cc: Ms. Daniels Rivera by Scan
Ms. Mailloux by Scan
Ms. Bordeaux by Scan
Mr. Cohen by Scan
BOA by scan
SAPA File

Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

May 6, 2026

CERTIFIED MAIL/RETURN RECEIPT

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RE: In the Matter of Medicare B Supplies, Ltd.

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
Chief Administrative Law Judge
Bureau of Adjudication

NJB:nm
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

COPY

In the Matter of the Appeal of **Medicare B Supplies, Ltd.** Medicaid Provider #0040222 from a determination to recover Medicaid Program overpayments.	**DECISION AFTER HEARING** Audit No. 20-5801

Before: Kathleen Dix
Administrative Law Judge

Hearing dates: June 16, 2025 and July 8, 2025
By WebEx Videoconference

Parties:

NYS Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
By: Michael Joseph, Esq.
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and

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JURISDICTION

The New York State Department of Health (Department) acts as the single state agency to supervise the administration of the Medicaid Assistance (Medicaid) Program in New York State. 42 USC 1396a; Public Health Law (PHL) § 201(1)(v); Social Services Law (SSL) § 363-a. The New York State Office of the Medicaid Inspector General (OMIG), an independent office within the Department, is authorized to investigate and pursue civil and administrative enforcement actions to recover improperly expended Medicaid funds. PHL §§ 31-32.

The OMIG determined to recover Medicaid Program overpayments from Medicare B Supplies, Ltd. (Appellant) for the rate period January 1, 2015 through December 31, 2017. The Appellant requested this hearing pursuant to SSL § 145-a and former Department of Social Services (DSS) regulations at 18 NYCRR 519.4 to review the determination.

HEARING RECORD

OMIG Witnesses:		Ursula Harrison, Audit Supervisor
OMIG Exhibits:	A.	Audit Notification Letter, dated August 12, 2020
	B.	Entrance Conference Outline and Sign-in Sheet
	C.	Exit Conference Summary
	D.	Draft Audit Report and Attachments, dated April 16, 2024
	E.	Response to Draft Audit Report
	F.	Final Audit Report and Attachments, dated November 12, 2024
	G.	Request for Administrative Hearing, dated December 30, 2024
	H.	Certification of Krista Bryk
	I.	Certification of Dr. Karl Heiner
	J.	Audit Findings Category 1 – Sample Documents
	K.	Audit Findings Category 2 – Sample Documents
	L.	Audit Findings Category 3 – Sample Documents
	M.	Audit Findings Category 4 – Sample Documents
	N.	Audit Findings Category 5 – Sample Documents
	O.	Audit Findings Category 6 – Sample Documents
	P.	Audit Findings Category 7 – Sample Documents
	Q.	Audit Findings Category 8 – Sample Documents
	*R[1]	Pre-Hearing Revised Attachment B of Final Audit Report
	*S.	April 1, 2025 Revised Statistical Analysis
Appellant Witnesses:		Sarah Kulzer, Medicaid Integrity Specialist 3 for OMIG Ben Jacobowitz, Director of Operations for Appellant.

[1] *OMIG Exhibits "R" and "S" were submitted with, and are attached to, the OMIG's post hearing brief dated August 27, 2025, and were included therewith at the direction of the ALJ at the hearing.

Appellant Exhibits:	2.	CMCS-MMCO- CM Informational Bulletin (June 7, 2013)
	3.	DME MAC Jurisdiction A Supplier Manual
	5.	Relevant Sections of New York Medicaid State Plan
	6.	NYS Medicaid Program- Information for All Providers (2011)
	7.	Medicare Crossover FAQs
	8.	Medicare Crossover Article (December 3, 2009)
	9.	OMIG Audit Protocol
	10.	July 29, 2021 OMIG Email chain (Kulzer)
	11.	August 29, 2024 - OMIG Email chain (Kulzer)
	12.	DME Policy Guidelines 2013-1
	13.	"Email B" - December 13, 2023 OMIG Email chain (Greco)
	14.	"Email C" - December 14, 2023 OMIG Email chain (Harrison)
	15.	"Email E" – June 10, 2025 OMIG Email chain (Kulzer)
	16.	"Email G" - June 18, 2025 OMIG Email chain (Shalke)
	17.	March 21, 2025 OMIG Email chain (redacted) (Shalke)

A transcript of the hearing was made. (Transcript [T.]: June 16, 2025 ["Day 1"] pages 1-146 and July 8, 2026 ["Day 2"] pages 1-103.) Each party submitted two post-hearing briefs and the record closed on September 19, 2025.

