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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 9, 2022

CERTIFIED MAIL/RETURN RECEIPT

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New York State Office of the Medicaid Inspector General
90 Church Street, 4th Floor
New York, New York 10007

RE: In the Matter of Concourse Rehabilitation and Nursing Center Inc.

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

ORIGINAL

In the Matter of

DECISION

CONCOURSE REHABILITATION and
NURSING CENTER INC.
Provider ID: 00310623

Audit No. #14-4090

Appellant,

from a determination by the NYS Office of the
Medicaid Inspector General (OMIG)
to recover Medicaid Program overpayments.

Before: Jean T. Carney
Administrative Law Judge

Held at: Via WebEx Videoconference

Hearing Dates: June 3, 2021 and June 9, 2021

Parties: New York State Office of the Medicaid Inspector General
90 Church Street, 4th Floor
New York, New York 10007
By: Ferlande Milord, Esq.

Concourse Rehabilitation and Nursing Center, Inc.
1072 Grand Concourse
Bronx New York 10456
By: Marvin Neiman, Esq.
Theodore T. Mairanz, Esq.
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39 Broadway, 25th Floor
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JURISDICTION

The New York State Department of Health (Department or DOH) acts as the single state agency to supervise the administration of the Medical Assistance (Medicaid) Program in New York. (Public Health Law [PHL] § 201[1][v]; Social Services Law [SSL] § 363-a). The New York State Office of the Medicaid Inspector General (OMIG), an independent office within the DOH, is authorized to investigate and pursue administrative enforcement actions to recover improperly expended Medicaid funds. (PHL §§ 31-32).

The OMIG determined to recover Medicaid Program overpayments from Concourse Rehabilitation and Nursing Center (Appellant) for the rate period from January 1, 2010 through February 28, 2012. The Appellant requested a hearing pursuant to SSL § 145-a, and Department of Social Services (DSS) regulations at 18 NYCRR § 519.4 to review the OMIG's determination.

HEARING RECORD

The hearing was scheduled to commence on January 9, 2019 and adjourned several times on consent of the parties to June 3, 2021. The OMIG presented the audit file with supporting documents (OMIG Exhs 1, 1a, 2-5, 5a, 6a-6c, 7 and 8); and the testimony of Kevin Banach, HMS Systems Manager of long-term care reviews. The Appellant presented documents (Appellant Exhs A, A1, and E-L); and the testimony of Barry Hyman, CPA; Solomon Neiman, facility Comptroller; and Jacob Bokow, Associate Comptroller. A stenographic transcript of the proceedings was made (pages 1-223). The parties submitted post-hearing briefs, and the record closed on August 17, 2021 upon receipt of the parties' reply briefs.

APPLICABLE LAW

Medicaid providers are required, as a condition of their enrollment, to prepare and 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 to the Department upon request. All information regarding claims for payment is subject to audit for six years. (18 NYCRR §§ 504.3[a] and 504.3[h], 504.8, 517[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 §§ 504.8 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]).

Interest may be collected upon any overpayments determined to have been made. (18 NYCRR § 518.4[a]). Interest accrues from the date of overpayment. (18 NYCRR §§ 518.4[b] and 518.4[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 Medicaid provider is entitled to a hearing to review the OMIG's final determination requiring repayment of any overpayments. (18 NYCRR § 519.4). The burden lies with the Appellant to prove by substantial evidence that the OMIG's determination is incorrect. (18 NYCRR § 519.18[d] and 18 NYCRR § 519.18[h]; New York State Administrative Act (SAPA) § 306[1]). Substantial evidence means such relevant proof as a reasonable mind may accept as adequate to support a conclusion or fact; less than preponderance of evidence, but more than mere surmise, conjecture, or speculation, and constituting a rational basis for decision. (*Stoker v. Tarantino*, 101 A.D.2d 651, 475 N.Y.S.2d 562 [3rd Dept. 1984], *appeal dismissed* 63 N.Y.2d 649 [1984]).

The issues and documentation considered at the hearing are limited to issues directly related to the OMIG's 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 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 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 recipient's local social services district, which determines 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 that establishes the recipient's NAMI amount. (SSL § 366; 18 NYCRR §§ 360-4.1, 360-4.6, 360-4.9). 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, www.emedny.org). 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).*

ISSUE

Has the Appellant shown that the OMIG erred in recovering overpayments, with interest, to the Medicaid Program?

FACTS

Citations in parentheses refer to testimony (T) and exhibits (Exh) found persuasive in arriving at a particular finding. Conflicting evidence, if any, was rejected in favor of cited evidence.

