STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of **RIVER MANOR CARE CENTER** Medicaid ID: 00312703 from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments	:	**Decision After Hearing** Audit Number: 14-4113

Before: Natalie J. Bordeaux, Administrative Law Judge

Hearing Dates: November 2, 2020 and February 4, 2021
The record closed May 10, 2021

Hearing via: Cisco WebEx Videoconference

Parties:
New York State Office of the Medicaid Inspector General
584 Delaware Avenue, 2nd Floor
Buffalo, New York 14202
By: Kendra Vergason, Esq.

River Manor Care 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 River Manor Care 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 Reviews, Health Management Systems, Inc. (HMS)
OMIG exhibits:	1-7, 9-11
Appellant witnesses:	[redacted], Excelsior Care Group[1] [redacted] Martin Friedman CPA, PC
Appellant exhibits:	A, Q

A transcript of the hearing was made. (T 1-202.) Each party submitted two post-hearing briefs.

FINDINGS OF FACT

1. The Appellant is a residential health care facility (also referred to as a nursing home) in Brooklyn, New York. It is licensed under Public Health Law Article 28 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. (Exhibits 1 and 3.)

[1] Excelsior Care Group provides management consulting services for the Appellant. (T 143.)

3. On July 22, 2014, the OMIG issued a draft audit report to the Appellant, which identified overpayments of $528,876.81 and accrued interest of $72,208.30, with total overpayments of $601,085.11. 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.
5. Medicaid reimbursements billed for dates of service beyond the date of resident discharge.

(Exhibit 1.)

4. On September 23, 2014, the Appellant submitted its response to the draft audit report, in which the Appellant contended that it was entitled to offset the overpayment with "uncollectable" NAMI totaling $504,017.53. The Appellant also contended that it was entitled to reimbursement from the Medicaid Program for "uncollectable" NAMI amounts as "bad debts." Finally, the Appellant alleged that "[t]he State of New York has never begun charging interest until after the date of the final audit report and then only if the payment stretched beyond 90 days after the date of the final audit report." (Exhibit 2.)

5. On June 18, 2015, the OMIG issued a final audit report, which removed several disallowances set forth in the draft audit report and advised that HMS had reduced the overpayment amount to $598,267.89, including interest. The remaining disallowances 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 billed at the incorrect rate code based on the recipient's Medicare eligibility.
4. Medicaid reimbursements billed for dates of service beyond the date of resident discharge.

(Exhibit 3.)

6. On August 13, 2015, the Appellant requested this hearing to contest the findings set forth in the final audit report. Aside from renewing its objections to the draft audit report, the Appellant also contended that the "interest charges as computed…are illegal." (Exhibit 4.)

7. The Appellant has withdrawn its challenges to the findings set forth in revised categories 2, 3, and 4. However, it continues to dispute the OMIG's imposition of interest on all four disallowance categories. (T 10.)

8. 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 $4,872.69 based upon the removal of $4,187.04 for disallowed claims and $685.65 of interest applied to those disallowances. After this adjustment, the disallowances in category 1 equal $407,404.29 ($358,567.15 in disallowances plus $48,837.14 interest.) The total overpayment, as amended at the hearing, equals $593,395.17 ($522,152.73 in disallowances plus $71,242.44 interest.) (Exhibit 9; T 9.)

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, 3, and 4 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.

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 and § 435.832; 18 NYCRR § 360-4.9; *see also* NY Dept. of Health Office Admin. Directive 00 OMM/ADM-6.

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 and each resident's NAMI. Portions of reimbursements were disallowed for residents' NAMI amounts when the auditors determined that the Appellant submitted claims for, and received, its monthly rate for those residents without reductions for residents' NAMI obligations. (Exhibits 3, 7, 9.)

