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NEW YORK STATE OF OPPORTUNITY. Department of Health

**KATHY HOCHUL**
Governor

**JAMES V. McDONALD, M.D., M.P.H.**
Acting Commissioner

**MEGAN E. BALDWIN**
Acting Executive Deputy Commissioner

January 17, 2023

**CERTIFIED MAIL/RETURN RECEIPT**

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

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39 Broadway, 25th Floor
New York, New York 10006

**RE: In the Matter of Dutchess Center for Rehabilitation and Healthcare Audit # 14-4092**

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,

Natalie J. Bordeaux /cmg

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB: cmg
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

COPY

In the Matter of the Appeal of
Dutchess Center for Rehabilitation and Healthcare
Medicaid ID # 00309013 Audit #14-4092
from a determination by the NYS Office of the
Medicaid Inspector General to recover Medicaid
Program overpayments.

DECISION

Before: Kimberly A. O'Brien
Administrative Law Judge

Held at: New York State Department of Health
90 Church Street
New York, New York
& Via WebEx Video Conference

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

Dutchess Center for Rehabilitation and Healthcare
9 Reservoir Road
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## 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 United States Code (USC) 1396a, New York Public Health Law (PHL) 201(1)(v), New York 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 Dutchess Center for Rehabilitation and Healthcare (Appellant). Appellant requested a hearing pursuant to SSL145-a and the former Department of Social Services (DSS) regulations at 18 New York Codes Rules & Regulations (NYCRR) 519.4 to review the determination.

## HEARING RECORD

| | |
|---|---|
| OMIG Witnesses: | Kevin Banach, HMS Manager of Long-term Care Reviews. |
| OMIG Exhibits: | 1-6, 8, 10 & 11. |
| Appellant Witnesses: | [redacted] CPA, Martin Friedman Company; [redacted] Assistant Comptroller, Centers Health Care; [redacted] Financial Tracking Supervisor, Centers Health Care; [redacted] Program Research Specialist IV.[1] |
| Appellant Exhibits: | A, C, U. |

[1] Pursuant to Appellant's subpoena, OMIG produced Ms. [redacted] [Tr. 263-264.]

Hearing Dates: November 30, 2020; August 11, 2021; October 19, 2021.
A transcript of the hearing was made, pages 1-319.
The parties agreed on a briefing schedule and the record closed on January 10, 2022.

## APPLICABLE LAW

Medicaid providers are required, as a condition of their enrollment in the Medicaid 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).

Nursing homes enrolled as Medicaid providers are paid a per diem rate for the cost of care rendered to Medicaid recipients. Each provider's per diem rate is determined based on a provider's reported allowable costs (cost report). All information regarding the cost report is subject to audit (rate audit). PHL § 2808; 10 NYCRR § 86-2.10 18 NYCRR 517.3(a). The per diem rate represents the maximum amount receivable for each day care is provided to Medicaid recipients. However, 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 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 and 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.

Medicaid providers must subtract Medicaid recipients' NAMI before submitting monthly claims to the Medicaid Program. 42 CFR § 435.725; Residential Health Care UB-04 Billing Guidelines, www.emedny.org. "Both the statute and regulations make clear that the financial responsibility for patient NAMI is not borne by the Medicaid Program. The burden of uncollectible NAMI does not fall on the city, state or federal government but rather on the institutional provider." Florence Nightingale Nursing Home v. Perales, 782 F.2d 26 (2nd Cir. 1986).

When the Department determines 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). When an audit is conducted, the Department issues a draft audit report which advises the provider it must submit any contemporaneous records that it wants to be considered before the audit becomes final. 18 NYCRR 517.5(c).

Interest may be collected upon any overpayments determined to have been made and will accrue from the date of each overpayment as recorded in Medicaid payment record and at the prescribed rate. 18 NYCRR 518.4(b), 518.4(c). These records are entitled to a presumption of accuracy. 18 NYCRR 519.18(f).

A Medicaid provider is entitled to a hearing to have the Department's determination reviewed if the Department requires repayment of an overpayment. 18 NYCRR 519.4. "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 or notice of proposed agency action." 18 NYCRR 519.18(a).

At the hearing, Appellant has the burden of proving by substantial evidence 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), 519.18(h); New York State Administrative Procedure (SAPA) § 306(1).

## FINDINGS OF FACT

The following Findings of Fact ("FOF") were made after a review of the entire record in this matter. Citations in brackets refer to transcript page numbers ["Tr."] and exhibits ["Ex."] that were accepted into evidence and represent evidence found persuasive in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Appellant operates a residential health care facility (nursing home) in Pawling, New York. It is licensed under PHL Article 28 and enrolled as a provider in the Medicaid Program. [Ex. 1.]

2. The OMIG initiated an audit of Appellant's Medicaid reimbursement for Medicaid recipients who resided at the nursing home during the period October 1, 2009 through October 31, 2011. Specific fee-for-service claims submitted by Appellant for services provided to Medicaid recipients during the audit period were audited. The claims audit was conducted by the OMIG's contracted agent, Health Management Systems, Inc. (HMS). [Ex.1; Tr. 54-73.]

3. The OMIG issued a Draft Audit Report (DAR) on July 21, 2014 detailing proposed audit findings of Medicaid Program overpayments. Included with the DAR "is a listing of all claims (Appellant) submitted to Medicaid with either none of or only part of each resident's Net Available Monthly Income (NAMI)" deducted from the claims resulting in overpayments. [Ex. 1.]

