STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of **Northern Metropolitan RHCF Inc.** Medicaid ID # 02994512 from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments.	**Decision After Hearing** #14-4097

Before: John Harris Terepka
Administrative Law Judge
February 27, August 26, 2020
Kimberly A. O'Brien
Administrative Law Judge
July 31, 2019

Held at: New York State Department of Health
90 Church Street
New York, New York
Record closed November 2, 2020

Parties: New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12205
By: Michael J. Derevlany, Esq.
800 North Pearl Street
Albany, New York 12204

Northern Metropolitan RHCF Inc.
225 Maple Avenue
Monsey, New York 10952
By: Marvin Neiman, Esq.
Theodore Mairanz, Esq.
Neiman & Mairanz P.C.
39 Broadway, 25th floor
New York, New York 10006

JURISDICTION

The Department of Health (the 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.

The OMIG determined to seek restitution of payments made under the Medicaid Program to Northern Metropolitan RHCF Inc. (the Appellant). The 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

OMIG witnesses:	Kevin Banach, HMS manager of long-term care reviews
OMIG exhibits:	1-15, 20, 23, 26
Appellant witnesses:	Usher Halberstam
	Barry Hyman, CPA
	Yaakov Bedziner
Appellant exhibits:	A

A transcript of the hearing was made. (Transcript, pages 1-254.) The parties each submitted two post hearing briefs. The record closed on November 2, 2020.

SUMMARY OF FACTS

1. Appellant Northern Metropolitan RHCF Inc. is a 120-bed residential health care facility (RHCF), or nursing home, in Monsey, New York. It is licensed under PHL Article 28 and enrolled as a provider in the Medicaid Program.

2. In March 2013, the OMIG initiated a review of the Appellant's reimbursement for Medicaid recipients who resided at Northern Metropolitan RHCF during the period June 1, 2010 through August 31, 2012. The audit was conducted by the OMIG's contracted agent, Health Management Systems, Inc. (HMS). (Exhibit 1; Transcript, page 26.)

3. The OMIG issued a draft audit report on July 22, 2014 detailing proposed audit findings of Medicaid Program overpayments. The draft audit report invited the Appellant to respond with any issues or documentation that it wanted to be considered before the audit became final. (Exhibit 9.)

4. The Appellant submitted a response to the draft audit report on September 16, 2014. The Appellant did not submit any documentation with the response, but demanded that "uncollected NAMI's [sic] in the amount of $374,319.00, that our client has suffered and for which our client seeks offset or repayment" be applied against the $27,754.66 overpayment identified in the draft audit findings. (Exhibit 10.)

5. The OMIG considered the Appellant's response to the draft audit report but its findings remained unchanged. The OMIG then issued a final audit report dated August 12, 2015, which identified Medicaid Program overpayments of $26,340.96, plus interest in the amount of $1,413.70, for a total of $27,754.66. The final audit report set forth findings and overpayments in three categories:

1. Medicaid reimbursements paid without being reduced by partial or full net available monthly income (NAMI). Disallowances in the total amount of $15,475.22.

2. Medicaid reimbursements paid for services covered either partially or in full by other payor sources including Medicare, commercial insurers and other private payors. Disallowances in the total amount of $5,730.33.

3. Medicaid reimbursements billed at the incorrect rate code based on the recipient's Medicare eligibility. Disallowances in the total amount of $5,135.41.

(Exhibit 11, Bates pages 0077-0079.)

6. The final audit report findings were revised on July 15, 2016, reducing the overpayment to $23,619.88 plus interest in the amount of $1,192.93, for a total of $24,812.81. (Transcript, pages 8, 89; Exhibit 13.)

7. The Appellant does not contest the overpayments in categories 2 and 3. (Transcript, pages 23, 90-91.) Remaining at issue in this hearing are the category 1 (NAMI) disallowances in the total amount of $15,475.22. (Exhibit 13, Bates pages 0113-0116; Transcript, pages 92, 94-95.)

8. The Appellant also disputes the OMIG's determination regarding the amount of interest that it may collect on the overpayments. (Transcript, pages 23, 92.)

ISSUES

Was the OMIG determination to recover Medicaid Program overpayments from Appellant Northern Metropolitan RHCF correct? Was the OMIG 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), 504.8, 517.3(b), 540.7(a)(8).

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, the 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 on a cost report. 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 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 its full Medicaid rate to the Medicaid Program.

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 net available monthly income (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 360-4.1, 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; Residential Health Care UB-04 Billing Guidelines, November 2008.

