

**STATE OF NEW YORK  
DEPARTMENT OF HEALTH**

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In the Matter of the Appeal of	:	
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<b>Concourse Rehabilitation &amp; Nursing Center, Inc.</b>	:	<b>Decision After Hearing</b>
Provider # [REDACTED]	:	
	:	
from a determination to recover Medicaid Program overpayments	:	#97 W04-3052

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Before: John Harris Terepka  
Administrative Law Judge

Held at: New York State Department of Health  
90 Church Street  
New York, New York 10007  
January 11, September 22, 2011  
Record closed December 16, 2011

Parties: New York State Office of the Medicaid Inspector General  
217 Broadway, 9<sup>th</sup> floor  
New York, New York 10007  
By: Maura Hayes-Chaffe, Esq.

Concourse Rehabilitation & Nursing Center, Inc.  
1072 Grand Concourse  
Bronx, New York 10456  
By: Marvin Neiman, Esq.  
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## **JURISDICTION**

The New York State Department of Health (the Department) acts as the single state agency to supervise the administration of the Medicaid Program in New York State. Social Services Law 363-a. The New York State Office of the Medicaid Inspector General (OMIG), an independent office within the Department, is responsible for the Department's duties with respect to the prevention, detection and investigation of fraud and abuse in the Medicaid Program and the recovery of improperly expended Medicaid funds. Public Health Law 31.

The OMIG issued a final audit report for Concourse Rehabilitation & Nursing Center, Inc. (the Appellant) in which the OMIG concluded that the Appellant had received Medicaid Program overpayments. The Appellant requested this hearing pursuant to SSL 22 and former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the overpayment determination.

## **SUMMARY OF FACTS**

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. At all times relevant hereto, Concourse Rehabilitation & Nursing Center, Inc. was a 240 bed proprietary residential health care facility (RHCF), licensed under PHL Article 28 and enrolled as a provider in the Medicaid Program. The facility is located in the Bronx, New York City.
2. Auditors from the OMIG reviewed the Appellant's reimbursement from the Medicaid Program for the rate period January 1, 1983 through December 31, 1985.

3. On June 10, 2008, the OMIG issued a final audit report that identified overpayments in the Appellant's Medicaid reimbursement for employee salaries and fringe benefits. The OMIG's letter accompanying the audit report advised the Appellant that it intended to recover Medicaid Program overpayments in the amount of \$456,742. (OMIG Exhibit 11.)

4. OMIG auditors determined that fringe benefits of Registered Nurses, Licensed Practical Nurses, Nurse's Aides and Orderlies were included twice in the calculation of the Appellant's Medicaid reimbursement. The audit overpayment was the result of a recalculation that eliminated the duplicated costs.

5. By letter dated August 6, 2008, the Appellant requested an administrative hearing to challenge OMIG's determination. (Appellant Exhibit E.)

#### **ISSUE**

Has the Appellant established that the OMIG's determination to recover Medicaid overpayments attributable to the audit report "correction of ratesheet error- fringe benefits included twice" is not correct?

#### **APPLICABLE LAW**

A residential health care facility, or nursing home, can receive reimbursement from the Medicaid Program for costs that are properly chargeable to necessary patient care. 10 NYCRR 86-2.17. As a general rule, these kinds of costs are allowed if they are actually incurred and the amount is reasonable. Allowable costs usually include employee wages and salaries, employee fringe benefits, administration, maintenance and supplies, and other operating expenses. 10 NYCRR 86-2.10(a)(7).

The facility's costs are reimbursed by means of a per diem rate set by the Department on the basis of costs reported by the facility. A facility's rate is provisional and subject to audit. If an audit identifies an overpayment the Department can retroactively adjust the rate. SSL 368-c; 10 NYCRR 86-2.7; 18 NYCRR 517.3. An overpayment includes any amount not authorized to be paid under the Medicaid Program, including amounts paid as the result of mistake. 18 NYCRR 518.1(c).

The Department may require the repayment of any amounts not authorized to be paid under the Medicaid Program. 18 NYCRR 518.1. If the Department determines to recover an overpayment, the facility has the right to an administrative hearing. 18 NYCRR 519.4. The facility has the burden of showing that the determination of the Department was incorrect. 18 NYCRR 519.18(d)(1).

DSS regulations pertinent to this hearing are found at 18 NYCRR Parts 517, 518 and 519, and address the audit, overpayment and hearing aspects of this case. Also pertinent are DOH regulations at 10 NYCRR Part 86-2 (reporting and rate certifications for RHCFs.)

### **DISCUSSION**

As a result of a prehearing request by the OMIG, a "preliminary hearing" was held before Administrative Law Judge Frederick Zimmer on April 23, September 2, 3, November 17, 2009, April 22 and June 23, 2010 in an effort to narrow the issues for this hearing. ALJ Zimmer issued an "interim decision" on September 29, 2010 in which he reviewed the issues and made several rulings limiting the scope of this hearing. This hearing decision fully agrees with the dispositions made by ALJ Zimmer and affirms his determinations and rulings.