FINDINGS OF FACT

1. At all times relevant hereto, Appellant Medicare B Supplies, LTD, located in Brooklyn, New York, was a durable medical equipment (DME) supplier enrolled as a provider in the New York State Medicaid Program and supplied specific categories of DME to residents of nursing homes. (Appellant brief, page 2; T. Day 1, page 11; T. Day 2, pages 80-81.)

2. By notice dated August 12, 2020, the OMIG initiated an audit to determine whether the Appellant's records reflected compliance with Medicaid Program requirements. (Exhibit A; T. Day 1, pages 23-24.)

3. An entrance conference was conducted pursuant to 18 NYCRR 517.3(f) on September 16, 2020 wherein the OMIG explained the scope and purpose of its review and the audit procedures, and advised the Appellant what documents it would be requesting for review. (Exhibit B; Tr. Day 1, pages 25-27.)

4. During the period January 1, 2015 through December 31, 2017, the Appellant was paid $1,864,104.16 by the Medicaid Program for 112,065 DME claims. The OMIG audit reviewed

a randomly selected stratified sample of 250 of the claims with Medicaid payments totaling $13,294.96. (Exhibits D, F; T. Day 1, pages 26-28.)

5. On November 8, 2023, an exit (closing) conference was held pursuant to 18 NYCRR 517.5(a), at which the OMIG shared its proposed findings with the Appellant, advised it of the calculated overpayment and gave the Appellant an opportunity to provide additional documents before it issued the draft audit report. (Exhibit C; T. Day I, pages 28-29.) The Appellant provided additional documentation following the exit conference, which was reviewed and accepted in part by the OMIG. (T. Day 1, pages 29-30.)

6. The OMIG issued a draft audit report dated April 16, 2024, which identified one or more violations of Medicaid Program requirements in 85 of the 250 sampled claims, and disallowed payments in the amount of $4,068.57. The draft audit report advised the Appellant that the OMIG had preliminarily determined to seek restitution of Medicaid Program overpayments in the amount of $649,955. (Exhibit D; T. Day 1, pages 30-31.)

7. The draft audit report advised the Appellant, pursuant to 18 NYCRR 517.5(b), that it was entitled to submit objections to the proposed action, which objections were required to include any additional material or documentation that the Appellant wished to be considered. (*Id.*)

8. On June 6, 2024, the Appellant submitted objections to the draft audit report, including additional documents and records which were reviewed and accepted in part by the OMIG. (Exhibit E; T. Day 1, pages 31-33.)

9. The OMIG issued a final audit report dated November 12, 2024, which advised the Appellant that the final audit report incorporated consideration of the additional documentation and information presented in the Appellant's June 6, 2024 response to the draft audit report. The final audit report reduced the disallowed sample claims from 85 to 58, and sought restitution of Medicaid Program overpayments in the amount of $404,067, based upon a sample overpayment amount of $2,816.29 for the 58 disallowed claims. (Exhibit F; T. Day 1, pages 32-33.)

10. After the issuance of the final audit report, and prior to the hearing, the OMIG agreed

to withdraw the disallowances of samples 71, 77, 86 and 230 and reduced the restitution sought to $385,833. (Exhibits R, S; T. Day 1, pages 15, 35; OMIG brief page 5-6.)

11. Except for eight claims identified in audit report finding number 3, the OMIG's restitution claim is an extrapolation based upon a statistical sampling method in which the value of the disallowed claims found among the randomly selected stratified sample of 250 claims was projected to the total of 112,065 claims paid by the Medicaid Program during the audit period. (Exhibit F; *see*, T. Day 1, page 35.)

