this audit of $118,286.19 (Ex 18, p 2471). Thus, the total principal amount due to Appellant on this audit is $69,244.81.

At page 23, Appellant argues

> the unrefuted amount of these bad debts is $187,531.00 (Ex 16, p 2279) [footnote] This was the amount of bad debt reported to the auditors. The auditors had all the information needed to verify it (T 141-142) and did not challenge the amount of bad debts. Nor was the amount refuted at the hearing. Accordingly, this amount must be accepted as fact.

This is based on its argument at page 19 that

> Appellant presented testimony at the hearing that detailed the processes that it engages in to collect the NAMI's [*sic*] and also explained that in some cases, after all of its efforts fail, it has to write-off these amounts as bad debts. (T 260-263) It presented the *detail* (italics added) of the amounts written off. (Ex 16, p 2279).

The "*detail of the amounts written off*" in Ex 16, p 2279 consisted of a table as follows:

Rate Dif	11,182.54
BH Overbilling	62,561.64
NAMI Audit	65,451.98
Total HMS/OMIG	**139,196.16**
O/S NAMI (Audit Period)	187,531.00
NAMI W/O's (Audit Period)	
O/S NAMI (Prior Period)	
NAMI W/O's (Prior Period)	
Total Creits (sic)	**187,531.00**
Net Due To/(From) DOH	**(48,334.84)**

Appellant's argument is

> Appellant established that [Appellant] did claim Medicare bad debts in its cost reporting process and after Medicare reviewed its collection efforts, Medicare decided to actually reimburse the claimed bad debts in the Medicare settlement, which could only occur if [Appellant] met the Medicare Program's requirements therefor relating to the "good faith collection efforts" in the Medicare principles. (T 192-193, 194-195, 215-216)

Appellant seeks to make the leap that its witnesses' testimony that Medicare reimbursed Appellant for bad debt, a settlement that could only occur if Appellant met the *Medicare* Program's requirements, means that it should now be reimbursed by the Medicaid program dollar-for-dollar in this audit of Appellant's fee-for-service claims. Appellant did not present anything more than general assertions that it has a policy of making collection efforts (T 179-180, 260-263). Appellant has not explained how it made "good faith efforts" to obtain payment before charging the Medicaid Program for these residents' NAMI contributions. For example, Appellant has not explained (other than the statements by its witnesses 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.

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 offset overpayments identified in an audit of fee-for-service claims. Appellant misrepresents the holding in Eden Park Health Services v. Axelrod, 114 A.D.2nd 721; 494 N.Y.S.2nd 524 (3rd Dept. 1985) (Ex G). 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.

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 "NAMI bad debt" contention is meritless in that it asserts a connection between uncollected resident NAMI and the audit findings; there is no such connection. In its September 16, 2014 response to the draft audit report, Appellant itself took this very position about the contentions it now seeks to raise in this hearing:

> We believe that the issues in the audit relate to issues of Medicaid rate methodology, which are beyond your office's purview and are not subject to an administrative hearing. (Ex 16)

Appellant is attempting to confuse and to obscure the result it seeks, which is to obtain Medicaid reimbursement for resident NAMI obligations that under federal and state Medicaid regulations, and the pertinent court decisions, are not reimbursable by the Medicaid Program. It is well settled that the NAMI obligation is between the resident and the nursing home, and that the Medicaid Program will not pay any amounts that are the patient's responsibility. 42 CFR 435.725; 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).

Appellant claims that Eden Park establishes that New York Medicaid must reimburse providers for "bad debt" (App brief, p 18; App reply, p 4). 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.* Appellant's suggestion (App brief, p 14-15) 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, 161 A.D.3d 669, 78 N.Y.S.3d 60 (1st

Dept. 2018), *lv denied* 32 N.Y.3d 904, 84 N.Y.S.3d 859 (2018) (Ex C). Appellant misrepresents the Concourse decision by claiming that the Appellate Division "on the issue of whether *Eden Park* applied *vel non*, ruled that the matter should first proceed in the administrative process before the Court would entertain the issue." (App brief, p 1, 6). The reason for this hearing being scheduled is that OMIG issued a final audit report and Appellant then requested an administrative hearing.

The Appellate Division did not 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 accord 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 $60,000 that were the responsibility of the residents are not disputed by Appellant. Appellant's response (Ex 16), which did not address the specific disallowed payments, did not, pursuant to Concourse "detail items of objection to the draft report."

OMIG's witness, by giving testimony about samples representative of all the disallowances, described in detail how the disallowances were calculated, thereby meeting OMIG's responsibility under 18 NYCRR 519.17 to present the audit file and summarize the case (Ex 2; Ex 3; Ex 4; Ex 5; Ex 6; Ex 10; Ex 15; T 121-138, 147-151, 156-160, 167-168).

