LeadingAge® New York

December 30, 2020

Erin E. Ives
Acting Medicaid Inspector General
Office of the Medicaid Inspector General
800 North Pearl Street
Albany, NY 12204

RE: Nursing Home Rate Audits: Disallowances of Certain Operating Costs

Dear Ms. Ives:

I am writing on behalf of the membership of LeadingAge New York with regard to a series of recent nursing home Medicaid rate audits. LeadingAge NY represents approximately 400 not-for-profit and public providers of long-term and post-acute care and housing throughout New York State including nursing homes, assisted living programs, adult day health care programs, home health agencies and other Medicaid providers.

We have recently become aware of desk audits of nursing homes that seek to disallow certain services, such as laboratory and radiology (i.e., x-ray) services, in their entirety from those providers' Medicaid rates. As justification, the letter accompanying the draft audit report states as follows:

> "The findings listed in the attachment include base year services that were no longer performed by the Provider yet were reimbursed in the Provider's Medicaid nursing home rate during the rate period reviewed and services that should be billed under Medicare Part A in accordance with consolidated billing requirements as outlined in the Department of Health and Human Services Health Care Financing Administration Publication 60B dated November 27, 2000 (Transmittal B-00-67). Changes of this nature must be reported by the Provider in accordance with 10 NYCRR 86-2.27."

This justification and the associated audit findings are inconsistent with New York State law, regulations and policies and federal regulatory requirements, as detailed below:

1. **Audited providers may not have discontinued providing the noted services, as is being suggested.** 10 NYCRR § 86-2.27 requires providers to notify the Department of Health (DOH) of the deletion of any previously offered service or of the withholding of services from patients paid for by government agencies. However, unless it can be demonstrated that the facility in fact discontinued offering the service (e.g., it did not incur any cost in the relevant cost center(s) during the rate years in question), this regulation does not provide a valid basis for disallowing the associated base year costs. We understand that these audits may be disallowing services costs, such as those for laboratory and radiology services, included in the rate, even in cases when the facility offered the services and incurred costs during the relevant rate years, as reflected in the applicable cost centers in the cost reports. It is our understanding that the audits in question were completed via desk audits and, thus, these findings do not reflect a determination by OMIG that the facility did not have supporting documentation to substantiate the costs incurred. Indeed, as noted below,

13 British American Blvd. Suite 2, Latham, New York 12110-1431
p 518.867.8383 | f 518.867.8384 | www.leadingageny.org

nursing homes are *required* pursuant to 10 NYCRR § 415.20 to provide laboratory and radiology services. Thus, to the extent these audits relate to such services, the audited facilities could not have discontinued providing these required services.

2. **These proposed disallowances contradict the state's Medicaid statewide pricing methodology and the reporting requirements for these costs – which require the reporting of costs across all payor sources – and attempt to selectively disassemble the Medicaid statewide pricing system for nursing homes.** It appears that OMIG has disallowed these costs based on the erroneous conclusion that costs incurred for dual eligible patients should not have been reported. This contradicts both the statewide pricing regulations and the cost reporting instructions. According to DOH, the statewide pricing system authorized in law [see Public Health Law § 2808(2-c)] is intended to:

   > "…significantly reduce administrative burdens on both nursing homes and the Department and, by limiting the potential bases of subsequent administrative rate appeals and audit adjustments, enhance the stability and certainty of initial Medicaid payments and reduce the likelihood of litigation. The new methodology will also, by limiting the potential bases of subsequent administrative rate appeals and audit adjustments, enhance the stability and certainty of initial Medicaid payments and reduce the likelihood of litigation."[1]

   The operating component of the statewide pricing system is based largely on allowable costs as reported in facilities' 2007 annual cost reports (RHCF-4) or extracted from hospital-based facilities' 2007 annual cost reports (RHCF-2) and the institutional cost reports of their related hospitals after first deducting costs attributable to specialty units, and to the hospital by applying appropriate trace back percentages. More specifically, the operating component of the price is the sum of the direct price, the indirect price, and a facility-specific non-comparable price. Laboratory services and radiology services costs, which we understand are a focus of these audits, are considered "allowable costs" under the non-comparable component of the price and include the costs reported in those functional cost centers in a facility's annual cost report, irrespective of whether such costs were attributable to Medicaid, Medicare or from another third party source. Laboratory costs are reported based on the requirements of 10 NYCRR § 455.23, while radiology costs are reported in accordance with 10 NYCRR § 455.26.

   Neither the statewide pricing regulations at 10 NYCRR § 86-2.40 nor the reporting requirements for these cost centers instruct facilities to report only the allowable costs of providing services to Medicaid patients. Instead, New York's nursing home reimbursement methodology is entirely and necessarily based on all-payor costs since there is no payer-specific reporting. In fact, according to the RHCF-4 instructions, reported costs must be tied directly to the facility's audited financial statements, which reflect costs incurred regardless of payor. These and other statewide, peer group, and facility-specific metrics are used by DOH to calculate facility rates that are intended to reasonably reflect the total cost of providing care to a patient at the facility. For this purpose, other than the Part B offset discussed in #6 below, the payor of such costs is irrelevant and does not result in duplicative payment. Indeed, duplicative payment could *only* occur if the facility actually billed and received the daily rate from both Medicare Part A and Medicaid. However, as explained in more detail below, facilities are required by law to bill Medicare Part A first for the

[1] See DOH Feb. 19, 2014 regulatory publication, **Statewide Pricing Methodology for Nursing Homes (ny.gov).**

cost of care for a dual eligible patient and can only bill Medicaid if Medicare Part A does not pay for that care. Thus, a facility cannot receive payment from both Medicare and Medicaid for the cost of care for that patient.

