STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of **Concourse Rehabilitation and Nursing Center** Medicaid ID # 00310623 from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments.	:	**Decision After Hearing** #13-1130

Before: John Harris Terepka
Administrative Law Judge

Held at: New York State Department of Health
By videoconference
July 7, 20, 2021
Record closed October 22, 2021

Parties: New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12205
By: Ferlande Milord, Esq.
90 Church Street
New York, New York 10007
Ferlande.Milord@omig.ny.gov

Concourse Rehabilitation and Nursing Center
1072 Grand Concourse
Bronx, New York 10456
By: Marvin [redacted] Esq.
Theodore T. Mairanz, Esq.
[redacted] & Mairanz P.C.
39 Broadway, 25th floor
New York, New York 10006
tmairanz@ngmpc.com

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 Concourse Rehabilitation and Nursing 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.

HEARING RECORD

The hearing was scheduled to commence on March 14, 2019 but was rescheduled at the mutual request and consent of both parties to July 7 and 20, 2021.

OMIG witnesses:	Kevin Banach, HMS Systems manager of long-term care reviews
OMIG exhibits:	1, 1a, 2, 2a, 3, 3a, 3b, 3c, 4, 4a, 5, 6
Appellant witnesses:	[redacted] CPA [redacted] controller [redacted] associate controller
Appellant exhibits:	B-D

A transcript of the hearing was made. (Transcript, pages 1-192.) The parties each submitted two post hearing briefs and the record closed on October 22, 2021.

SUMMARY OF FACTS

1. Appellant Concourse Rehabilitation and Nursing Center is a 240-bed residential health care facility (RHCF), or nursing home, in the Bronx, New York City. It is licensed under PHL Article 28 and is enrolled as a provider in the Medicaid Program.

2. The OMIG conducted a review of the Appellant's Medicaid reimbursement for its residents during the period January 1, 2006 through December 30, 2009. The audit was conducted by the OMIG's contracted agent, Health Management Systems, Inc. (HMS). (Exhibit 1; Transcript, pages 31-32.)

3. The OMIG issued a draft audit report dated January 7, 2013 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, 1a.) The Appellant did not submit a response to the draft audit report.

4. The OMIG then issued a final audit report dated May 9, 2013. 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 $178,148.03, inclusive of interest. (Exhibits 2, 2a.)

5. The OMIG subsequently revised the final audit report findings, reducing the overpayment to $128,507.11 plus interest in the amount of $24,424.38, and seeks restitution in the total amount of $152,931.48. (Exhibit 3.)

6. By letter dated June 27, 2013, the Appellant requested that the OMIG "provide our client with whatever rights the law provides." The Appellant also commenced an action in Bronx Supreme Court for a declaratory judgment that "the

issues in the audit... are not subject to an administrative hearing." (Exhibit 4.) That action was dismissed, which dismissal was affirmed by the Appellate Division on May 29, 2018. The Appellant then renewed its administrative hearing request by letter to the OMIG dated June 19, 2018 and this hearing ensued. (Exhibits 4a, 5.)

7. The final audit report (Exhibit 2) 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 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 five percent.

4. Medicaid reimbursements billed at the incorrect rate code based on the recipient's Medicare eligibility.

8. The Appellant does not challenge the OMIG's final overpayment determinations in categories 2, 3 and 4. (Transcript, pages 6, 13.)

9. The Appellant disputes the OMIG's determination regarding the amount of interest that it may collect on the overpayments. (Transcript, page 5.)

ISSUES

Was the OMIG determination to recover Medicaid Program overpayments from the Appellant correct? Was the OMIG determination to recover interest correct?

APPLICABLE LAW

Medicaid providers are required, as a condition of their enrollment, 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 504.8, 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 it requires repayment of an overpayment. 18 NYCRR 519.4. At the hearing, the Appellant has the burden of showing that the determination 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 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 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 (2d Cir. 1986).

DISCUSSION

The Appellant specifies the issues it raises in this hearing as follows:

> This matter relates to a remand from the Appellate Division of the issues in dispute in this matter; *viz*,. the entitlement of a nursing home to be reimbursed by the Medicaid Program for it's *[sic]* uncollected and written off NAMI bad debts. An additional issue is whether the imposition of interest on this audit by OMIG, was authorized by law, and also whether the manner with which such interest was calculated was correct. (Appellant brief, page 1.)