It is Appellant's burden to provide evidence and prove that OMIG's disallowances should not stand. 18 NYCRR 519.18(d). Appellant's witnesses, [redacted] and [redacted] testified in a general way about audits, NAMI, and Appellant's efforts to collect NAMI (T 178-180, 260-263, 265-266). Mr. [redacted] and Mr. [redacted] testified that the Medicaid Program does not pay or reimburse facilities for bad debt (T 236, 267). Mr. [redacted] testified on direct examination, "Does that also occasionally include NAMI bad debts? Yes. For who was that, *which patient*? *I don't know the specific patients offhand*, but it's pretty common that we should have at least one of them on every single report where a dual-eligible patient was billed and did not pay, so we would then put it on the Medicare bad debt log." (emphasis added) (T 186-187). Mr. [redacted] was not involved in this audit, and he did not review any documents to determine whether good faith efforts were made to collect the NAMI (T 190, 191, 192). Mr. [redacted] testified that he did not "have any familiarity with [this] audit" (T 237) and that he has "never reviewed or seen" Appellant's Exhibit F which is a printout of 42 CFR 413.89 (T 238). 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.

Brooklyn Center

Appellant's "uncollected NAMI" arguments were raised by its counsel in a New York State Medicaid Program administrative hearing in 1991 and found to be without merit. Aishel Avraham Residential Health Facility (FH#1617411L, issued November 20, 1992) (Ex 26, p 3033-3041). Appellant's arguments, raised again by its counsel in more recent administrative hearings for twelve more nursing homes (including Concourse, *supra*), have repeatedly been found to be without merit. Suffolk Center for Rehabilitation and Nursing (Audit #14-4118, issued April 27, 2020); Northern Metropolitan RHCF (Audit #14-4097, issued November 19, 2020); Richmond Center for Rehabilitation and Specialty Healthcare (Audit #14-4174, issued January 29, 2021); Kings Harbor Multicare Center (Audit #14-4095, issued March 17, 2021); Staten Island Care Center (Audit #14-4115, issued April 21, 2021); River Manor Care Center, (Audit #14-4113, issued July 8, 2021); Concourse Rehabilitation and Nursing Center, (Audit #13-1130, issued November 2, 2021); Regeis Care Center, (Audit #14-4103, issued April 8, 2022); Bronx Center for Rehabilitation and Healthcare, (Audit #14-4039, issued April 19, 2022); University Nursing Home, (Audit #14-4121, issued July 11, 2022); Queens Center for Rehab & Residential Healthcare, (Audit # 14-4173, issued August 5, 2022); Concourse Rehabilitation and Nursing Center, Inc. (Audit #14-4090, issued August 9, 2022).

These hearing decisions all rejected, for multiple reasons, Appellant's contentions that a nursing home's allegedly uncollected resident NAMI has any relevance to an audit of payments for resident care that exceed the amounts permissible under 42 CFR 435.725. These reasons include that Appellant's arguments in various ways confuse Medicaid cost reporting and rate setting with Medicaid claims reimbursement; confuse Medicare with Medicaid; are not supported by any evidence; are contrary to state and

federal rules, regulations and the pertinent case law; misrepresent appellate court decisions in Concourse, *supra,* and Eden Park, *supra*; attempt to improperly shift the applicable presumptions, documentation obligations, and burden of proof; were not timely raised in the audit; and raise issues irrelevant to the Medicaid claims under review. Appellant has not brought forward any facts or arguments at this hearing that are new or materially different or were not fully addressed and decided against it in the previous hearing decisions.

Interest on the Overpayments

Interest on claim overpayments accrues from the date of each overpayment, at a rate specified by the regulations. OMIG calculated interest from the date of the overpayments in accordance with 18 NYCRR 518.4(b), (c) and (d). Appellant's argument that OMIG incorrectly imposed interest from the date of the overpayments pursuant to 18 NYCRR 518.4(b) and (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 27-28; 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) and (c).

The draft and revised final audit reports specified the date of, and separately calculated the interest assessed on, each overpayment (Exhibits 7, 8, 9, 10). As it was in possession of the date and amount of each overpayment, Appellant was in possession of all information necessary to verify OMIG's calculations. Appellant offered no specific evidence (Ex 16; Ex B) 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 now argues that the interest assessments are incorrect because it may not have actually received possession of the overpayments until weeks after the dates recorded in the Department's payment records ("lag time"). The dates of payment were established by computer-generated documents prepared by the Department, which show the nature and amount of the payments and are "presumed, in the absence of direct evidence to the contrary, to constitute an accurate itemization of the payments made." 18 NYCRR 519.18(f). Mr. [redacted] and Mr. [redacted] testified about the "lag time" (Ex E; T 188, 219-222, 224, 244-247), but Appellant did not present any *direct* evidence to support this, to show a different or later date of receipt of these payments, to show when any of the payments in dispute were *actually* made and how, or to otherwise demonstrate that OMIG's interest calculations for any of the overpayments identified in this audit were inaccurate. Mr. [redacted] testified that he was not involved in this audit, and he did not review the audit report's attachments to determine how the interest was calculated or to compare the overpayment date with the date received by Appellant (T 190, 191). Mr. [redacted] when presented with the EMEDNY cycle calendar (Ex E) and Appellant's ledger for one resident in the audit (Ex 15, p 498, 503) testified as to when it appeared a check was received (T 227-230). However, he later testified,

