STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of	:	
KINGS HARBOR MULTICARE CENTER Medicaid ID: 00310292	:	**Decision After Hearing**
from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments	:	Audit Number: 14-4095

Before: Natalie J. Bordeaux, Administrative Law Judge

Hearing Dates: October 20 and 29, 2020
The record closed February 8, 2021

Hearing Conducted via: 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.

Kings Harbor Multicare Center
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JURISDICTION

The New York State Office of the Medicaid Inspector General (OMIG) determined to seek restitution of payments made under the Medicaid Program to Kings Harbor Multicare Center (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 Review, Health Management Systems, Inc. (HMS)
OMIG exhibits:	1-12, 20
Appellant witnesses:	Benjamin Weinberger, Director of Accounts Receivable, Kings Harbor Multicare Center (Kings Harbor) Ralph Zimmerman, Chief Financial Officer, Kings Harbor Barry Hyman, Partner, Martin Friedman CPA, PC
Appellant exhibits:	A, T

A transcript of the hearing was made[1]. Each party submitted two post-hearing briefs.

FINDINGS OF FACT

1. The Appellant is a Bronx 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 claims for long-term care services paid by the Medicaid Program from January 1, 2007 through December 31, 2011. (Exhibit 1.)

[1] The October 29, 2020 hearing transcript was mispaginated, as it begins with page 1 rather than continuing the October 20, 2020 transcript's pagination. As such, each transcript will be referred to by hearing date.

3. On July 22, 2014, the OMIG issued a draft audit report to the Appellant, which identified overpayments of $87,502.61 and accrued interest of $15,005.25, with total overpayments of $102,507.86. 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 $1,212,737.83 and enclosed cash receipts journal entries pertaining to its nursing home residents, including several who were not identified in the audit sample. The Appellant's payment records were not categorized and were applied to dates of service within and outside the period audited. 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 $102,507.86. (Exhibit 4.)

6. On November 4, 2014, the Appellant submitted further objections to the audit findings. 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 12, 2015, the OMIG issued a revised final audit report, which identified overpayments of $76,577.52 plus accrued interest of $12,959.07, for total overpayments of $89,536.59. 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 August 31, 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 $24,131.69. After this adjustment, the disallowances in category 1 equal $41,778.40 ($32,581.27 in disallowances plus $5,436.30 interest.) (Oct. 20 T 6-7.)

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 the contention that the OMIG's imposition of interest on all three disallowance categories contravened applicable regulations. (Oct. 20 T 7.)

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. While 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 own 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 January 1, 2007 through December 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 and 7.)

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).

Despite its objection to the disallowances in this category, the Appellant offered no information to disprove the auditors' findings regarding the portions of the claims disallowed. Instead of addressing the findings, the Appellant asserted in its responses to the audit reports that it was entitled to reimbursement for "uncollected" NAMI amounts for residents in an attempt to offset the amount it is required to return to the Medicaid Program. To bolster this unrelated

argument, the Appellant submitted ledgers of miscellaneous cash receipts for residents (including those not named on audited claims) that were applied to dates of service within and outside the scope of the period audited. (Exhibit 3.)

The Appellant's witnesses offered no information relevant to the audit findings. The Appellant's Director of Accounts Receivable prepared worksheets showing that the Appellant had "written off" $840,383.99 from patient accounts during the period audited. (Exhibit A.) Business decisions regarding patient accounts do not explain why the Appellant billed the Medicaid Program its full monthly rate without deducting residents' NAMI amounts.

The Appellant's attempt to argue that the Medicaid Program is obligated to reimburse it for uncollected NAMI amounts is founded upon Medicare reimbursement principles. Medicare recipients are required 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). Medicare policy reimburses providers for a portion of deductibles and coinsurance amounts deemed uncollectible.[2] 42 CFR § 413.89. Nursing homes submit cost reports to the Medicare Program, which detail uncollectible deductibles and coinsurance with supporting documentation required by Medicare guidelines. (Oct. 29 T 109-10.) The Appellant failed to establish the relevance of these Medicare cost policies to this Medicaid claims audit.

