

**STATE OF NEW YORK
DEPARTMENT OF HEALTH**

In the Matter of the Appeal of	:	
	:	
Staten Island Care Center	:	Decision After
Medicaid ID # 00314690	:	Hearing
	:	
from a determination by the NYS Office of the	:	
Medicaid Inspector General to recover Medicaid	:	
Program overpayments.	:	#14-4115
	:	

Before: John Harris Terepka
Administrative Law Judge

Held at: New York State Department of Health
By videoconference
January 7, 13, 2021
Record closed April 6, 2021

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JURISDICTION

The Department of Health (the Department) acts as the single state agency to supervise the administration of the Medicaid Program in New York State. 42 USC 1396a; Public Health Law (PHL) 201(1)(v); 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 Staten Island Care Center (the Appellant). The Appellant requested a hearing pursuant to SSL 22 and the former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the determination. The hearing was scheduled to commence on October 17, 2019, but was rescheduled at the mutual request and consent of both parties to February 13, 2020, June 14, 2020, and then January 7, 2021.

HEARING RECORD

OMIG witnesses:	Kevin Banach, HMS Systems manager of long term care reviews
OMIG exhibits:	1-6, 10
Appellant witnesses:	██████████ CPA, consultant Aaron Kaufman, CFO, Staten Island CC
Appellant exhibits:	A, U

A transcript of the hearing was made. (Transcript, pages 1-207.) The parties each submitted two post hearing briefs and the record closed on April 6, 2021.

SUMMARY OF FACTS

1. Appellant Staten Island Care Center is a 300 bed residential health care facility (RHCF), or nursing home, in Staten Island, New York. It is licensed under PHL Article 28 and enrolled as a provider in the Medicaid Program.

2. The OMIG conducted a review of the Appellant's reimbursement for Medicaid recipients who resided at Staten Island Care Center during the period October 1, 2006 through September 30, 2010. The audit was conducted by the OMIG's contracted agent, Health Management Systems, Inc. (HMS). (Exhibit 4.)

3. The OMIG issued a draft audit report on July 22, 2014 detailing proposed audit findings of Medicaid Program overpayments. Pursuant to 18 NYCRR 517.5, the draft audit report invited the Appellant to respond with any issues or documentation that it wanted to be considered before the audit became final. (Exhibits 1, 2.)

4. The Appellant submitted a response to the draft audit report on November 24, 2014. The Appellant demanded an adjustment of the audit findings to include "a payment to us for the uncollected NAMI's [sic] for the period." The Appellant also objected to the OMIG's imposition of interest on the overpayment on the grounds that pursuant to 18 NYCRR 518.4(c), interest may not be collected for any period prior to 90 days after the issuance of the final audit report. (Exhibits 3, 3a.)

5. After considering the Appellant's objections in response to the draft audit report pursuant to 18 NYCRR 517.6(a), the OMIG issued a final audit report dated July 22, 2015. The final audit report listed and set forth reasons for each disallowed payment, and notified the Appellant that the OMIG had determined to seek restitution of Medicaid

Program overpayments in the amount of \$452,521.68, inclusive of interest. (Exhibits 4, 5.)

6. The OMIG subsequently revised the final audit report findings, reducing the overpayment to \$372,106.25 plus interest in the amount of \$68,721.66, and seeks restitution in the total amount of \$440,827.91. (Exhibit 6.)

7. The final audit report (Exhibit 4) set forth findings and overpayments in four 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 at for [sic] dates of service beyond the date of resident discharge.

8. The Appellant does not contest the OMIG's final overpayment determinations in categories 2, 3 and 4. Remaining at issue in this hearing are the category 1 (NAMI) overpayments in the total amount of \$301,957.53. (Exhibit 6, Bates page 0472; Transcript, pages 3-5.)

9. The Appellant also disputes the OMIG's determination regarding the amount of interest that it may collect on the overpayments. (Transcript, page 4.) The interest on categories 2, 3 and 4 is \$12,478.31. (Exhibit 6, Bates page 0429.) The interest on category 1 is \$56,243.35. (Exhibit 6, Bates page 0472.) The total interest on the overpayment is \$68,721.66. (Exhibit 6, Bates page 0473.)

ISSUES

Was the OMIG determination to recover Medicaid Program overpayments from Appellant Staten Island Care Center correct? Was the OMIG determination to recover interest from the date of the overpayments correct?

APPLICABLE LAW

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

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 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 will accrue from the date of the overpayment. 18 NYCRR 518.4(b)&(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 person is entitled to a hearing to have the Department's determination reviewed if the Department requires repayment of an overpayment. 18 NYCRR 519.4. At the hearing, the Appellant has the burden of showing 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).

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 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, however, that a nursing home is always entitled to charge its full Medicaid rate to the Medicaid Program.