The Appellant offered no information to disprove the auditors' findings regarding the portions of the claims disallowed. The Appellant acknowledges that its claims to the Medicaid Program for nursing home stays must deduct residents' NAMI amounts from the total amount billed. (Appellant's 4/12/21 Post-Hearing Brief, p. 13.) The Appellant also does not dispute that it received payment from the Medicaid Program for services rendered minus individual resident NAMI amounts. Nevertheless, the Appellant is seeking to obtain indirectly what it is not legally authorized to receive directly. The Appellant has attempted to confuse the purpose of this audit to deflect attention from its liability for overpayments and justify a reimbursement request for NAMI amounts that it has labeled "uncollectable." (Exhibits 2, 4, 10.)

The OMIG clearly advised the Appellant, and the Appellant was manifestly aware, that the purpose of this audit was to review claims paid for long-term care services pursuant to 18 NYCRR § 519.4(a)(2). (Exhibits 1-4, 10, 11.) The Appellant is also aware 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 and that the reimbursement of costs is made via a rate decision. (Exhibits 2, 4, 10; Appellant's 4/12/21 Post-Hearing Brief, pp. 10-11, 14, 17-19.)

Despite clear regulatory guidance on this matter, the Appellant insists that the issues are related and should be addressed in tandem. (Appellant's 4/12/21 Post-Hearing Brief, pp. 24-25; Appellant's 5/10/21 Reply Brief, pp. 9-10.) Among other errors, the Appellant's irrelevant argument that the Medicaid Program is obligated to reimburse it for uncollected NAMI amounts is founded upon Medicare cost reimbursement principles. 42 CFR § 413.89. The Appellant failed to establish the relevance of Medicare cost policies to this Medicaid claims audit.

The Appellant incorrectly asserts that its request for reimbursement of unpaid NAMI must be addressed in this decision because there is no other way that these uncollected amounts

can be considered for reimbursement by the Department. (Appellant's 5/10/21 Reply Brief, p. 15.) A nursing home is entitled to notify the Department of its disagreement with rate computations in the following ways: (1) during an 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. This claims audit is not the appropriate event for a provider to request a rate adjustment.

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). Contrary to the Appellant's repeated claim that the reviewing courts "affirmed" and "remanded" the matter for review consistent with specific directives (Appellant's 4/12/21 Post-Hearing Brief, p. 1; Appellant's 5/10/21 Reply Brief, p. 7,) both the First Department and the lower court dismissed this action in its entirety.

None of the cases cited by the Appellant hold 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 4/12/21 Post-Hearing Brief pp. 4-5, 7-8, 18-19, 21-22; Appellant's 5/10/21 Reply Brief, p. 8), 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:

> 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.

The Appellant argues that without reimbursement by the Medicaid Program for unpaid NAMI amounts, it will never receive full payment for nursing home care at the "full" Medicaid reimbursement rate. (Appellant's 4/12/21 Post-Hearing Brief, p. 3; Appellant's 5/10/21 Reply Brief, pp. 2, 4-5.) Citing a provision in its Medicaid provider agreement whereby the Medicaid Program agrees to reimburse the Appellant for rendered services, the Appellant asserts that it is contractually owed its full payment rate from the Medicaid Program. (Appellant's 4/12/21 Post-Hearing Brief, pp. 3, 11.) Pursuant to federal and state law, and as reiterated in eMedNY Provider Manuals, the Appellant received from the Medicaid Program what it was legally entitled to receive.

Medicaid payments to nursing homes must be reduced by NAMI amounts. An unpaid NAMI (even if uncollectible) is not reimbursable by the New York State Medicaid Program. Most importantly in this case, even if the Appellant had provided legal authority for its assertion

(which did not occur in this matter) that uncollected NAMI is somehow pertinent to rate setting, the Appellant's contention remains irrelevant to the audit findings.

Offering an absurd and wildly distorted view of the parties' obligations, the Appellant alleges that the Medicaid Program should collect NAMI amounts from residents who have not paid the NAMI to the facility. (Appellant's 4/12/21 Post-Hearing Brief, p. 4; Appellant's 5/10/21 Reply Brief, pp. 3-4.) The Medicaid Program renders eligibility determinations based upon budgetary computations. It is not tasked with collecting unpaid amounts charged by and owed to a Medicaid provider. (Appellant's 4/12/21 Post-Hearing Brief, pp. 12-13, 16.)