4. Appellant submitted a response to the DAR on August 25, 2014. [Ex. 2.]

5. The OMIG issued a final audit report (FAR) on August 20, 2015. The OMIG determined that the final overpayment amount is $37,409.04 inclusive of interest, $3008,07. [Ex. 3; Tr. 7.]

6. Appellant requested a hearing in a letter dated August 31, 2015 and a hearing was scheduled for November 16, 2015. Appellant requested and upon consent was granted an indefinite adjournment pending litigation in another matter. When the litigation concluded this hearing was placed back on the calendar and the hearing was completed. [Ex. 4, 5; Tr. 315-317.]

## ISSUES

Was the Department's determination to recover Medicaid Program overpayments from Appellant correct? Was the Department's calculation of interest on the overpayments correct?

DISCUSSION

The OMIG witness Kevin Banach, HMS, presented the audit file and summarized the case as required by 18 NYCRR 519.17(a). [Tr. 26-176.] He explained that this is a claims audit of specific fee-for-service claims submitted by Appellant for services it provided to individual nursing home residents who are Medicaid recipients, not a rate audit of the cost reports Appellant submitted to establish its per diem rate. Auditors reviewed Appellant's Medicaid claims that it submitted for each of the residents identified in the audit to determine whether Appellant reduced its claims by each resident's NAMI obligation. The audit revealed overpayments made to the Appellant in instances where Appellant failed to deduct a resident's NAMI from the claims it submitted to the Medicaid Program. The NAMI overpayments are itemized in a revised attachment to the audit report which includes the name of the resident, the amount of their individual NAMI and the amount Appellant claimed. Appellant was also charged interest on the overpayments, which accrued from the date of each overpayment at the prescribed rate. The interest charged appears throughout the audit in separately listed amounts for each overpayment at the prescribed rate. Appellant's response to the DAR, at the hearing and in its post-hearing briefs Appellant argues that it should be entitled to Medicaid Program payment of a resident's NAMI if, after reasonable efforts, the facility has been unable to collect the NAMI from the resident, which it describes as "bad debt."

Appellant attempts to conflate cost report and rate setting issues including "bad debt," with fee for service claims issues which are the subject of a claims audit. Appellant's response to the DAR states "we believe that the issues in the audit related (sic) to issues of Medicaid rate methodology, which are beyond your office's purview and are not subject to an administrative hearing ... (emphasis added)." [Ex. 2 at page 2.] Appellant's response to the DAR also includes a list/table created by Appellant labeled "DUTCHESS CENTER." The list/table contains a list of months and years during the audit period, and a list of "Outstanding" dollar amounts without any reference to individual Medicaid recipients including those identified in the DAR, and without any reference to individual NAMI amounts or attempts made to collect the NAMIs. [Ex. 2.] No contemporaneous facility records were offered to substantiate any of the "Outstanding" amounts. In support of its position Appellant cites to Eden Park v. Axelrod, 114 A.D.2d 721, 494 N.Y.S.2d (3d

Dept. 1985), in which several nursing homes contested rate-setting determinations, and the court found that the nursing homes should have been afforded a hearing to appeal rate reviews denying reimbursement for bad debt expenses.

On October 26, 2001 the Department issued a "Dear Administrator Letter" (DAL) to all nursing homes licensed in New York State. [ALJ Ex. 1.] The DAL among other things states that a nursing home is required to deduct a Medicaid recipient's NAMI from its Medicaid claim even in instances where the nursing home "is unable to collect the NAMI." "[T]he facility is responsible for collecting the NAMI from the resident or the resident's representative." [ALJ Ex. 1 at pages 1-3.] This DAL letter is entirely consistent with Department and Federal Medicaid reimbursement regulations and with the relevant case law, which is Florence Nightingale, supra, not Eden Park, supra.

In a similar attempt to conflate rate setting issues that are the subject of a rate audit, with fee-for-service claims issues that are the subject of a claims audit, Appellant argues that the OMIG incorrectly imposed interest in this audit from the date of payment instead of the date of issuance of the audit report. 18 NYCRR 518.4(b),(c),(e). What distinguishes 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. As this audit was not an audit of the Appellant's costs, 18 NYCRR 518.4(e) is inapplicable.

This proceeding concerns a claims audit, not a rate audit. Appellant attempts to raise issues not directly related to the Department's final determination, and therefore will not be considered. 18 NYCRR 519.18 (a). Appellant does not dispute that it did not reduce its Medicaid claims by each resident's NAMI. To substantiate its right to payment the Appellant was required to produce evidence showing that the NAMI amounts for each resident listed in the audit were incorrect and/or that Appellant deducted the individual NAMIs from each of its claims before submitting them to the Medicaid Program and did not do so.

Finally, at the hearing Appellant asserts that interest may have been imposed for periods before the overpayments were received. In accordance with 18 NYCRR 518.4(b)&(c), interest was calculated from the date of each overpayment as recorded in Medicaid payment records. These records are entitled to a presumption of accuracy Appellant failed to refute. 18 NYCRR 519.18(f). Appellant failed to raise this issue in

response to the audit and offered no alternative dates for any of these payments and presented no evidence to show when it submitted any of the disallowed claims or when they were paid, that the dates identified by the Department as the dates of payment were not accurate, or that the Department's calculation of interest on the overpayments is incorrect. Instead, Appellant required the OMIG to produce Ms. [redacted] to provide testimony about the calculation of interest on overpayments. Her testimony only confirmed Appellant was appropriately charged interest on the overpayments, which accrued from the date of each payment at the prescribed rate. [Tr. 265-315.]

## DECISION

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

DATED: Albany, New York
January 13, 2023

Kimberly A. O'Brien
Administrative Law Judge