1. The Appellant is a residential health care facility (RHCF) licensed under Article 28 of the PHL, and is enrolled as a Medicaid provider. (Exh 5).

2. The OMIG, through its contracted agent Health Management Systems, Inc. (HMS), conducted a review of the Appellant's Medicaid reimbursement for the period of January 1, 2010 to February 28, 2012. The auditors compared data of paid Medicaid claims with the Appellant's books and records. (Exhs 1 and 5; T Banach @ pp. 19 and 55).

3. On July 21, 2014, the OMIG issued a draft audit report detailing its preliminary findings and calculating an estimated Medicaid overpayment of $103,695.21, including interest in the amount of $8,043.56. (Exh 1).

4. On September 16, 2014, The Appellant submitted its response to the draft audit report, objecting to the OMIG's findings. (Exh 2).

5. After reviewing the Appellant's submission, the OMIG issued its final audit report on October 16, 2014, making no changes to the overpayments identified in the draft audit report. On August 20, 2015, the OMIG rescinded that Final Audit Report and replaced it with a Revised Final Audit Report with attachments, detailing the basis of the OMIG's findings. As of the date of the hearing, the OMIG sought overpayments in the amount of $50,098.92. (T Banach @ p. 29).

6. The Appellant disputes Finding #1, Medicaid reimbursements that were paid without being reduced by the residents' Net Available Monthly Income (NAMI) in the amount of $44,204.37, including interest. The Appellant also objects to that portion of Finding #2 assessing interest in the amount of $499.35, for a total amount of $44,703.72 being disputed. (Exhs 4, 6, 6a, 6b, 6c, and 7).

DISCUSSION

The Appellant failed to meet its burden of proving that the OMIG erred in recovering overpayments, with interest, to the Medicaid Program. The audit found that the Appellant submitted claims to Medicaid without applying the NAMI, resulting in overpayments. The provider has a duty to provide accurate information in submitting claims for payment; and comply with the rules, regulations, and official directives of the department. (10 NYCRR § 504.3). Official directives include the New York State Medicaid Program Residential Health Care UB-04 Billing Guidelines, which state that providers must enter the NAMI amount as the resident's monthly budget. These amounts must be updated if a resident's budget changes.

The Appellant argues that it should be entitled to claim a resident's NAMI if, after reasonable efforts, the facility has been unable to collect the NAMI from the resident. In support of its position, the Appellant cites to *Eden Park v. Axelrod,* 114 A.D.2d 721, 494 N.Y.S.2d (3d Dept. 1985) for the proposition that because Medicare allows reimbursement for certain bad debts, the Medicaid program must also do so. (Appellant's brief at pp. 7-8). *Eden Park* concerned several nursing homes who contested several rate-setting determinations, and the court found that the nursing homes should have been afforded a hearing to appeal rate reviews denying claims for reimbursement for bad debt expenses. The current proceeding concerns a claims audit, not a rate appeal. The Appellant's argument attempts to conflate two very different types of audits, raising an issue not directly related to the OMIG's final determination, and therefore will not be considered. (18 NYCRR § 519.18).

The OMIG's witness credibly testified to claims the Appellant submitted to Medicaid without applying NAMI amounts. The Appellant did not refute this testimony; but claimed that these residents had not paid their NAMI, and therefore the Appellant was entitled to include the NAMIs in their claims to Medicaid. Federal regulations stipulate that the agency must reduce its payment to the facility by a resident's NAMI.

(42 CFR § 435.700). The Appellant presented no evidence to support its contention that it is entitled to claim reimbursement for a resident's NAMI. The evidence presented by the Appellant confirmed that the resident is responsible for paying his or her NAMI to the facility. The local Medicaid office determines the amount of the NAMI, but that is the extent of Medicaid's obligation regarding NAMIs. Therefore, it is reasonable for the OMIG to determine that claims submitted for payment should be reduced by the NAMI amount.

The Appellant objected to interest assessed by OMIG for overpayments found in the audit. The Appellant relies on 18 NYCRR § 518.4(e) to support its position. However, that regulation pertains to cost audits, not claims audits. This matter concerns an audit for claims, and OMIG correctly assessed interest from the date of overpayment as authorized by 18 NYCRR §§ 518.4(b) and 518.4(c). The Appellant's remaining arguments were not raised in response to the draft audit, and therefore are not preserved for this appeal.

DECISION

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

This Decision is made pursuant to the designation by the Commissioner of Health of the State of New York to render final decisions in hearings involving Medicaid provider audits.

DATED: August 9, 2022
Albany, New York

JEAN T. CARNEY
Administrative Law Judge