STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of	:	
RICHMOND CENTER FOR REHABILITATION AND SPECIALTY HEALTHCARE Medicaid ID: 01453263	:	**Decision After Hearing**
from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments	:	Audit Number: 14-4174

Before:	William Lynch, Administrative Law Judge Natalie J. Bordeaux, Administrative Law Judge
Hearing Dates:	March 4 and September 9, 2020
Hearing Locations:	New York State Department of Health 90 Church Street New York, New York 10007 Cisco WebEx Videoconference
Parties:	New York State Office of the Medicaid Inspector General 90 Church Street, 14th Floor New York, New York 10007 By: Ferlande Milord, Esq. Richmond Center for Rehabilitation and Specialty Healthcare 91 Tompkins Avenue Staten Island, New York 10304 By: Marvin Neiman, Esq. Neiman & Mairanz P.C. 39 Broadway, 25th Floor New York, New York 10006

JURISDICTION

The New York State Office of the Medicaid Inspector General (OMIG) determined to seek restitution of payments made under the Medicaid Program to Richmond Center for Rehabilitation and Specialty Healthcare (Appellant). The Appellant requested a hearing pursuant to Social Services Law § 22 and Department of Social Services (DSS) regulations at 18 NYCRR § 519.4 to review the OMIG's determination.

HEARING RECORD

OMIG witnesses:	Kevin Banach, Manager of Long-Term Care Reviews, Health Management Systems, Inc. (HMS)
OMIG exhibits:	1-17
Appellant witnesses:	Usher Halberstam, Assistant Controller, Centers Health Care (Centers) Yaakov Bedziner, Financial Tracker Supervisor, Centers Barry Hyman, Partner, Martin Friedman CPA, PC
Appellant exhibits:	A-I, L-M, P-T

A transcript of the hearing was made. (T 1-279.) Each party submitted two post-hearing briefs. The record closed on December 4, 2020.

FINDINGS OF FACT

1. The Appellant is a Staten Island residential health care facility (also referred to as a nursing home) licensed under Article 28 of the Public Health Law and enrolled in the New York State Medicaid Program.

2. HMS, acting on behalf of the OMIG, audited the Appellant's reimbursements received from the Medicaid Program from February 1, 2007 through January 31, 2011 for long-term care services. (Exhibit 1; T 57.)

3. On July 22, 2014, the OMIG issued a draft audit report to the Appellant, which identified overpayments of $619,104.51 and accrued interest of $102,283.42, with total overpayments of $721,387.93. The findings were organized into the following categories:

1. Medicaid reimbursements paid without being reduced by partial or full Net Available [Monthly] Income (NAMI.)
2. Medicaid reimbursements paid for services covered either partially or in full by other payor sources including Medicare, commercial insurers and other private payors.
3. 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%.
4. Medicaid reimbursements billed at the incorrect rate code based on the recipient's Medicare eligibility.

(Exhibits 1 and 2.)

4. On August 25, 2014, the Appellant submitted its response to the draft audit report, in which the Appellant contended that it had "uncollected" NAMI totaling $470,099.88. The Appellant also incorporated its response to another audit of a different nursing home by reference, in which the Appellant contended that it was entitled to reimbursement from the Medicaid Program for uncollected NAMI amounts as "bad debts." (Exhibit 3.)

5. On October 16, 2014, the OMIG issued a final audit report, which reiterated the findings set forth in the draft audit report and advised that HMS had validated the overpayment amount as $721,387.93. (Exhibit 4.)

6. On November 4, 2014, the Appellant submitted a response to the final audit report. Aside from renewing its objections to the draft audit report, the Appellant also contended that the "interest charges contained in the audit are illegal." (Exhibit 5.)

7. On August 13, 2015, the OMIG issued a revised final audit report, which identified overpayments of $269,970.52 plus accrued interest of $40,865.25, for a total overpayment of $310,835.77. The findings were organized into the following categories:

1. Medicaid reimbursements paid without being reduced by partial or full NAMI.
2. Medicaid reimbursements paid for services covered either partially or in full by other payor sources including Medicare, commercial insurers and other private payors.
3. Medicaid reimbursements billed at the incorrect rate code based on the recipient's Medicare eligibility. (Exhibits 6 and 7.)

8. On September 3, 2015, the Appellant requested a hearing to contest the findings set forth in the revised final audit report. (Exhibit 8.)