12. By letter dated December 30, 2024, the Appellant requested this hearing to review the determination and findings set forth in the final audit report. (Exhibit G.)

ISSUES

Is the OMIG's determination to recover Medicaid Program overpayments from the Appellant correct? If so, what is the amount of the overpayment?

APPLICABLE LAW

As a condition of their voluntary enrollment in the Medicaid Program, providers are required to prepare, maintain, and furnish to the Department upon request, contemporaneous records fully disclosing the nature and extent of the care, services and supplies they provide and demonstrating their right to receive payment from the program. The information provided in relation to any claim must be true, accurate and complete. All records necessary to disclose the nature and extent of services furnished must be kept by the provider and are subject to audit for six years. 18 NYCRR 504.3(a)&(h), 517.3(b), 540.7(a)(8). Notification by the Department of its intent to audit, followed by commencement of the audit within 60 days, shall toll the six-year period for record retention and audit. 18 NYCRR 517.3(c)&(d).

When the Department has determined that claims for medical care, services or supplies 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), 518.3. 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 504.8, 518.1(b)&(c).

If the Department determines to recover an overpayment, the provider has the right to an administrative hearing. 18 NYCRR 519.4. At the hearing, the provider has the burden of showing that the determination of the Department was incorrect and that all costs claimed were allowable. 18 NYCRR 519.18(d)(1). Regulations pertinent to this hearing are found at 18 NYCRR Parts 517, 518 and 519, and address the audit, overpayment, and hearing aspects of this case.

DISCUSSION

All of the Appellant's claims under audit were for DME and supplies provided to residents who were Medicare beneficiaries, but who were also eligible for benefits under the Medicaid Program. (Exhibit 14, attached excel spreadsheet, column "J" claim type; Exhibit F; T. Day 2, pages 25, 85.) The Appellant did not directly bill the Medicaid Program; the Appellant submitted all claims to the residents' Medicare Part B insurance. (T. Day 2, page 85.) After processing the claims, Medicare transmitted them to the Department of Health for whatever cost-sharing benefits were payable under the Medicaid Program. Medicare generally paid 80% and Medicaid paid 20%. (T. Day 1, pages 107-108; T. Day 2, page 85.) *See*, 42 USCA §§ 1395j-1395w-4(j). The OMIG's audit disallowances were made for the Medicaid portion of DME claims which the OMIG determined were not documented in accordance with applicable Medicaid Program requirements. (Exhibit F.)

At the hearing, the OMIG presented the audit file and summarized the case, as required by 18 NYCRR 519.17. Ursula Harrison, an audit supervisor in the "fee-for-service" department of the OMIG, supervised the senior auditors assigned to the Appellant's audit and reviewed the audit findings. (T. Day 1, pages 22-23.) Claims were disallowed when the OMIG determined that the Appellant had violated New York State Medicaid Program regulations at 18 NYCRR and/or the NYS Medicaid Program DME manual policy guidelines. (T. Day 1, pages 37-38, 41, 43, 47; Exhibit F.) Audit supervisor Harrison testified that only Medicaid rules and regulations were reviewed when making findings in this audit and that Medi*care* rules and regulations were not considered. (T. Day

1, pages 66, 68, 69, 85-86, 88, 105-106.) The OMIG's position is that if a provider receives payment from the Medicaid Program, whether it is co-insurance or not, the provider must comply with Medicaid Program documentation requirements. (T. Day 1, page 86.) Ms. Harrison admitted that she was not familiar with the NYS Medicaid Program, Information For All Providers, General Policy, Version 2011-1, June 1, 2011, manual [general policy manual]. (Exhibit 6.) When, at the hearing, she was shown the manual, Ms. Harrison stated that it was her first time seeing "that document." (T. Day 1, pages 52- 54.)