The assertion that this hearing "relates to a remand from the Appellate Division" to consider the issue of Medicaid reimbursement for bad debts (Appellant brief, pages 1, 24; reply brief, page 7) is false. No such remand exists. Concourse Rehabilitation & Nursing Center, Inc. v. Shah, 161 A.D.3d 669, 78 N.Y.S.3d 60 (1st Dept. 2018), *lv denied* 32 N.Y.3d 904, 84 N.Y.S.3d 859 (2018) was dismissed in its entirety.

It was the Appellant's decision to attempt to connect its "NAMI bad debt" contentions with this claims audit and then attempt to litigate that spurious connection before the audit findings had been reviewed in an administrative hearing. The attempt was properly dismissed solely on the grounds that the audit had not been administratively reviewed. No court has directed a "remand" or any other proceeding to consider "NAMI bad debt" or any other issue in connection with this 18 NYCRR Part 517 audit. This hearing was conducted to review the audit findings because the Appellant requested an administrative hearing pursuant to 18 NYCRR 519.7. (Exhibits 4, 4a.)

In any event, the Appellant's stated issues have now been raised by its counsel in administrative hearings for six nursing homes and found to be without merit. 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); Staten Island Care Center (Audit #14-4115, issued April 21, 2021); River Manor Care Center, (Audit #14-4113, issued July 8, 2021).

These hearing decisions all rejected the Appellant's contention that alleged "NAMI bad debt" of a nursing home has any relevance to an audit to review payments for resident care that exceeded the amounts permissible under 42 CFR 435.725. They also rejected the Appellant's contention that the OMIG has not correctly assessed the interest on such overpayments. 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.

"NAMI bad debt."

Alleged but unproven "bad debt" attributed to some residents, for charges unrelated to the Medicaid overpayments for other residents identified in this audit, are not relevant to the audit findings. The Appellant repeatedly misrepresents the nature and purpose of this audit hearing in its attempt to bring in these irrelevant "bad debt" contentions. For example, in addition to falsely claiming this hearing is a "remand" from the Appellate Division to review them, the Appellant further asserts: "This audit was intended as a verification that the facility's billings to the Medicaid Program, and its collections thereon, were accurate." (Appellant brief, page 3.) As the audit reports made clear, this audit was for the purpose of reviewing Medicaid billings, but was never about "collections" of any kind, let alone "uncollected NAMI." (Exhibit 1, Bates page 2; Exhibit 2, Bates page 51.)

The Appellant offers a bare claim that it had over $687 thousand "written off as bad debt" during the audit period (Exhibit 4, Bates page 253; Appellant brief, page 9), but it never offered any evidence to prove this, nor did it present anything more than vague assurances that it made "collection efforts." (Appellant brief, page 20; Transcript, pages 135-36, 165-66.) It now argues instead that OMIG auditors should have combed through its records to find its "NAMI bad debt" themselves. (Appellant brief, pages 9-10.) As it formed no part of this audit, the OMIG was under no obligation to search the Appellant's records for allegedly uncollected receivables the Appellant might have had, determine "that in some cases, after all of its collection efforts fail, it has to write-off these amounts as bad debts" (Appellant brief, page 20), and then "credit Appellant for its NAMI bad debts in the audit." (Appellant brief, pages 4-6, 9-10, 34.)

The "NAMI bad debt" argument ultimately arrives at the remarkable claim:

> Appellant is entitled to reimbursement for its NAMI bad debts, the amount of facility has written off as bad debt of $687,415.84 (Exhibit 4, Bates page OMIG 000253) should be allowed in the final audit, as is required by § 86-2.17(a) and netted out and offset against the full amount sought in this audit of $128,507.11 (Exhibit 3, Bates page OMIG000143). Thus, the total amount due to Appellant on this audit is $558,908.73. (Appellant brief, page 27; reply brief, page 19.)

This contention that the Appellant should simply be paid, as a result of this audit, $687,415.84 in unproven collections shortfalls attributed to allegedly unpaid obligations of unidentified residents, relies on an entirely factitious connection between "NAMI bad debt" and the audit findings. Even if the Appellant's contention that it is entitled to Medicaid reimbursement for unpaid resident NAMI obligations had any merit, it would have nothing to do with this audit of Medicaid overpayments on specific claims for specific Medicaid recipients.

In its attempt to litigate this matter in state court, the Appellant itself took this very position. Its June 27, 2013 letter to the OMIG in response to the final audit report, stating "we request that this matter *[sic]* be considered as a notice to you to provide our client with whatever rights the law provides," added:

> Since we believe that the issues in the audit related to issues of Medicaid rate methodology, which are beyond your office's purview and are not subject to an administrative hearing, we have commenced such a declaratory action in the Supreme Court, Bronx County. (Exhibit 4, Bates pages 248-49.)