DISCUSSION

At issue in this hearing are the finding of overpayments attributable to resident NAMI (audit report disallowance category 1); and the imposition of interest on the overpayments. The NAMI overpayments are itemized in a revised attachment to the final audit report showing a total amount of $15,475.22. (Exhibit 13, Bates pages 0113-0116.) The interest on the overpayments appears throughout the audit report in separately listed amounts for each overpayment. The total interest reflected in the revised audit findings is $1,192.93. (Exhibit 13, Bates page 0117.)

I. The reason for this hearing.

The Appellant continues to misrepresent, in this and other similar hearings, the significance of Concourse Rehabilitation & Nursing Center, Inc. v. Shah, 161 A.D.3rd 669, 78 N.Y.S.3rd 60 (1st Dept. 2018), *lv denied* 32 N.Y.3rd 904, 84 N.Y.S.3rd 859 (2018). (Appellant brief, pages 1, 5, 22; Appellant reply brief, pages 1, 4.) The Appellate Division in Concourse did not reverse any determination, nor did it remand any matter for any further proceedings. The issues the Appellant seeks to raise in this hearing were not "actually tried" by any court in Concourse, nor has the Appellate Division "directed the parties to proceed with a hearing" on any issue. (Appellant brief, pages 1, 5.)

The Appellate Division in Concourse affirmed a lower court decision on a motion for summary judgment that dismissed in its entirety and without any further directive, an attempt to annul an OMIG audit like this one before it had even been performed. The New York Court of Appeals denied leave to appeal that decision. This hearing was not held because of Concourse. It was held because on August 12, 2015 the OMIG issued a final audit report that identified specific Medicaid overpayments on paid claims, and on August 31, 2015 the Appellant exercised its right to request a hearing to contest them. (Exhibits 11, 14.)

Nor does Concourse offer any support for the Appellant's assertion that this Medicaid claims audit is an appropriate forum in which to raise its "bad debt" contentions. The Appellate Division dismissed Concourse without addressing in any way a nursing home's "ability to write-off bad debts related to a Medicaid recipient's NAMI" or the OMIG's "treatment of its allegedly uncollectible NAMI debt." Concourse v. Shah, *supra*. Nowhere does Concourse suggest that in this administrative review of an audit of

paid Medicaid claims, the Appellant is entitled to a review of issues that pertain to the reimbursement rate at which those claims were billed and paid. Such a review is explicitly impermissible under Department regulations. 18 NYCRR 519.18(a).

II. The audit findings.

Auditors reviewed Medicaid eligibility information on the Appellant's residents during the audit period to determine whether its Medicaid claims for their care were reduced to accurately reflect the residents' NAMI obligations. In many instances the auditors found that the Appellant did not reduce its claims to reflect the residents' NAMI. The audit findings that the Appellant's claims to the Medicaid Program included amounts that were the responsibility of the residents, and that those amounts total $15,475.22, have not been challenged by the Appellant. Neither in response to the draft audit report nor at this hearing did the Appellant offer any evidence to show that the overpayments identified by the audit were incorrect or that it was entitled to the payments that were disallowed.

According to the Appellant:

> The issue is... is the facility also a *guarantor* of collection? Or saying it another way, when there is an inability to actually collect the NAMI's [sic], which party is to absorb the resulting loss? The State is taking the position that the facility is a guarantor of the NAMI's [sic] and should suffer the loss for its inability to collect them. (Appellant brief, page 1.)

The State's position is correct. The Second Circuit Court of Appeals, reversing a District Court decision, explicitly rejected the lower court's view that states rather than providers should be the guarantors of payment, holding that "[t]his interpretation is inconsistent with both the statute and the other regulations." Florence Nightingale Nursing Home v. Perales, 782 F.2d 26 (2nd Cir. 1986).

A resident's NAMI obligation is between the resident and the facility and is not chargeable to Medicaid. That is the entire point of a NAMI. It is the nursing home's responsibility to collect that NAMI from the resident. The facility is not entitled to turn to the Medicaid Program to make good its loss if the resident owes but does not pay it. That is the plain meaning of 42 CFR 435.725, and of the holding in Florence Nightingale:

> 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 burden of uncollectible NAMI does not fall on the city, state, or federal government but rather on the institutional provider. *Id.*

This completely disposes of the overpayment issue in this audit.