The Appellant challenged the audit finding on two bases. First, it disagreed that the documentation reviewed upon audit did not meet the Medicaid Program billing requirements. Second, it asserted that in any event because Medicare (Part B) was the primary payor for these claims and the Medicaid Program paid only its cost-sharing responsibility, it was only required to follow Medicare billing requirements and did not have to also meet Medicaid-only documentation or billing requirements. (Appellant brief, page 9; reply brief page 1.)

Ben Jacobowitz, Director of Operations for the Appellant, testified that the Appellant provides specific types of DME to residents of skilled nursing facilities, for which it submits its claims to Medicare, not Medicaid, "100% of the time." (T. Day 2, pages 80-81, 84-85.) Mr. Jacobowitz said that the Appellant complied with all Medicare rules and regulations when submitting the audited claims to Medicare. (T. Day 2, pages 84-86; *see*, Exhibit 3.) He argued that compliance with the Medicare Program rules for all claims for recipients who have both Medicare and Medicaid is sufficient to satisfy Medicaid Program rules for these individuals. (T. Day 2, pages 100-101.)

Under Medicare Part B, a Medicare-eligible person must pay insurance premiums. Once coverage under Part B is obtained, Medicare then pays 80% of the "reasonable costs" of covered services. The remaining balance, *i.e.*, the "coinsurance" amount (20%) and the annual deductible are generally the financial responsibility of the Medicare beneficiary. 42 USCA §§ 1395j-1395w-4(j); *see*, New York City Health and Hospitals Corp. v. Perales, 954 F.2d 854 (1992).

When Medicare is an individual's primary Part B insurance *and* the individual is also enrolled

in a Medicare supplemental policy, *i.e.*, a Medigap plan, after Medicare processes and pays the Part B claim, it automatically transmits the claim, along with its explanation of benefits, directly to the supplemental policy issuer for payment of any benefits due thereunder. This process is called the Medicare crossover program, which is primarily managed through the Coordination of Benefits Agreement (COBA) program[2], and is authorized by CMS[3] to streamline claims processing for beneficiaries with secondary insurance. It operates under the authority of 42 USCA § 1395ss(g), which governs Medigap plans, and 42 USCA § 1395u(h)(3)(B), which governs the administration of Medicare Part B benefits. (*See*, Medicare Claims Processing Manual, Chapter 27[4].)

Medi*care* beneficiaries who are also enrolled in the Medi*caid* Program are referred to as "dual eligible" or "dually eligible" enrollees. (Exhibit 12, NYS Medicaid Program, DME Manal Policy Guidelines, Version 2013-1 (4/2013) *[DME manual]*, 11th page; Exhibit 6, general policy manual, page 60, bates page MBS_000105; and Exhibits 10, 14; T. Day 1, page 56; T. Day 2, page 25.) For Medicare dual-eligible enrollees, Medicare will pay the claim, apply the deductible/coinsurance or co-pay amount as usual, and then automatically forward the claim, *i.e.*, cross the claim over, to the Medicaid Program. (Exhibit 8, NYS DOH Medicare Crossover Process Frequently Asked Questions, February 2010 *[Crossover FAQs]*; T. Day 2 page 57.)

The OMIG asserts that there are various levels of dual-eligible individuals enrolled in Medicare and not all dually-eligible enrollees are treated the same. (OMIG brief, page 13; citing to "Exhibit 1," which is not in evidence[5], and Exhibit 6, the general policy manual.) The OMIG agrees that there is a group of dual-eligible Medicare beneficiaries called "Qualified Medicare Beneficiaries" (QMB) for whom states are obligated to pay benefits through its Medicaid Program pursuant to a cost-sharing arrangement, as long as Medi*care* policies or guidelines are followed. (OMIG brief,

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[2] https://www.cms.gov/files/document/coordination-benefits-agreement.pdf; https://www.cms.gov/medicare/coordination-benefits-recovery/coba-trading-partners/agreement#:~:text=The%20Coordination%20of%20Benefits%20Agreement%20(COBA)%20is.contractor%2C%20houses%20COBA%20trading%20partner%20eligibility%20information.