The Appellant elected to participate in the Medicaid Program and accept Medicaid-eligible residents. By doing so, the Appellant accepts the maximum amount it is eligible to receive per resident from the Medicaid Program, based upon each Medicaid-eligible resident's budget. If this is a hardship to the Appellant, the Appellant accepted it voluntarily.

In its post-hearing submissions, the Appellant incorrectly contends that the revised findings still included "retroactive" NAMI amounts, despite the OMIG's affirmation that findings in Disallowance Category 1 were adjusted to eliminate situations where NAMI amounts were changed by the local Department of Social Services retroactively.[2] The instances raised by the Appellant were not retroactive NAMI changes instituted by a local district. The Appellant is attempting to label as "retroactive" the institution of a NAMI in situations in which budget letters were received for certain residents after they entered the facility and after the Appellant billed the Medicaid Program. The Appellant acknowledges that it submitted claims before receiving budget letters based upon its own computations. (Appellant's 4/12/21 Post-Hearing Brief, pp. 27-29; Appellant's 5/10/21 Reply Brief, pp. 10-12, 17; Exhibit 2.)

[2] Pursuant to Administrative Directive 00 OMM/ADM-6, an increase in an institutionalized individual's net available monthly income may be made only with timely and adequate notice.

The Appellant made the decision to bill the Medicaid Program before receiving the requisite budget eligibility information and in contravention of program guidance. This situation is therefore not a retroactive adjustment by the Medicaid Program. For nearly 20 years (including at least 5 years before the earliest claims reviewed in this audit), providers have been advised not to bill the Medicaid Program until a budget letter is issued that indicates the NAMI amount and the effective date of the NAMI amount. DOH Office of Medicaid Management (OMM) Dear Administrator Letter, October 26, 2001. The Appellant bears the financial responsibility for differences between its estimate and an actual budget determination.

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).

The Appellant asserts that the OMIG improperly computed interest owed with respect to disallowances in all four categories. It argues 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. (Exhibit 2; Appellant's 4/12/21 Post-Hearing Brief, pp. 31-32; Appellant's 5/10/21 Reply Brief, p. 20.) 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 claims audits and audits of costs is legally wrong. This was not an audit of the Appellant's costs. It was an audit of paid claims. For that reason, subsection (e) is inapplicable.

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 failed to refute this presumption of accuracy in the payment dates reflected in the Department's records. At the hearing and in its post-hearing submissions, the Appellant argued that a time lag exists between the date of claim submission and the Appellant's receipt of payment. (T 165-74; Appellant's 4/12/21 Post-Hearing Brief, pp. 32-35; Appellant's 5/10/21 Reply Brief, pp. 19-20.) The Appellant also submitted documentation to show that the Medicaid Program delayed payment release to providers. (Exhibit Q.)

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). The Appellant failed to raise this issue in any of its responses to the auditors or in its response to the draft audit report. (Exhibits 2, 4, 10.) The Appellant claimed in its brief (Appellant's 4/12/21 Post-Hearing Brief, p. 34) that the OMIG was somehow "put on notice" of this issue. The Appellant's response to the draft audit report contends that "[t]his is only a draft audit report and

should not contain any interest charges," while its hearing request asserts that "interest charges as computed…are illegal." (Exhibit 4.) This does not constitute a timely raising of a factual or legal dispute about the dates of payment on the claims with audit findings, which must be raised, at the latest, in response to the draft audit report. The Appellant's complaint about the imposition of any interest in its response to the draft audit report and its belated assertion in its hearing request that the interest is "illegal" are ambiguous and inadequate to justify review of the payment dates in this decision. This hearing is not a continuation of the audit, but rather a review of the audit and its findings. The Appellant's argument regarding a later payment receipt date for interest computation will therefore not be considered.

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, 3, and 4 was correct and is affirmed.

Dated: July 8, 2021
Menands, New York

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