9. Before the first date of this hearing, the OMIG revised the disallowances set forth in category 1 downward by removing disallowances attributed to retroactive NAMI adjustments, a total reduction of $16,368.96 based upon the removal of $14,230.99 for disallowed claims and $2,137.97 of interest applied to those disallowances. After this adjustment, the disallowances in category 1 equal $73,587.97 ($64,498.54 in disallowances plus $9,089.43 interest.) (T 10, 184.)

10. The Appellant has withdrawn its challenges to the findings set forth in revised categories 2 and 3. However, it continues to dispute the revised findings set forth in category 1. The Appellant also maintains that the OMIG's imposition of interest on all three disallowance categories in the amount of $38,727.28 contravened applicable regulations. (T 10, 184.)

ISSUES

Was the OMIG's determination to recover Medicaid Program overpayments for the Appellant's failure to deduct residents' NAMI amounts from submitted claims correct?

Was the OMIG's determination to recover interest from the date of the overpayments identified in categories 1, 2, and 3 correct?

APPLICABLE LAW

The Department of Health (Department) is the single state agency for the administration of the Medicaid Program in New York State. PHL § 201(1)(v); SSL § 363-a. The OMIG is an

independent office within the Department with the authority to pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts or unacceptable practices perpetrated within the Medicaid Program. Such actions may include the recovery of improperly expended Medicaid funds. PHL §§ 30-32.

By enrolling in the Medicaid Program, Medicaid providers agree to prepare and to maintain contemporaneous records demonstrating the right to receive payment under the Medicaid Program and to furnish such records and information, upon request, to the Department. Such records must be maintained for at least six years from the date of service. 18 NYCRR § 504.3(a). Medicaid providers agree to permit audits by the Department of all books and records or, in the Department's discretion, a sample thereof, relating to services furnished and payments received under the Medicaid Program, including patient histories, case files and patient-specific data. 18 NYCRR § 504.3(g), § 517.3(b), § 540.7(a)(8). In addition, Medicaid providers must comply with the rules, regulations, and official directives of the Department. 18 NYCRR § 504.3(i).

When it is determined that a provider has submitted or caused to be submitted claims for medical care, services or supplies for which payment should not have been made, the Department may require repayment of the amount determined to have been overpaid. 18 NYCRR § 504.8(a)(1) and § 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).

A Medicaid provider is entitled to a hearing to review the OMIG's final determination to require repayment of any overpayment or restitution. 18 NYCRR § 519.4. The Appellant has

the burden of showing by substantial evidence that the OMIG's determination was incorrect and that all claims submitted and denied were due and payable under the Medicaid Program. 18 NYCRR § 519.18(d)(1).

A nursing home (also referred to in New York statutes and regulations as a residential health care facility) is a facility, institution, or portion thereof subject to PHL Article 28 which provides nursing care and other health-related services to sick, invalid, infirm, disabled or convalescent persons in addition to lodging. PHL §§ 2801(2)&(3); 10 NYCRR § 415.2(k). In the State of New York, a nursing home receives reimbursement for the cost of care rendered to Medicaid recipients in the form of a per diem rate determined by reported allowable costs. PHL § 2808; 10 NYCRR § 86-2.10. That rate represents the maximum amount receivable for each day in which care is provided to Medicaid recipients. A nursing home must reduce the amount billed to the Medicaid Program by a resident's net available monthly income (NAMI), the amount which the Medicaid recipient must contribute towards the cost of his/her nursing home care. 42 CFR § 435.725; 18 NYCRR § 360-4.9.

A recipient's NAMI is computed by a formula set forth in regulations at 18 NYCRR § 360-4.6 and § 360-4.9. When a local social services district determines that an applicant is eligible for institutional Medicaid benefits, the applicant receives notification, including a budget computation, to explain their personal financial responsibility for the cost of their nursing home care. 18 NYCRR § 360-2.5.

DISCUSSION

Audit Findings:

Disallowance Category 1: Medicaid reimbursements paid without being reduced by partial or full NAMI.

For this category, the auditors reviewed the Medicaid Program payments for long-term care services received by the Appellant from February 1, 2007 through January 31, 2011 to verify that the Appellant's reimbursements for long-term care services equaled the net amount of the difference between the facility's monthly rate minus each resident's NAMI amount. Portions of reimbursements were disallowed for residents' NAMI amounts when the auditors determined that the Appellant received its monthly rate for those residents without reductions for their NAMI obligations. (Exhibits 6, 7, 9.)