[3] Centers for Medicare and Medicaid Services; www.cms.gov.

[4] https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c27.pdf.

[5] At the hearing the OMIG objected to the admission of Exhibit 1 into the hearing record because the document was dated September 6, 2024, after the audit period. Exhibit 1, due to the OMIG's own objection to it, is not part of this hearing record. (T. Day 1, pages 8 and 51.)

pages 12-13 (*emphasis added*).) The OMIG asserts, however, that "[n]ot all Medicaid enrollees who have Medicare Part B coverage are QMBs". (*Id.*, at page 13, citing Exhibit 6, the general policy manual, and Exhibit 2, CMS Informational Bulletin dated June 7, 2013 *[CMS Bulletin].*)

According to the OMIG, a state's "Medicaid program may limit coverage for non-QMB dual eligible enrollee claims where State Medicaid rules are not followed" and that "[f]or other full-benefit dually eligible individuals who are not in the QMB eligibility group, the state does not pay for Medicare cost-sharing of Medicare-only covered items and services unless the state opts to extend coverage of Medicare cost-sharing to these categories of dual eligibility." (*Id.* at pages 13-14, citing to "Exhibit 4," which is also not in evidence[6].) Under the OMIG's own analysis, then, a state may opt to extend coverage of Medicare cost-sharing to these categories of dual-eligibles. (*See*, OMIG brief pages 13-14; T. Day 2, pages 8-9, 10, 26; Exhibit 14.) The OMIG, however, did not ever address whether New York had opted to extend Medicare cost-sharing to all categories of dual-eligible enrollees. It ignores this issue and simply claims that the "policy issuance from CMS fully supports OMIG's decision to disallow samples where non-QMB dual-eligible claims did not comply with New York Medicaid guidelines/policies." (*Id.* at page 14.).

Qualified Medicare Beneficiaries are defined as "a select group of elderly and disabled Medicare enrollees with low income and very limited assets." For this group the Medicaid Program must pay Medicare deductibles and coinsurance, as appropriate, for certain Medicare Part B services provided, and "claims for QMBs are exempt from Medicaid policies/guidelines." (OMIG brief, page 13; Exhibit 6, the general policy manual, bates page MBS 053, manual page 8.)

OMIG audit supervisor Harrison acknowledged that after the final audit report was issued, four disallowances were removed because the claims were for Medicaid Program enrollees who were "qualified Medicare beneficiaries" and said that to her knowledge, no further disallowances for this category of beneficiary remain in the final audit report. (T. Day 1, pages 35-36, 109.) Ms. Harrison

[6] At the hearing the OMIG objected to the admission of Exhibit 4 into the hearing record because the document was dated January 14, 2025, after the audit period. Exhibit 4 is not in the hearing record.. (T. Day 1, page 9 and T. Day 2, page 51.) These FAQs can be found at https://www.medicare.gov/basics/costs/help/medicaid.

testified that she reversed all the findings related to QMB based upon the instructions of Sarah Kulzer, the "subject matter expert" for the OMIG. Ms. Harrison did not know why Ms. Kulzer instructed her to remove the QMB findings and deferred the question to Ms. Kulzer as the "best person to answer that." (T. Day 1, pages 50, 110.) On cross-examination Ms. Harrison admitted that she did not even know what a "QMB" was or the basis of the removal of corresponding disallowances from the final audit report. (T. Day 1, pages 50, 53, 109).

Sarah Kulzer, Management Specialist 2, testified that she is the OMIG's "subject matter expert" for DME audits based on her experience doing these audits and, as such, audit teams reach out to her as needed when they have questions regarding a DME audit. (T. Day 2, page 7.) Ms. Kulzer testified that as the subject matter expert she acts as a liaison between the OMIG and the Department when it is necessary to consult with the Department for questions that arise, and that she reviews all DME audits. She admitted that she did not have any discussions with the Department about the findings in this audit. (T. Day 2, pages 69-70.)