By seeking to "pick apart" the rate and disallow payment for certain services on the premise that Medicare is responsible for a significant portion of the costs, OMIG is violating the statutory and regulatory scheme underlying statewide pricing in a manner which is wholly inconsistent with both the letter and spirit of the law. Moreover, if payment for these services can be eliminated after the fact, what other services included in the payment price will be targeted next? Furthermore, based on how these costs are reported, pursuant to Medicare and Medicaid billing rules (nursing home care is billed as an all-inclusive service and not itemized based on individual service), OMIG has no way of validly determining the volume or cost of these services by payer.

3. **Assessment of the appropriateness of all-payor costs in these cost centers requires audit of the 2007 RHCF-4 and RHCF-2, which is barred by the applicable statute of limitations.** To the extent that the basis of OMIG's determination in these audits is that facility rates are inflated by the improper inclusion of costs paid for by Medicare in their cost reports, these audits are time-barred. As discussed above, under the statewide pricing system, rates are established based on allowable costs reported in facilities' 2007 RHCF-4 or RHCF-2 reports. Thus, the inclusion of costs paid for by Medicare, even if it were improper, would only affect facilities' rates if such costs were reported in the facilities' *2007* cost reports. Thus, OMIG cannot determine whether a facility's rate is or is not based on the inclusion of Medicare costs without auditing the 2007 RHCF-4 or RHCF-2 cost report. However, the period for auditing facilities' 2007 cost reports has long expired. 18 NYCRR § 517.3(a)(2) ("All required fiscal and statistical reports are subject to audit for a period of six years from the date of their filing or from the date when such reports were required to be filed, whichever is later."). Reviving a time-barred audit of 2007 base year cost reports by recasting OMIG's objection to the costs as "dropped services", is plainly improper and would effectively nullify 18 NYCRR § 517.3(a)(2).

4. **Medicare skilled nursing facility (SNF) consolidated billing (CB) requirements provide no further justification for these audit disallowances.** The CB requirement, as mandated by the federal Balanced Budget Act of 1997 [Public Law 105-33, Section 4432(b)], confers on the SNF billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay, other than certain specifically excluded services. Physical, occupational, and speech-language therapy are also subject to CB requirements, regardless of whether the resident who receives them is in a covered Part A stay. The original intent of CB was to eliminate the potential for duplicative billings for the same service to the Part A fiscal intermediary by the SNF and to the Part B carrier by an outside supplier. CB requirements thus effectively prevent a nursing home from discontinuing its responsibility for furnishing such services either directly or under arrangements.

5. **Nursing homes are required to pursue third party sources of reimbursement, including Medicare, prior to billing Medicaid.** With respect to potential Medicare beneficiaries, Chapter 76 of the Laws of 1976 states that until a Medicare claim is formally denied, no Medicaid payment will be made on behalf of a patient who could reasonably be expected to have that care paid for by Medicare. Furthermore, Chapter 81 of the laws of 1995 imposes quantitative requirements on nursing homes to maximize Medicare Part A reimbursement on behalf of dual eligible (Medicare/Medicaid) residents which, if not met, subjects them to financial penalties. This policy significantly benefits

the State since any resident day that can be billed to Medicare Part A on behalf of a dual eligible is a day not paid for by Medicaid. Nursing homes are further incentivized to bill Medicare Part A for care provided to dual eligibles since Medicare rates of payment cover facilities' actual costs of providing care, whereas Medicaid rates most often do not. Consequently, a facility that receives Medicare Part A reimbursement for the care of a patient does not receive Medicaid reimbursement for that patient's stay and no duplicative Medicaid payment occurs.

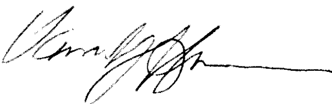
6. **Furthermore, the state derives a benefit by paying a reduced Medicaid rate for days of service rendered to Medicare Part B recipients, thus accounting for a Medicare payment in such rate.** The Medicaid Part B eligible rate incorporates a "priced out" Medicare Part B offset, which accounts for those services that are incorporated in the nursing home rate for which Medicare Part B can be billed. Effectively, the state is already capturing savings for those services that Medicare Part B covers. Taken together with the requirement to maximize Part A reimbursement, this policy already ensures that the state is not bearing the financial burden of services provided to Medicare patients through nursing home Medicaid rates.

7. **These audits would disallow costs for services that nursing homes are required to offer.** State regulations at 10 NYCRR § 415.20 require all nursing homes to provide for blood and laboratory services to meet the needs of their residents, pursuant to orders by authorized licensed practitioners, and bear responsibility for the quality and timeliness of such services. Similarly, 10 NYCRR § 415.21 requires all nursing homes to provide or obtain radiology and other diagnostic services to meet the needs of their residents pursuant to an order by an appropriate practitioner, and bear responsibility for the quality and timeliness of such services. The state regulations largely reflect federal regulations at 42 CFR § 483.50 which require nursing homes to provide or obtain laboratory, radiology, and other diagnostic services to meet the needs of their residents. While these regulations do not require a facility to directly provide these services, the Medicaid statewide pricing methodology contemplates nursing homes incurring costs to provide these services. The current experience with COVID-19 has underscored the importance of providing laboratory and diagnostic services to nursing home residents.

For all of the above reasons, LeadingAge NY respectfully urges the OMIG to immediately discontinue its policy of disallowing the costs of services such as laboratory and radiology (i.e., x-ray) in their entirety from nursing home Medicaid rates.

Thank you for considering our recommendations. We look forward to your response.

Sincerely,



Daniel J. Heim
Executive Vice President

cc: Howard Zucker, M.D.
Donna Fescatore
Michael Ogborn
Sean Doolan, Esq.