During the period audited, Medicaid providers were repeatedly advised of their responsibilities with respect to claims submissions for long-term care services. They were specifically instructed to input the amount of residents' NAMI on claims for long-term care services, and that payment of the facility's monthly rate would be reduced accordingly. eMedNY New York State Medicaid Program Residential Health Care Billing Guidelines versions 2007-1 (effective 01/09/07), 2008-1 (effective 01/08/08), 2008-2 (effective 02/15/08), 2008-3 (effective 06/04/08), 2008-4 (effective 11/11/08), 2009-1 (effective 10/01/09), 2009-2 (effective 12/01/09), 2010-1 (effective 5/31/10).

In contesting this disallowance, the Appellant offered no specific information to disprove the auditors' findings regarding the portions of the claims disallowed. The Appellant's witnesses offered no such information, either. At the behest of the Appellant's counsel in preparation for this hearing, Usher Halberstam, the Assistant Controller to Centers[1], determined that the

[1] Centers Health Care manages financial matters for the Appellant. (T 39.)

Appellant has not received a total of $412,772.04[2] in NAMI amounts from residents. (Exhibit A; T 239.) This information was not provided to the auditors and is not supported by any documentation. Mr. Halberstam provided no basis for his computations. Exhibit A merely identifies the total amount which he stated the Appellant has "written off". At the hearing, he confirmed that the stated total was a composite of uncollected and uncollectible NAMI amounts. (T 198, 208.) Although he testified that the Appellant submits claims to the Medicaid Program for the facility's monthly rate reduced by a resident's NAMI, he had no first-hand knowledge regarding the claims at issue in this audit. Mr. Halberstam was not employed by Centers Health Care during the audit period. (T 190.)

Similarly, Yaakov Bedziner, Financial Tracker Supervisor, first commenced his employment with Centers in 2015. (T 242-43.) Nevertheless, he was called to testify as to the billing processes used by his employer. Mr. Bedziner affirmed that Centers waits two years before "writing off" uncollected NAMI amounts. (T 250.) The Appellant's discretionary accounting neither obligates nor authorizes the Medicaid Program to reimburse it for those amounts.

The Appellant relies heavily on its claim that the Medicaid Program is obligated to reimburse it for the uncollected NAMI amounts in accordance with Medi**care** policy. It is undisputed that Medicare recipients are obligated to pay a skilled nursing facility a daily coinsurance amount once a covered stay exceeds a certain number of days. 42 USC § 1395d(a)(2) and § 1395e(a)(3). According to the Appellant, Medicare policy reimburses

[2] In its August 25, 2014 response to the draft audit report, the Appellant contended it was owed $470,099.88 for uncollected NAMI amounts for the audit period, consisting of amounts outstanding and amounts written off. There too, the Appellant made no attempt to identify specific claims pertaining to specific Medicaid recipients and failed to provide supporting documentation. (Exhibit 3.)

providers for a portion of deductibles and coinsurance amounts deemed uncollectible.[3] 42 CFR § 413.89. Yet, the Appellant failed to establish the relevance of this Medicare policy to this Medi**caid** audit.

The Appellant contends that its position is supported by applicable case law. (Appellant's 11/6/20 Brief, p. 17.) However, none of the cases cited by the Appellant held that the New York State Medicaid Program is required to reimburse Medicaid providers for uncollected (including uncollectible) NAMI amounts. In Eden Park Health Services, Inc. v. Axelrod, 114 A.D.2d 721 (App. Div. 3d Dep't 1985), owners of nine residential health care facilities contested eleven administrative rate determinations, including denial of a claim for reimbursement of bad debt expenses consisting of deductible and coinsurance amounts. The Appellate Division merely agreed with the lower court's order that the facilities be afforded a hearing regarding those bad debts to be considered in rate-setting, noting that the origin of those debts was "unclear." However, no ruling was made as to the viability of the petitioners' claims.

Even more puzzling is the Appellant's reliance on Concourse Rehabilitation & Nursing Center, Inc. v. Shah, et al., 161 A.D.3d 669 (App. Div. 1st Dep't 2018), in which counsel for the Appellant sought a declaratory judgment on behalf of another residential health care facility to annul an OMIG audit in which the facility claimed an ability to "write-off bad debts" pertaining to residents' NAMI obligations. The First Department affirmed the lower court's dismissal of the plaintiff's claim for failing to exhaust administrative remedies and nothing more. That ruling does not in any way vindicate the Appellant's argument in this case.