III. The Appellant's assertion of an entitlement to offset the overpayment with claimed "bad debt."

The Appellant does not even argue that it did not overbill the Medicaid Program by $15,475.22 for the residents identified in this audit. Instead, according to the Appellant, some other NAMI obligations owed by some other unidentified residents were not collected by it, and those uncollected NAMI obligations of other unidentified residents should be applied to reduce the overpayments attributable to NAMI obligations of the residents identified in this audit. The Appellant is not entitled to simply offset unrelated losses it claims it has experienced against the specific Medicaid overpayments identified in this audit.

The Appellant's entire argument is, in effect, that if residents A, B and C do not pay NAMI obligations for which those residents, and not the Medicaid Program, are responsible, a nursing home can make up that loss by billing the Medicaid Program for NAMI for which residents D, E and F, and not the Medicaid Program, are responsible.

The factual basis for the Appellant's position. As an initial matter, the Appellant has failed to substantiate by any facility records, at any time during the course of this audit, the alleged "bad debt" of other residents that it claims it is entitled to offset against its overbilling to the Medicaid Program for the residents identified in this audit. It offered a bare assertion in its response to the draft audit report of $267,367 in "uncollected NAMI's [sic]." (Exhibit 10.) It then offered a completely different figure at this hearing, $131,666.20, for what its witness Mr. Halberstam described as "NAMI balances that were either written off or for – just like they are still outstanding. Which means, we still intend to collect it somewhat." (Exhibit A; Transcript, page 199.)

The Appellant itself argues that to be deemed "bad debt" there must be some showing that a debt is uncollectible in spite of good faith efforts to collect it. (Transcript, pages 20-21.) Even the reported decision the Appellant relies on, Eden Park, *infra*, only authorized a hearing at which it was the provider's responsibility to show good faith collection efforts. The Appellant has presented only general assertions, not evidence, of good faith efforts to collect allegedly unpaid NAMI attributable to this audit period that it now seeks to apply against the audit findings. (Appellant brief, page 18; Transcript, page 197.)

Instead of evidence, the Appellant offers the suggestion that the OMIG could have conducted, in connection with this audit of Medicaid claims, an investigation into all of its records to look for "bad debt" during the audit period and to verify its sources and amounts. (Transcript, pages 157, 214; Appellant brief, pages 3, 4-5, 8-9.) That was not the purpose of this audit. (Exhibit 1.) The Appellant has not met its burden of proof simply by claiming that the auditors could have examined the Appellant's own records

and looked for evidence to substantiate and reconcile its inconsistent, bare assertions. (Appellant brief, page 22.)

The legal argument. There is, however, an even more fundamental deficiency in the Appellant's case that renders any attempt by the Appellant to establish the existence of "bad debt" irrelevant to this audit. In addition to being unsupported by any evidence the Appellant's theory that it is entitled to credit in this audit for uncollected NAMI is not supported by any legal authority.

The Appellant's objections to the audit findings 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. The 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).

The Appellant attempts to obscure the nature of its position with claims about case law to the effect that uncollected NAMI is a form of "bad debt" that can be reimbursable under Medicaid. It relies primarily on Eden Park Health Services, Inc. v. Axelrod, 114 A.D.2nd 721, 494 N.Y.S.2d 524 (A.D. 3rd Dept. 1985). Eden Park merely recognizes that certain bad debts may be an item that can be looked at as a reported cost used to determine a nursing home's Medicaid rate, and under some circumstances might be allowable in the calculation of the rate. This is hardly a holding that facilities are entitled to dollar-for-dollar payment from the Medicaid Program for uncollected resident NAMI that under federal law, and the holding in Florence Nightingale, is not reimbursable by Medicaid.

The Appellant argues that Eden Park establishes an exception to Florence Nightingale. It does not. Nowhere does Eden Park recognize NAMI charges as Medicaid reimbursable charges. Eden Park noted that the alleged bad debt in that case, "the origin of which is unclear" might be recognizable in a rate calculation if, among other things, it was "related to covered services and derived from deductible and coinsurance amounts and that reasonable collection efforts had been made." *Id.* The origin of the alleged "bad debt" in this case is clear, and it is not related to covered services, deductible or coinsurance amounts: The Appellant itself claims the bad debt it wants applied to the overpayment in this audit is attributable to Medicaid NAMI obligations - that are not reimbursable by the Medicaid Program.

