January 27, 2021

Donna Frescatore
New York State Medicaid Director
One Commerce Plaza
Albany, NY 12210-2820

RE: Third Party Liability Billing Requirements

Dear Ms. Frescatore:

I am writing on behalf of the membership of LeadingAge New York with regard to new third party liability billing requirements for Medicaid providers. 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.

The Oct. 2020 edition of the *New York State Medicaid Update* includes an article entitled "Notification to Providers of Requirement to Attach Explanation of Benefits from Third-Party Payors to Medicaid Claims." According to this article, Medicaid providers will be required to attach an Explanation of Benefits (EOB) to fee-for-service (FFS) claims in order to receive payment from Medicaid for services rendered to a recipient who is also eligible for Medicare or has other third-party coverage. Pharmacy claims, Medicare crossover claims, and non-covered procedure codes identified by NYS Medicaid are exempt. The article further indicates that Medicaid claims will be denied if they are not accompanied by EOBs, and that OMIG will provide additional information on this initiative.

A follow up article in the Dec. 2020 *New York State Medicaid Update* indicates that providers must retain evidence – such as EOBs – that Medicaid claims were denied by the other insurers before seeking reimbursement from NYS Medicaid. While the article does not say that the third party EOB must be attached to the Medicaid claim submission, it also does not specifically indicate that the Oct. 2020 guidance has been fully superseded.

Consistent with the Dec. 2020 article, eMedNY emailed an alert on Dec. 4th entitled: "Submission Guidance for Claims with Third Party Liability (Medicare or Other Insurance)" which indicates that all Medicaid claims should accurately reflect payments received from other insurers, and that EOBs and other documentation supporting Medicare and third-party insurance reimbursement must be retained for audit or inspection for at least six years. The alert also indicated that for any claim submitted to Medicaid with a zero-fill reimbursement from Medicare or other third-party insurer, the provider must retain evidence that the claim was denied by the other insurer **BEFORE** seeking Medicaid payment. Items or services that are statutorily not covered by Medicare are not subject to this policy.

Under longstanding state policies, Medicaid is the payor of last resort when a Medicaid recipient has third party health insurance coverage and providers must bill Medicare or the other third-party

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insurance for services that may be covered prior to submitting a claim to Medicaid. Nursing homes and certified home health agencies are further subject to statutory penalties if they fail to maximize Medicare coverage of services for dual eligible individuals. Furthermore, providers are incentivized to bill Medicare for services provided to dual eligibles since Medicare rates of payment cover providers' actual costs of providing care, whereas Medicaid rates most often do not.

While mindful of the state policy of Medicaid as the payer of last resort and the obligation to seek third party recovery from other payers, LeadingAge NY is very concerned that adding a requirement to bill and obtain denials from Medicare and other third party insurers prior to submitting a Medicaid claim could significantly delay receipt of Medicaid payments and severely affect provider cash flow, especially at a time when long term care providers are facing challenges to their financial sustainability. We believe this policy is unnecessarily inflexible and should be modified for the following reasons:

1. **State and federal regulations require "reasonable measures" and "probable liability."** State regulations at 18 NYCRR 540.6(2)(e) read as follows:

   > "(1) As a condition of payment, all providers of medical assistance must take **reasonable measures** to ascertain the legal liability of third parties to pay for medical care and services.
   >
   > (2) No claim for reimbursement shall be submitted unless the provider has:
   >
   > (i) investigated to find third-party resources in the same manner and to the same extent as the provider would to ascertain the existence of third-party resources for individuals for whom reimbursement is not available under the medical assistance program; and
   >
   > (ii) **sought reimbursement from liable third parties**." [**emphasis added**]

   Requiring Medicaid providers to bill Medicare and other third party insurers for all services prior to billing Medicaid is unreasonable when it is clear that the third party will not pay for certain services. Reimbursement should be sought only when third parties are determined to be liable for the noted services. Federal regulations at 42 CFR § 433.139(c) rely on a probable liability standard for determining when Medicaid should pay for services:

   > "(c) **Probable liability is not established or benefits are not available at the time claim is filed.** If the probable existence of third party liability cannot be established or third party benefits are not available to pay the beneficiary's medical expenses at the time the claim is filed, the agency must pay the full amount allowed under the agency's payment schedule."

2. **Medicare, the third party insurer of most Medicaid beneficiaries in long-term care settings, invariably does not cover certain services.** Technical denials are made in Medicare when coverage requirements are not met for a particular item or service, in which case the service is not a Medicare benefit. A common example is long-term (i.e., custodial) care provided in a skilled nursing facility (SNF) or by a home health agency. Medicare also denies payment for items or services because of failure to meet a condition of payment required by regulations, such as the 3-day prior hospital stay requirement for SNF services or the homebound requirement for home health agency services. In these instances, the provider issues an Advance Beneficiary Notice (the SNF ABN is issued for Part A claims) to the beneficiary. Issuance and retention of an ABN should suffice in these instances, rather than requiring the provider to wait for a Medicare EOB before billing Medicaid.

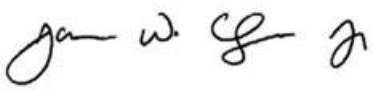
3. **This policy will further delay Medicaid payments and exacerbate provider cash flow issues.** New York State already delays payment to Medicaid providers by two weeks, in addition to regular claims submission and processing timeframes. Imposing a requirement to bill and receive denials from Medicare and all other third party insurers prior to billing Medicaid will further delay Medicaid FFS payments to providers and is tantamount to increasing the current 2-week lag. Nursing homes and other long-term care providers derive a substantial portion of their revenues from Medicaid and will see their cash flow disrupted as their Medicaid accounts receivable balances increase. As it is, the current pandemic has severely disrupted facility and program revenues and significantly increased costs as providers struggle to meet state and federal mandates and contain the spread of the coronavirus. Further delays in Medicaid payment could lead to provider business failures and adversely affect beneficiary access to needed services.

A more balanced approach would be to follow the federal guidance requiring reasonable measures to ascertain third party liability, investigate third party resources and seek reimbursement under those circumstances.

For these reasons, LeadingAge NY respectfully urges the State to reconsider its policy of requiring Medicaid providers to bill and obtain EOBs from Medicare and other third party insurers prior to submitting a Medicaid claim.

Thank you for the opportunity to provide input and for considering our recommendations.

Sincerely,



James W. Clyne
President and CEO

cc: Erin Ives, OMIG
Michael Ogborn
Sean Doolan, Esq.