Ms. Kulzer testified that she is familiar with the term "qualified Medicare beneficiary," or "QMB," and that her knowledge is derived from a CMS bulletin that she read and from what she was told by her director. (T. Day 2, pages 7, 45; Exhibit 2.) Ms. Kulzer said that while she does not know much about Medicare co-insurance, that for QMB enrollees, New York State's Medicaid Program is federally required to cost-share with Medicare, that it does not matter if the QMB does not qualify for Medicaid, and that the cost-sharing payment from the Medicaid Program is *not dependent on the provider meeting Medicaid Program billing requirements*. (T. Day 2, pages 8-9, 10, 26; Exhibit 14.)

Ms. Kulzer acknowledged that during the audit the Appellant asserted that because Medicare was the primary Part B insurance for the audited claims, it did not have to follow Medicaid Program rules regarding claim documentation. (T. Day 2, page 19.) Ms. Kulzer inquired of her director, Scott Lephart, who inquired of another OMIG employee, Beth Perue, who Ms. Kulzer said had more insight into Medicare cost-sharing than she and her director did, and that they were told that a provider *did* have to follow both Medicare and Medicaid Program billing rules unless the beneficiary was a

QMB. Thus, the amount that the Medicaid Program paid as a secondary payor to non-QMB enrollees was subject to all Medicaid Program rules and regulations. (T. Day 2, pages 19-20, 25-26; Exhibits 13, 14.)

Based upon this information, Ms. Kulzer instructed the audit team to remove findings for QMB enrollees from the audit findings. (T. Day 2, page 20; Exhibits 13, 14.) Ms. Kulzer stated that she conducted no independent research regarding Medicaid Program requirements for QMB enrollees, as distinguished from any other Medicare beneficiaries, in order to make recommendations to Ms. Harrison; she relied upon that which Mr. Lephart had told her. (T. Day 2, page 22.) Ms. Kulzer testified that she was unaware that New York had a state Medicaid Plan for its Medicaid Program, was unfamiliar with the Medicare crossover process and that she did not review SSL § 367-a with respect to dual-eligible enrollees. (T. Day 2, pages 26, 47, 55-56.)

The OMIG contends that the Appellant failed to establish it was not required to follow New York Medicaid Program policies/guidelines and rejected its position that the Medicaid Program guidelines are not relevant to any crossover claims for dual-eligible enrollees. (OMIG brief, page 14.) The OMIG dismissed the testimony of Appellant director of operations Ben Jacobowitz, stating that he "erroneously claimed that all dual eligible enrollees follow the same rules as QMBs" and that *he* failed to "cite to, or provide any, rule, regulation, guideline or document supporting that position." (*Id.* at page 14; citing T. Day 2, page 101.) In fact, SSL § 367-a and the State Medicaid Plan, on which the Appellant relies, were raised at the hearing. (T. Day 1, page 17; Day 2, pages 47, 49, 54-56, 63.)

The OMIG argues that the CMS guidance (Exhibits 2 and 4[7]) discusses that a state Medicaid Program may limit coverage for non-QMB dual-eligible enrollee claims where Medicaid Program rules are not followed "unless the state opts to extend coverage of Medicare cost-sharing to these categories of dual eligibles", and that this guidance supports the OMIG's decision to disallow samples where non-QMB dual-eligible claims did not comply with the New York Medicaid Program

[7] To which the OMIG objected at the hearing. See footnote 6.

guidelines. (OMIG brief pages 13-14, citing Exhibit 4, bates page 38.)