The Appellant next argues that although Florence Nightingale concededly held that resident NAMI is not reimbursable under federal law, it recognized that uncollected NAMI can be reimbursed by a state Medicaid program if that state separately undertakes to pay it under state law. Florence Nightingale also specifically noted, however, that there is no such requirement in New York, nor does Eden Park suggest that during the audit period New York decided "voluntarily to reimburse providers for costs not covered by Medicaid, such as patients' NAMI." Florence Nightingale, *supra.*[1]

---

[1] The Appellant alludes to New York's discontinuance "about 20 years ago" of a former policy of reimbursing providers for unpaid NAMI by claiming "That policy was phased out, *sub silentio*, without any change in the statutes or regulations." (Appellant brief, page 21.) It is difficult to understand in what sense "[t]hat policy was phased out, *sub silentio,*" given the background set forth in Florence Nightingale and a 1982 HHS administrative decision stating:

> The fact that the providers, knowing that the recipients should pay for the costs, claimed them from the State did not transform them into allowable costs. New York State Department of Social Services, DAB No. 284 (Department of Health and Human Services Grant Appeals Board, April 29, 1982.)

It is instead more reasonable to conclude "[t]hat policy" ended because HHS, and Florence Nightingale, denied the New York Medicaid Program reimbursement for unpaid NAMI – because unpaid NAMI is not reimbursable by the Medicaid Program.

The Appellant nevertheless goes on to argue that "bad debt" attributable to uncollected Medicaid NAMI should be recognized for Medicaid reimbursement in New York because New York incorporates Medicare reimbursement principles in determining Medicaid rates. The Appellant relies on 10 NYCRR 86.2.17(a), a regulation that invokes Medicare principles regarding reported costs allowable in setting Medicaid rates, not claim reimbursement. (Transcript, pages 18-19.) Furthermore, those rate setting principles apply "[e]xcept as otherwise provided in this Subpart, or in accordance with specific determination by the commissioner."

The Appellant's claim that "Medicare will reimburse an uncollected NAMI to the extent that NAMI relates to the co-insurance and deductibles" is irrelevant to any issue in this audit. The Appellant's own witness on this point, Mr. Halberstam, testified: "The requirement is it has to stem from a Medicare charge." (Transcript, page 196.) Furthermore, even Medicare, as Appellant witness Barry Hyman testified, "allows reimbursement of bad debt only through the cost report." (Transcript, page 224; Appellant brief, page 15.) The Appellant's cost reports are not under review in this audit.

According to Mr. Hyman, Medicare reimburses 65 percent of demonstrably uncollectible co-insurance and deductibles. (Transcript, page 221.) The existence of a process by which Medicare reimburses a portion of unpaid Medicare co-insurance is not a reason to require the Medicaid Program to reimburse allegedly uncollected Medicaid NAMI in this Medicaid claims audit.

In short, the Appellant concedes Florence Nightingale holds there is no obligation under federal law to reimburse uncollected Medicaid NAMI. Yet it is the Appellant's own argument that it is entitled to such reimbursement under New York law - because

New York follows federal law. The Appellant ends up arguing that New York Medicaid must recognize uncollected NAMI as reimbursable even though New York does not recognize resident NAMI obligations as reimbursable, because New York, as it is required to do, incorporates federal law - which also does not recognize Medicaid NAMI obligations as reimbursable.

The Appellant has offered no intelligible reason why it should be reimbursed for alleged losses that it never reported and has not proved, by directly offsetting them against unrelated overpayments that it clearly received. If the Appellant asserts it has reimbursable costs attributable to "bad debt" it must report them on a cost report, seek reimbursement for them in its rate, and prove them on an audit of that rate. That is, at best, what Eden Park suggests. Eden Park provides no support for the argument that the Appellant can simply add to its Medicaid billings unproven, allegedly uncollected NAMI amounts owed by any of its residents. This is what it is attempting to do by arguing the overpayments identified in this audit should be offset by them.

The Appellant's own response to the draft audit report states:

> 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. (Exhibit 10, Bates page 68.)

It is not the issues in this audit, which made findings of overpayments in the amount of $15,475.22 for specific claims, that relate to rate methodology. It is the issues the Appellant has attempted to raise in order to offset the audit findings that relate to rate methodology. The Appellant is correct in pointing out that those issues are not subject to review in this administrative hearing.

The Appellant complains that there is no way to report its NAMI bad debt on a Medicaid cost report, and if it is reported it is not allowed for inclusion in the rate calculation. Its witness Barry Hyman testified that Medicaid cost reporting has a line for reporting bad debt but he also acknowledged that Medicaid does not recognize it as a cost in rate calculations. (Transcript, page 220.)