[3] Interestingly, despite the Appellant's consistent claim that the Medicaid Program should adhere to Medicare reimbursement principles, it has made no attempt to identify which unpaid NAMI amounts were uncollectible, a fundamental requirement for reimbursement pursuant to Medicare rules. 42 CFR § 413.89(e).

The only decision cited by the Appellant that is relevant to its substantive claim is Florence Nightingale Nursing Home v. Perales, 782 F.2d 26 (2d Cir. 1986). In that case, the Second Circuit Court of Appeals held that Congress devised the Medicaid Program with the intention **not** to reimburse providers for costs not covered by Medicaid. Since Medicaid payments to nursing homes must be reduced by NAMI amounts, an unpaid NAMI (even if uncollectible) is ergo not reimbursable by the New York State Medicaid Program.

The Appellant has attempted to confuse the purpose of this audit to justify its request (in the form of a counterclaim) against the OMIG for NAMI amounts that it has labeled "uncollected." (Exhibits 3, 5, 8.) The OMIG has clearly advised the Appellant that the purpose of this audit was to identify overpayments. (Exhibits 1, 2, 4, 6, 7.) The Appellant's responses clearly reflect its understanding that it was requesting a hearing to contest the overpayment pursuant to 18 NYCRR § 519.4(a)(2) and clearly reflect its understanding that rate issues are not within the OMIG's "purview," a correct assertion supported by Medicaid regulations regarding costs and rate-setting methodology. (Exhibits 3, 8.) The auditors were not reviewing the Appellant's reported costs or its reimbursement rate. The auditors were reviewing the accuracy of the Appellant's claims and resulting payments by the Medicaid Program. (Appellant's 11/6/20 Brief, p. 11.) The Appellant's dissatisfaction with its rate is only reviewable by the Department and only when initiated by formal application for review of a certified rate with supporting documentation. 10 NYCRR § 86-2.13 and § 86-2.14. The Appellant has failed to establish that the OMIG's determination to disallow reimbursements consisting of all or portions of residents' NAMI amounts was incorrect.

Imposition of Interest on the Overpayment

The OMIG may collect interest on any overpayment determined to have been made. Prior to the issuance of a notice of determination, interest accrues from the date of the overpayment at the annual rate of interest fixed by the Department. After the issuance of a notice of determination, interest accrues at the current rate, plus two percentage points, or the maximum legal rate, whichever is lower. 18 NYCRR §§ 518.4(a)-(d).

The Appellant asserts that the OMIG improperly computed interest owed with respect to all three overpayment categories. The Appellant argues that because it is an inpatient facility established by Article 28 of the Public Health Law, 18 NYCRR § 518.4(e) precludes the OMIG from charging interest until 90 days after the issuance of the Final Audit Report. That subsection states the following:

> Interest may be waived in whole or in part when the department determines the imposition of interest would effect an unjust result would unduly burden the provider or would substantially delay the prompt and efficient resolution of an outstanding audit or investigation. 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.

The Appellant has seized on the first half of the second sentence of subsection (e) while ignoring the second half. As already explained above regarding the Appellant's challenges to the remaining disallowed amounts in Disallowance Category 1, the attempted conflation of audits involving claims reviews and audits of costs is simply wrong. No matter how many times the Appellant makes this argument, the purpose of this audit # 14-4174 was not to review the Appellant's costs.

Computer-generated documents prepared by the Department or its fiscal agent to show the nature and amounts 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 § 518.18(f). Although it did not raise this point in its responses to the audit report, the Appellant's witness testified at the hearing that a time lag existed between the date of claim submission and the Appellant's receipt of payment. (T 228-29.) This allegation was unsupported by any evidence and does not establish errors in the OMIG's interest computations. The Appellant has made no attempt to identify any disallowance in which the OMIG's interest computations failed to adhere to 18 NYCRR §§ 518.4(b)-(c). The Appellant has failed to meet its burden of showing that the OMIG's determination was incorrect.

DECISION

The OMIG's determination to recover Medicaid Program overpayments for the Appellant's failure to deduct residents' NAMI amounts from submitted claims was correct and is affirmed.

The OMIG's determination to recover interest from the date of the overpayments identified in categories 1, 2, and 3 was correct and is affirmed.

Dated: January 28, 2021
Menands, New York

/Natalie J. Bordeaux/
Natalie J. Bordeaux
Administrative Law Judge