The Appellant agrees with the OMIG that Federal Law only *requires* cost sharing for the QMB enrollees. (Appellant brief, page 1.) The Federal statute clearly states that a state plan for medical assistance, *i.e.,* the Medicaid Program, must make Medicaid Program benefits available for Medicare cost-sharing of coinsurance and deductibles for QMB enrollees. 42 USCA §§ 1396a(10)(E)(i), 1396d(p)(1) and (3). The Appellant points out, however, as did the OMIG, that Federal law *also* gives the states the option to extend to other dual-eligibles (who are not QMB) this same cost-sharing treatment for crossover claims. (Appellant brief, page 1; 42 USCA §§ 1395v[a] and [h]; *see*, *New York City Health & Hosp. Corp v. Bane*, 87 N.Y.2d 399 [1995]; OMIG brief page 14.) The Appellant asserts that New York *did* opt to extend cost-sharing treatment to all dual-eligible enrollees in its state Medicaid Plan and as codified in SSL § 367-a. (Appellant brief page 10, citing to Exhibit 2, bates page 007 and Exhibit 7, bates page 110.)[8] Neither at the hearing nor in its briefs did the OMIG address whether New York has exercised its option to extend cost-sharing for non-QMB dual-eligible individuals, and it remained silent on the application of the state Medicaid Plan or SSL § 367-a to non-QMB individuals.

In its Medicaid plan, New York exercised its option and agreed to pay Medicare Part B deductible and coinsurance costs on behalf of *all* Medicaid Program recipients "covered under Part A or B of [the Medicare Act] who are eligible for Part A or B services covered by Medicaid." (Exhibit 5; New York's Medicaid plan attachments 3.2-A and 4.19-B, Supplement 1.) New York's agreement to cover deductible and co-insurance costs on behalf of all dual-eligible enrollees is codified in SSL § 367-a(1)(d)(ii), which directs that for both dual-eligible individuals *and* QMB enrollees that the Medicaid Program pay "not less than the amount of any deductible liability" that the enrollee would be liable for under Medicare Part B. The same information is in the general policy manual which explicitly states: "Any individual who is fully Medicaid-eligible and has Medicare coverage, <u>even if</u>

[8] Neither at the hearing nor in its briefs did the OMIG address whether New York has exercised its option to extend cost-sharing for non-QMB dual-eligible individuals, and remained silent on the application of the state Medicaid Plan or SSL § 367-a to the same.

not a QMB, ***is also entitled to have Medicare coinsurance and deductibles paid for by Medicaid***." (Exhibit 6, general policy manual page 5, bates page MBS 050; [*emphasis added*].)

This conclusion that New York has opted to extend coverage of Medicare cost-sharing to all dual-eligible individuals is supported by other evidence in this record. For example, in the "Durable Medical Equipment Services Audit Checklist" (Exhibit J) in lines numbered "3" and "4", no disallowances were taken because "Provider adhered to Medicare regulations." (Exhibit J, bates page 2656; T. Day 1 page 65.) OMIG audit supervisor Harrison claimed that the reference to "Medicare" in those instances was an "oversight" or a "spelling error," and that it should have said "Medicaid" regulations because "we do not have Medicare regulations." (T. Day 1, pages 65-66.) Ms. Harrison's attempt to disavow these notations in Exhibit J as "errors" is not persuasive and is rejected.

Exhibit J is an OMIG workpaper and lines "3" and "4" referenced therein are related to enteral feeding. (Exhibit J, bates page 2656.) Enteral feeding products require prior authorization according to the DME Manual except, "[p]rior approval is not required when claiming the Medicare co-insurance . . ." (Exhibit 12 at pages 11of 19.) The notations in Exhibit J are correctly stated as "Medicare regulations" because those line items relate to enteral feeding products, which do not require prior authorization when Medicare is the primary insurance. The general policy manual clearly states "[p]roviders must follow Medicare rules for care and services provided to Medicare primary beneficiaries. Medicare approved care and services provided to Medicare primary beneficiaries do not require prior approval from New York State Medicaid." (Exhibit 6, bates page 0065, manual page 20 of 64.)

Further, OMIG Medicaid integrity specialist Kulzer confirmed the same in her email to Ms. Harrison on July 29, 2021 referencing enteral product quantity limits, when she stated "[i]t also states in a 'general policy' document from 2011 that . . . , '[p]roviders must follow Medicare rules for care and services provided to Medicare primary beneficiaries'" and once approved, Medicare primary beneficiaries do not require prior approval from the Medicaid Program. (Exhibit 10, bates page 0135.)