> Q: How were the checks received by [Appellant]?
> A: That I don't know … I don't deal with this facility personally.
> ……..
> Q: So is it fair to say that the check release date may very well have included the mailing time?
> A: It's possible, but I couldn't answer that question.
> Q: Did you review the claims attachments to the final audit report in this matter?

A: No, I did not.
Q: Did you attempt to reconcile the overpayment dates with the check release dates?
A: No, I did not.
Q: Were you asked to or did you provide any alternative interest calculation in this matter?
A: No. (T 233-234)

Appellant's arguments that because OMIG possessed Appellant's financial records, OMIG could go through each resident's ledger to ascertain when credits etc. were made to figure out when payment was made is an attempt to once again shift the burden Appellant bears under 18 NYCRR 519(d) to OMIG, and to sidestep 18 NYCRR 519.18(a). Appellant had the amounts of the overpayment and interest with their respective dates in the Draft but did not challenge those amounts and dates in its response or by presenting specific testimony regarding any resident identified in the audit. Only at hearing did it raise in a general way when payments/overpayments occurred. None of Appellant's witnesses was familiar with the specific residents' details nor with the documents in evidence other than Appellant's Exhibit E which was for the first time offered at hearing but not raised during the audit.

Appellant's speculations about the accuracy of the payment dates and interest assessments are new matter not considered by the Department upon submission of objections to a draft audit report. Appellant failed to raise any question about the accuracy of the dates of payment or interest assessments when they were all listed in the July 21, 2014 draft audit report (Ex 7). As Appellant did not raise objections in response to the draft audit report, OMIG did not have the opportunity to consider them in the audit and it is not now obligated to consider them. Pursuant to 18 NYCRR 519.18(a), these

arguments may not be raised and should not be considered in this hearing to review the completed and closed audit[1].

However, Appellant did raise in its November 4, 2014 letter (following OMIG's issuance of the final audit report which was later rescinded when OMIG issued its August 12, 2015 revised final audit report) the following argument:

> ...the interest charges contained in the audit are illegal. 18 NYCRR §518.4(e) provides ... No interest will be imposed upon any inpatient facility established under article 28 of the Public Health Law as a result of an audit of its costs for any period prior to the issuance of a notice of determination, nor for a period of at least 90 days after issuance of such notice (Ex B).

The previous twelve administrative hearing decisions, *supra,* correctly rejected Appellant's contention that OMIG has improperly assessed interest on the identified overpayments. This argument has been considered and is rejected in this Decision as well.

DECISION

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

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[1] *Appellant inexplicably cited, and attached to its post hearing reply brief, Matter of Cleve Dawson (FH#1721945M, issued July 8, 1993) in support of its attempt at this hearing to challenge the interest assessments. (Appellant reply, p 17) That New York Medicaid Program administrative hearing decision simply held that a provider who fails to respond to a draft audit report or notice of proposed agency action is still entitled to an administrative hearing if a final audit report is issued. Appellant has been given that administrative hearing. Cleve Dawson did not recognize any right to raise at such a hearing, new matter in the form of argument or evidence that was not considered in a response to a draft audit report. To the contrary it pointed out, consistent with 18 NYCRR 519.18(a) and the decision herein:*

> *If a provider wants to raise matters not addressed by the Department in the proposed findings, or if he wants additional records reviewed, he must submit them for consideration in a timely response to the proposed agency action. If he does not submit a response, he cannot, over the Department's objection, present them for the first time at a hearing. (Id. at 9)*

Brooklyn Center

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 Gayle, Bureau of Adjudication, who has been designated to make such decisions.

DATED: New York, New York
August 16, 2022

Ann Gayle
Administrative Law Judge

TO:
Marvin Neiman, Esq.
Theodore T. Mairanz, Esq.
Neiman and Mairanz, P.C.
39 Broadway, 25th Floor
New York, New York 10006-3003

Philip Hoffman, Esq.
Office of the Medicaid Inspector General
90 Church Street, 14th Floor
New York, New York 10007