Among those matters resolved in the interim decision was the Appellant's contention that this audit was not commenced within the six year limit authorized for such audits. Contrary to the Appellant's claim in its post hearing brief (page 1), this contention was discussed and rejected by ALJ Zimmer in his decision. (Interim decision, pages 36, 38-39.) It will not be revisited in this decision. (Transcript, pages 1285-86.)

The facts on which the audit finding depended – that the Appellant's reimbursement had included employee fringe benefits twice – are uncontroverted. The Appellant failed to offer any argument or evidence to call into question OMIG auditor Dennis Mastafiak's account and explanation of the duplication. (Transcript, pages 1299-1334; OMIG Exhibit 30; Appellant Exhibit J.) The Appellant's own witness, Henry Cassidy – the very person who calculated the original reimbursement (Transcript, pages 1468-69) - agreed with Mr. Mastafiak's analysis and conclusion that fringe benefits were erroneously included twice in the calculation. (Transcript, page 1488.)

The Appellant's characterization of the duplicate reimbursement as an "error of judgment, not an error of calculation" and a matter of reimbursement "methodology" (Transcript, pages 1283-84) relies on attempts throughout these proceedings and in its briefs to use terms such as "methodology," "judgment" and "error" in misleading ways. It was not a rate setting judgment or a matter of "methodology" to pay for fringe benefits twice. It was simply a mistake in the reimbursement calculation. Mr. Cassidy made it clear that this mistake had nothing to do with any "methodology":

If I knew the fringe benefits were included twice, I would not have used these numbers as I have in this calculation. (Transcript, page 1487.)

I would say that that is an analyst error and I was the analyst and I made the error. (Transcript, page 1499.)

It is well settled that this kind of error may be corrected in an 18 NYCRR Part 517 audit. Westledge v. Axelrod, 68 N.Y.2d 862, 508 N.Y.S.2d 414 (1986); Daleview v. Axelrod, 62 N.Y.2d 30, 475 N.Y.S.2d 826 (1984); Mayflower v. Office of Health Sys. Man., 59 N.Y.2d 935, 466 N.Y.S.2d 299 (1983).

The Appellant's real argument is not about "methodology" or "errors of judgment." It rests on a claim that in 1989 the Department gave up its right to audit the reimbursement in question. The Appellant contends that the "Gormley letter" (Appellant Exhibit B, attachment A thereto) constituted an agreement between the Appellant and the Department that included a rate setting judgment precluding the OMIG from correcting the Appellant's reimbursement for wages and benefits in a Part 517 audit.

If the Appellant is to be excused from repaying duplicate reimbursement on the grounds it had an agreement with the Department, the Appellant should come forward with some clear evidence of such an extraordinary arrangement. The Appellant's evidence falls far short of this.

The Appellant called Joseph Gormley as its own witness. Mr. Gormley, however, repeatedly refused to endorse the Appellant's theory that a letter he signed on behalf of the Department of Health in 1989 somehow precluded an audit such as this. (Transcript, pages 1426-29, 1444.) To the contrary, he testified that Appellant's reimbursement continued to be subject to audit by the DSS, the state agency which at the time had that responsibility. (Transcript, pages 1442-4.) The Appellant's only other witness, Mr. Cassidy, also testified that in his view there was nothing in the Gormley letter that precluded an audit. (Transcript, page 1495.)

As Mr. Gormley pointed out and as is clear on its face, the Gormley letter simply stated that the Department acknowledged it had authorized “approximately” \$8.2 million, as of the date of the letter, in reimbursement attributable to “parity” wage increases for the Appellant’s staff. (Transcript, page 1434.) The letter did not guarantee \$8.2 million or any other amount of reimbursement to the Appellant.

The purpose of the letter, as Mr. Gormley repeatedly made very clear, was to establish a procedure by which the Department could ensure that reimbursement attributable to the “parity” increase that was paid by the Medicaid Program actually found its way to the employees for whom it was intended. (Transcript, pages 1420-21, 1426-29, 1444.) There is nothing in this letter, which was written by the Appellant’s own counsel, to suggest that the reimbursement did not continue to be provisional and subject to audit in accordance with the general rule. 10 NYCRR 86-2.7; 18 NYCRR 517.3(a).

This case is, at bottom, very simple. It is about an overpayment attributable to the inadvertent inclusion of fringe benefits twice in the calculation of the Appellant’s Medicaid reimbursement. The facts regarding the duplication are uncontroverted. The Appellant has failed to meet its burden of proving that the Department ever waived the right to audit and recover the overpayment.

**DECISION:** The OMIG’s audit report “correction of ratesheet error- fringe benefits included twice” is affirmed.

This decision is made by John Harris Terepka, Bureau of Adjudication, who has been designated to make such decisions.

DATED: Rochester, New York  
March 13, 2012

\_\_\_\_\_/s/\_\_\_\_\_  
John Harris Terepka  
Bureau of Adjudication