The Appellant did not submit these claims to the New York State Medicaid Program. Medicare did so, after approving them. These claims are cross-over claims. Nothing in the Federal law, which gives the states the option to extend cost-sharing to all crossover claims, or in the state Medicaid Plan, wherein New York agreed to cost-sharing for all dual-eligible individuals, or in SSL § 367-a, which directs that the Medicaid Program pay cost-sharing for both dual-eligible individuals and QMB enrollees, or the Medicaid Program's general policy manual which states that any dually-eligible individual, even if not a QMB, is entitled to cost-sharing by Medicaid, differentiates the claim or billing requirements between QMB and non-QMB dually-eligible enrollees for these cross-over claims. Nor should the OMIG.

The OMIG acknowledged that the Medicaid Program is federally required to cost-share with Medicare for QMB individuals, and conceded that it does not matter if the QMB does not qualify for Medicaid as the cost-sharing payment from the Medicaid Program is *not dependent on the provider meeting Medicaid Program billing requirements*. (T. Day 2, pages 8-9, 10, 26; Exhibit 14.) The OMIG also acknowledged that when a state Medicaid Program opts to extend coverage of Medicare cost-sharing to non-QMB dual-eligible enrollees it may not limit coverage when Medicaid Program rules are not followed. (*See*, OMIG brief pages 13-14, citing Exhibit 4, bates page 38.)

The Appellant has established that New York agreed to extend cost-sharing coverage to non-QMB dual-eligible enrollees in its state Medicaid Plan. SSL § 367-a(1)(d)(ii) directs that the Medicaid Program pay the deductible liability under Medicare Part B for all dual-eligible enrollees codifying what New York agreed to do in the state Medicaid plan, and recognized in its Medicaid Program's general policy as its obligation. Thus, the Medicaid Program is required by SSL § 367-a(1)(d)(ii) to cost-share for all dual-eligible enrollees, and consistent with the Federal requirement regarding QMB enrollees, this requirement is not dependent on the Provider meeting Medicaid-only claim and billing requirements.

The OMIG's final contention is that even if the Appellant established that it only needed to follow Medicare policies/guidelines for crossover claims, the "OMIG's findings still should be

affirmed because [the Appellant] failed to establish that all the samples were [for] dual eligible individuals." (OMIG brief, page 14.) This assertion, which was never mentioned either in the audit or at this hearing, and only raised in passing in OMIG's post-hearing brief, is belied by the record. Appellant's director of operations Jacobowitz testified that the Appellant did not submit the audited claims to the Medicaid Program but that it billed Medicare "100% of the time" and then Medicare automatically crossed those claims over to the Medicaid Program. (T. Day 2, pages 84-85.) The final audit report attachment C notes that all claims have a primary carrier, and Exhibit 15, "Email E" has attached excel spreadsheet, which in columns "J" and "L" both list the description of the sampled claims as "CMS Medicare Crossover." (Exhibits F and 15.) Moreover, Ms. Kulzer acknowledged that the majority of the claims in audits involving Medicare are for dual-eligible Medicaid Program beneficiaries. (Exhibit E; T. Day 2, page 25.) The record establishes that all claims in this audit were for dual-eligible enrollees.

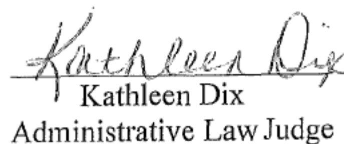
The Appellant has shown that it was not required to meet Medicaid-only claim and billing requirements for the DME it provided to dually-eligible nursing home residents and that the OMIG is not allowed to take audit disallowances based upon the Appellant's failure to do so. Having reached these conclusions, there is no need to address the individual categories of disallowances in the final audit report.

DECISION

The OMIG's determination to recover overpayments relating to disallowed DME claims in the adjusted point estimate amount of $404,067, in Final Audit Report for audit number 20-5801 is REVERSED.

This decision is made by Kathleen Dix, Bureau of Adjudication, who has been designated to make such decisions.

DATED: Menands, New York
May 5, 2026



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