The auditors were not reviewing the Appellant's reported costs as part of its rate. The auditors were reviewing the accuracy of the Appellant's claims and resulting payments by the Medicaid Program. The Appellant incorrectly asserts that its request for reimbursement of unpaid NAMIs must be addressed in this decision because "there is no other audit that can or

[2] Despite the Appellant's 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).

will be done of these claims." (Appellant's 2/8/21 Post-Hearing Brief, p. 13.) A dispute that the Appellant has with respect to its rate must be addressed by the Department and may be initiated: (1) during the audit of base year cost figures at or prior to the audit exit conference; or (2) by formal application for review of a certified rate with supporting documentation within 120 days of receipt of the initial computation sheets to bring errors to the attention of the commissioner. 10 NYCRR § 86-2.13 and § 86-2.14. A claims audit such as this one is not the appropriate event for a provider to request a rate adjustment.

The Appellant has attempted to confuse the purpose of this audit to justify its reimbursement request 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 review claims paid for long-term care services. (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 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 Appellant's post-hearing submissions also reflect awareness of the distinction between rate audits and claims audits, as it repeatedly concedes that it is seeking consideration of unpaid NAMI amounts as an allowable cost reimbursable via a rate decision. (Appellant's 1/11/21 Post-Hearing Brief, pp. 8-12, 16-19, 23; Appellant's 2/8/21 Post-Hearing Brief pp. 6-7, 10-11, 13-14.)

The Appellant contends that its position regarding reimbursement for unpaid NAMI amounts is supported by applicable case law. Counsel for the Appellant previously sought a declaratory judgment on behalf of another residential health care facility to annul an OMIG claims audit by claiming its entitlement to "write-off bad debts" pertaining to residents' NAMI

obligations. Concourse Rehabilitation & Nursing Center, Inc. v. Shah, et al., 161 A.D.3d 669 (App. Div. 1st Dep't 2018). However, both the First Department and the lower court dismissed this action in this entirety.

None of the cases cited by the Appellant held that the New York State Medicaid Program is required to reimburse Medicaid providers for uncollected (even uncollectible) NAMI amounts. For instance, 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 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, contrary to the Appellant's assertion (Appellant's 1/11/21 Post-Hearing Brief pp. 19-20), the Appellate Division made no ruling on the viability of the petitioners' claims.

The only cited decision relevant to the Appellant's 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. Nevertheless, it bears repeating that even if the Appellant had provided legal authority for its assertion (which did not occur in this matter), the Appellant's contention remains irrelevant to the audit findings.

The Appellant has failed to substantiate its contention that it is owed reimbursement from the Medicaid Program for NAMI amounts that it purportedly did not receive from residents for

an unspecified period that includes, but is not limited to, the period audited. More importantly, the Appellant has failed to establish that the OMIG's determination to disallow portions of claims payments made for 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).

Despite withdrawing its challenges to the disallowances set forth in categories 2 and 3, the Appellant asserts that the OMIG improperly computed interest owed with respect to disallowances in all three categories. The Appellant contends that the OMIG was precluded from charging interest before 90 days after the issuance of the Final Audit Report because it is an inpatient facility established by Article 28 of the Public Health Law. Pursuant to 18 NYCRR § 518.4(e):

> …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.

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 legally wrong. This audit # 14-4095 was not an audit of the Appellant's costs. It was an audit of paid claims.

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). The Appellant's witness testified at the hearing that a time lag exists between the date of claim submission and the Appellant's receipt of payment (Oct. 29 T 47, 95.) The Appellant's post-hearing submissions also raise this issue as a basis for adjusting the interest imposed in this audit. (Appellant's 1/11/21 Post-Hearing Brief, pp. 29-30; Appellant's 2/8/21 Post-Hearing Brief, pp. 16-18.) This contention was not raised in the responses to the audit reports and is entirely unrelated to the Appellant's consistent claim that interest on the overpayment should not be imposed until at least 90 days after the issuance of the final audit report. (Exhibit 5.) An appellant may not raise any new matter not considered by the OMIG upon submission of objections to a draft audit or notice of proposed agency action. 18 NYCRR § 519.18(a). For that reason, this argument will not be addressed in this decision.

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: February 17, 2021
Menands, New York

Natalie J. Bordeaux
Administrative Law Judge