Florence Nightingale directly addressed and explicitly rejected the theory that Medicaid should recognize uncollected NAMI as a reimbursable cost in a rate calculation:

> In authorizing reimbursement of providers for Medicaid care costs, Congress clearly intended *not* to reimburse for costs not covered by Medicaid. NAMI represents the amount that a patient is required to contribute toward his or her care. This contribution reduces the amount that the patient is eligible to have paid on his or her behalf under the Medicaid Program. [citations omitted.] 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." Florence Nightingale, *supra*.

If allegedly uncollected NAMI was never included or was not allowed as "bad debt" on the Appellant's cost reports, that is consistent with 42 CFR 435.725 and Florence Nightingale meaning what they say:

> ... uncollected NAMI is not reimbursable... The burden of uncollectible NAMI does not fall on the city, state, or federal government but rather on the institutional provider. *Id.*

Mr. Hyman himself testified: "Medicaid is not recognizing any bad debt, period." (Transcript, page 222.) It does not follow from this, that the Appellant somehow must have some other avenue, such as an offset to overpayments identified in this billing audit, to require the Medicaid Program to pay resident charges for which it is not responsible.

IV. The audit report calculation of interest on the overpayments.

The Appellant is seeking recognition in this audit of what it claims is a reportable "bad debt" cost, without having reported that cost. This confusion of a Medicaid cost-based reimbursement rate issue (*see* 18 NYCRR 517.3(a)) with fee-for-services reimbursement of claims (*see* 18 NYCRR 517.3(b)) is used to assert that the Medicaid Program is responsible for charges for which it has specifically and repeatedly determined it is not responsible. The Appellant's argument that the OMIG incorrectly imposed interest in this audit from the date of payment instead of the date of issuance of the audit report is a similar attempt in that it seeks to confuse audits of cost reports with audits of claims.

This audit was of claims submitted by the Appellant to the Medicaid Program for per diem services provided to individual residents. The Appellant received overpayments on those claims. Interest was properly charged pursuant to 18 NYCRR 518.4(b)&(c). As this audit was not an audit of the Appellant's costs, 18 NYCRR 518.4(e) is inapplicable.

The Appellant misrepresents the regulation:

> While under 18 NYCRR 518.4(b), charge based providers can be charged interest from the time of the overpayment, under 18 NYCRR 518.4(e), cost based providers are to be assessed interest only *after* an audit issues *and 90 days pass from the final audit determination.* (Appellant brief, page 26.)

The issue distinguishing 518.4(b)&(c) from 518.4(e) is not the nature or status of the Medicaid provider as "charge based" or "cost based." It is the nature of the audit being conducted. This was an audit of paid Medicaid claims, not reported costs. That the Appellant happens to be a cost-based provider is irrelevant to the audit findings.

The Appellant also suggests that the interest was incorrectly calculated because it may have been imposed for periods before the overpayments were actually received.

(Appellant brief, pages 27-28; Appellant reply brief, pages 13-14; Transcript, page 144.) In accordance with NYCRR 518.4(b)&(c), interest was calculated from the date of each overpayment as recorded in Medicaid payment records. (Exhibits 13, 20; Transcript, pages 34, 97.) These records are entitled to a presumption of accuracy the Appellant failed to refute. 18 NYCRR 519.18(f).

Mr. Halberstam alleged that the Appellant did not actually receive Medicaid payments for "approximately three weeks" after the date they were billed. (Transcript, page 209-10.) Mr. Hyman said "Generally, it's on three to four week lag." (Transcript, page 223.) Another Appellant witness, Yaakov Bedziner, said it was "approximately four weeks." (Transcript, page 239.) The Appellant failed to establish any inconsistency between these various assertions and the payment dates reflected in the Department's Medicaid payment records. (Exhibit 20; Transcript, page 97.)

Even if there is a lag between the time a Medicaid claim is submitted and payment is made, the Appellant made no attempt to show that the dates identified by the Department as the dates of payment were not accurate. The Appellant's claim that the payment date recorded in the Department's records "is the date of the processing of the claim by Medicaid (R. 143), which is at least 21 days before the actual payment is made" (Appellant brief, page 27) is not supported by the testimony at page 143 of the transcript or by any other evidence. The Appellant offered no alternative dates for any of these payments and presented no evidence to show when it submitted any of the claims disallowed or when they were paid, or to otherwise meet its burden of proving that the Department's calculation of interest on the overpayments is incorrect.

DECISION: The OMIG's determination to recover Medicaid Program overpayments, and its calculations of interest on the overpayments, are affirmed.

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

DATED: Rochester, New York
November 19, 2020

John Harris Terepka
Bureau of Adjudication