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 Medicaid 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, 4.6, 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 (2nd Cir. 1986).

DISCUSSION

At issue in this hearing are the findings of overpayments attributable to resident NAMI; and the imposition of interest on the overpayments. NAMI overpayments are itemized in the revised attachment to the final audit report, showing a total overpayment of \$301,957.53. (Exhibit 6, Bates pages 0429-0472.) The total interest on the revised overpayment finding is \$68,721.66. (Exhibit 6, Bates page 0473.)

The Appellant continues to falsely assert that this hearing "relates to a remand from the Appellate Division." (Appellant brief, page 1; reply brief, pages 6, 16.) No such remand exists. This audit was one of many OMIG audits undertaken to review nursing home Medicaid payments in relation to resident NAMI and other Medicaid coverage limitations. Approximately eighteen of the audited nursing homes were represented by the same counsel, who requested that their administrative hearings be consolidated. That request was denied after the OMIG opposed it on the grounds that each audit was of a different nursing home and necessarily involved reviews of completely unrelated Medicaid payments and different facts. Suffolk Center for

Rehabilitation & Nursing et. al. (Audit #14-4118 et. al., decision on “Motion for Consolidation,” May 14, 2019.) The only issue these hearings had in common was the irrelevant one that the Appellant seeks to raise: that it is somehow entitled, in connection with an audit of NAMI overpayments, to be reimbursed for unrelated “NAMI bad debts.”

The Appellant had previously attempted to raise this issue directly in the courts. It was to this attempt that the delay in proceeding to this hearing after the issuance of the final audit report in 2015 is largely attributable. (Appellant brief, page 6.) The attempt was dismissed in its entirety. Concourse Rehabilitation & Nursing Center, Inc. v. Shah, 161 A.D.3rd 669, 78 N.Y.S.3rd 60 (1st Dept. 2018), *lv denied* 32 N.Y.3rd 904, 84 N.Y.S.3rd 859 (2018). No court has directed a “remand” or any other proceeding to consider this or any other issue in connection with these 18 NYCRR Part 517 audits.

In any event, this issue has now been raised and disposed of in completed administrative hearings for four nursing homes. Suffolk Center for Rehabilitation & Nursing (Audit #14-4118, issued April 27, 2020); Northern Metropolitan RHCF (Audit #14-4097, issued November 19, 2020); Richmond Center for Rehabilitation & Specialty Healthcare (Audit #14-4174, issued January 29, 2021); Kings Harbor Multicare Center (Audit #14-4095, issued February 17, 2021.) These hearing decisions all rejected the Appellant’s contentions that alleged “NAMI bad debt” of any of these nursing homes has any relevance to audits for overpayments attributable to claims for patient care that exceeded the amounts permissible under 42 CFR 435.725. The issues the Appellant seeks to raise are explicitly excluded, pursuant to 18 NYCRR 519.18(a), from review in this hearing because they are irrelevant and unrelated to the Medicaid payments that were audited or the overpayments that were identified.

The Appellant's arguments attempt to confuse and to obscure the result it seeks, which is to obtain Medicaid reimbursement for resident NAMI obligations that under federal and state Medicaid regulations, and the pertinent court decisions, are not reimbursable by the Medicaid Program. It is well settled that the NAMI obligation is between the resident and the nursing home, and that the Medicaid Program will not pay any amounts that are the patient's responsibility. 42 CFR 435.725; Florence Nightingale Nursing Home v. Perales, 782 F.2d 26 (2nd Cir. 1986).

The Appellant has not brought forward any facts or arguments at this hearing that are new or materially different, or were not fully addressed and decided against it in the previous hearing decisions.

The audit findings

In its post hearing brief, the Appellant objected to overpayments among twenty residents identified in this audit under two of the "reason codes" used to explain the category 1 findings. (*see* Exhibit 6, Bates page 0473.)

Reason code 2. The Appellant did not take issue with the OMIG's factual determinations under reason code 2 - "facility collected more NAMI than applied to claim." It did not dispute that the audit correctly identified amounts collected from residents that exceeded what was applied to the Medicaid claims for the months in question. The Appellant instead maintains that it later refunded these NAMI amounts to the residents or their families. (Appellant brief, pages 25-26.)

The Appellant's attempt at the hearing to establish that identified NAMI overpayments were returned to one resident was not agreed to by the OMIG's witness and the Appellant failed to prove it either during the audit or at this hearing. (Transcript,

pages 97-103.) The existence of a copy of a [REDACTED] check from the facility to the resident dated [REDACTED] 2010, with no notation on the check itself to document what that payment was for, and an entry in the amount of [REDACTED] that appears in the Appellant's resident ledger in [REDACTED] 2011, do not establish a refund of three Medicaid overpayments of \$ [REDACTED] and one of \$ [REDACTED] totaling \$ [REDACTED] attributable to NAMI identified for [REDACTED] and [REDACTED] 2008. (Exhibit 3a, Bates page 0126; Exhibit 6, Bates page 0432; Exhibit 10, Bates page 0727.) As the OMIG's auditor pointed out, "we needed more information." (Transcript, page 97.)