The complete dismissal of the Appellant's court action to "annul" this audit - without any "remand" or other directive - is entirely consistent with the Appellant's own stated position that the "NAMI bad debt" issue is not reviewable in this hearing.

The Appellant's convoluted arguments and assertions about the Medicare Program and 10 NYCRR Part 86-2 cost reporting and rate issues (Appellant brief, pages 7-8, 11-12, 15-17), and its claim that it is somehow being "considered a payor" of resident NAMI if a resident does not pay (Appellant reply brief, pages 3-6), 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:

> Both the statute and the 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 (2d Cir. 1986).

Residents do not, as the Appellant would have it, "pay the NAMI's *[sic]* to the facility *for the benefit of the Medicaid Program*." (Appellant brief, page 13; reply brief, pages 3, 13.) They pay to cover charges for which the Medicaid Program is not responsible.[1]

Eden Park Health Services v. Axelrod, 114 A.D.2d 721, 494 N.Y.S.2d 524 (3d Dept. 1985), on which the Appellant primarily relies, does not support its contention – which is plainly contrary to specific Medicaid regulations and the very clear and specific holding in Florence Nightingale - that it is entitled to dollar-for-dollar Medicaid reimbursement for "NAMI bad debt" in a claims audit such as this. Eden Park concerns an appeal of 10 NYCRR Part 86-2 rate determinations, which are irrelevant to this 18 NYCRR Part 517 audit of paid claims.[2]

Interest.

The OMIG correctly assessed interest from the date of each overpayment, as authorized by 18 NYCRR 518.4(b)&(c). As this audit was not an audit of the Appellant's costs, 18 NYCRR 518.4(e), on which the Appellant relies, is inapplicable. (Appellant brief, pages 28-29; reply brief, page 21.) The Appellant's attempted

---

[1] That is why, as the Appellant itself inexplicably points out (Appellant reply brief, page 3 footnote), under New York law and regulations a nursing home can involuntarily discharge a resident who fails to pay the NAMI. PHL 2803-z; 10 NYCRR 415.3(i)(1)(i)(b); Blue v. Zucker, 192 A.D.3d 1693, 145 N.Y.S.3d 732 (4th Dept. 2021). If the Medicaid Program were responsible for unpaid NAMI, under these regulations a resident could object to discharge for failure to pay on the grounds that recourse to the Medicaid Program was still available. Why would, or should, any Medicaid eligible nursing home residents ever pay their charges, knowing that if they just ignore "collection efforts" they can defeat a discharge because the Medicaid Program is ultimately responsible and that Medicaid will eventually pay them?

[2] The Appellant attempts to explain that Florence Nightingale, which was decided after Eden Park, somehow would have recognized the interpretation the Appellant attempts to place on Eden Park if Eden Park just had not been so recently decided:

> … [Florence Nightingale] was argued on December 12, 1985 and was, therefore, briefed much earlier than that, probably before the *Eden Park* decision was issued… Had it been raised, the Court would have addressed it. (Appellant brief, page 22; reply brief, page 15.)

The more obvious reason why Florence Nightingale did not address the earlier Eden Park decision is that, as in this hearing, there was no reason to do so because it was irrelevant to the case under review.

distinction of "charge based providers" from "cost based providers" is irrelevant to the pertinent distinction in the regulation, which is the type of audit, not the type of provider. The Appellant's contention about interest is, in a simpler and more readily apparent form, another attempt deliberately to confuse cost reporting and claims payment issues.

The Appellant speculates that it may not have received possession of the overpayments identified in this audit until "about" three or four, or perhaps "more than" two weeks after the recorded dates of payment. (Appellant brief, pages 29-32; reply brief page 22.) The Appellant did not at any time during or after the audit offer direct evidence documenting any date of receipt that differs from the Department's records showing dates of payment. These records are presumed in the absence of direct evidence to the contrary to constitute an accurate itemization of the payments made. 18 NYCRR 519.18(f).

This is new matter not considered by the Department upon submission of objections to a draft audit report. 18 NYCRR 519.18(a). As the Appellant did not raise this objection during the audit, or indeed at any time before this hearing 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.

<u>Conclusion</u>. The Appellant has offered no other evidence or argument that meets its burden of proving entitlement to the overpayments identified in this audit or the interest assessed on them. The audit findings are affirmed.

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
November 2, 2021

John Harris Terepka
Bureau of Adjudication