In its post hearing brief, the Appellant claimed, solely on the basis of entries made by the Appellant in its resident ledgers, that NAMI overpayments were also refunded to three other residents. (Appellant brief, page 26.) These are similar attempts to simply point to unexplained payments made or credits given to residents at various times and appearing only on the running accounts kept by the Appellant, and claim that they reduce the NAMI overpayments identified by the audit.

Reason code 3. Reason code 3 disallowances were made because the resident's NAMI was not applied to reduce the Medicaid billing. In its post-hearing brief, the Appellant objected to disallowances for sixteen residents on the grounds that they were based on NAMI budget letters issued by the local social services district after the month of service. (Appellant brief, pages 26-28.) The Appellant claimed, for example, that a disallowance for failure to apply a resident's NAMI to the October 2006 Medicaid claim should not have been made because it was based upon a NAMI budget letter, effective September 2006, that was issued by the local social services district in December 2006. (Appellant brief, page 26.)

The Appellant did not dispute the accuracy of the OMIG determinations applying the correct NAMIs to the months in question. It offered no authority to support the argument that it is entitled to be reimbursed by Medicaid for a resident's NAMI because the local district's budget letter was issued after the month of service. As the OMIG's auditor pointed out at the hearing, these disallowances were not "retroactive NAMI" disallowances attributable to a local district's subsequent revision of its initial budget determination. These disallowances were based upon initial Medicaid budget determinations. (Transcript, page 106.) In these situations, as a Department "Dear Administrator" letter issued October 26, 2001 specifically instructs nursing homes: "A provider should not bill Medicaid until they receive a budget letter from the social services district indicating the NAMI amount and effective date of the NAMI."

The Appellant has offered no evidence or argument that raises any other question or meets its burden of proving entitlement to the overpayments identified in this audit, and they are affirmed.

Interest on the overpayments

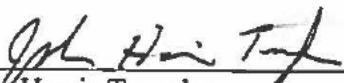
With regard to the interest issue, the OMIG's audit determination is also affirmed. Interest was correctly assessed pursuant to 18 NYCRR 518.4(b)&(c). As this audit was not an audit of the Appellant's costs, 18 NYCRR 518.4(e) is inapplicable. Interest is chargeable from the date of each overpayment. Dates of payment were established by computer-generated documents prepared by the Department, which show the nature and amount of the payments and are presumed to constitute an accurate itemization of the payments made. 18 NYCRR 519.18(f).

At this hearing the Appellant also contended, for the first time, that it may not have actually received possession of transmitted payment funds until approximately three weeks after the recorded dates of payment. (Appellant brief, pages 30-32; reply brief, page 17.) This is new matter not considered by the Department upon submission of objections to a draft audit report. As the Appellant did not raise this objection during the audit, or indeed at any time before this hearing had actually commenced, the OMIG did not have the opportunity to consider it in the audit and it is not now obligated to consider it. It may not be raised and will not be considered in this hearing to review the completed and closed audit. 18 NYCRR 519.18(a).¹

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

This decision is made by John Harris Terepka, who has been designated to make such decisions.

DATED: Rochester, New York
April 21, 2021



John Harris Terepka
Bureau of Adjudication

¹ The OMIG did not object to the inclusion in the record of such evidence and argument as Appellant did offer on this issue. (Exhibit U.) It failed to prove any error in the OMIG's interest calculations. An assertion that processing time for Medicaid payments generally takes as long as three weeks from submission of the bill to receipt of payment proved nothing of any significance. It was not accompanied by documentation to show when any of these disallowed payments was billed or documentation that any payment was actually received on a later date than reflected in the Department's records.

The Appellant failed to document or specify even one actual payment date among the hundreds of payments disallowed in this audit that it claims differed from the presumptively accurate Department record. The two examples it presented at the hearing to illustrate its general contention did not involve payments for which disallowances were made in this audit. (Transcript, pages 138-39, 174-75, 196-98; Exhibit 6, Bates pages 429, 436; Exhibit 10, Bates pages 482, 1011.) It is further noted with regard to the Appellant's general contention that payments were not likely to be processed and received within three weeks of the date of service, that the audit report shows the OMIG calculated interest on many of the overpayments identified in the audit report on the basis of a paid date that was well over three weeks, and in many instances several months after the date of the service. (Exhibit 6.)