ACHCA
American College of Health Care Administrators
NEW YORK CHAPTER

The Great Reimbursement Race

March 11, 2025

Presented by:

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AUDIT | TAX | CONSULTING

Introduction

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Agenda

Today's Topics for Discussion Include:

- Reimbursement Update
- Medicaid Operating Rates
- NYS Minimum Direct Resident Care Spending Provisions ("70/40/5 Rule")
- NYS Minimum Staffing Ratios
- Regulatory Items
- Questions

REIMBURSEMENT UPDATE

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MEDICAID OPERATING RATES

Medicaid Rate Basics

Some Key Terminology:

- WEF: Wage Equalization Factor
- Peer Group: Denotes if your facility is part of the HBF + 300 Bed Group or the -300 Bed Group.
- HBF + 300 Bed Group: Facilities that are Hospital Based or have a certified bed capacity of 300 or more beds.
- -300 Bed Group: Facilities who are not part of the HBF + 300 Bed Group.
- NF Beds: Certified bed capacity per the New York State Department of Health.

Medicaid Rate Basics

The Medicaid Rate has 5 components:

- Non-Comp Component (Line 1)
- Operating Component (Line 9), consisting of:
  - Direct Component (Lines 2 – 5)
  - Indirect Component (Lines 6 – 8)
- Rate Add-Ons (Lines 10)
- Statutory Adjustments (Lines 12 - 14)
- Capital Component (Line 17)

*Line numbers above refer to the lines of the Medicaid Rate Sheet.

Non-Comp Component

Nursing Home Price Calculation	Medicaid Rate	Medicaid Rate for Part B Eligible Patients	Medicaid Rate for Part D Eligible Patients	Medicaid Rate for Part B&D Eligible Patients
1 Facility Specific Non Comp Price (Schedule 1)	10.99	10.99	10.99	10.99

The Non-Comp Component reimburses ABC Facility for the following costs based on 2007's RHCF Cost Report Data

- Medical Director
- Utilization Review
- Dental
- Utilities
- Prescription Administration

These costs are fixed and not updated nor trended for reimbursement.

Direct Component

2 Statewide Direct Price	115.29	113.68	115.29	113.68
3 WEF Adjustment (Schedule 2)	1.0467	1.0467	1.0467	1.0467
4 Facility Case Mix Adjustment (Schedule 4)	1.2121	1.2121	1.2121	1.2121
5 WEF and Case Mix Adjusted Price	146.27	144.23	146.27	144.23

The Direct Component reimburses ABC Facility for nursing, activities, social services, therapy, pharmacy, and centrals supply. The rate is calculated by:

- Taking the Statewide Direct Price
- Multiplying by the WEF Adjustment, which is based on 2007 costs and is not changed nor trended for inflation.
- Multiply by the Facility Case Mix Adjustment, which is updated semiannually.

Statewide Direct Price

DIRECT COMPONENT			
RATE YEAR	TRANSITION YEAR	< 300 BEDS	> 300 BEDS	> 300 BED DIFFERENCE
2015	Year 4	114.32	124.46	10.14
2016	Year 5	114.85	125.03	10.18
2017 & Beyond	Year 6	115.37	125.59	10.22
Transportation Adjustment	Transition Completed	115.29	125.42	10.13

Statewide Pricing was introduced on 1/1/2012. As part of the conversion from cost based rates to a pricing system:

- Statewide Direct Prices were transitioned in from 2012 – 2017 in conjunction with the transition adjustment (line 11).
- In 2018, Statewide Direct Price was adjusted to carve out transportation costs.

Facility Case Mix Adjustment

Current Medicaid Only Case Mix Calculation
Schedule 4

Current MDS Case Mix Total	82.70
Current MDS Case Mix Patients	75
Facility Specific Case Mix	1.10
50% Peer Group/50% Statewide Case Mix	0.907504
Facility Case Mix Adjustment	1.2121

The Facility Case Mix Adjustment is calculated by:

- Taking the MDS submitted by ABC Facility. The rate will score these MDS based on a Case Mix Index (CMI)
- CMI is adjusted by a fixed factor of 0.907504 (members of the HB 300+ Peer Group Have a different factor)
- The resulting facility case mix adjustment is then plugged into the direct component of the rate.

Facility Case Mix Adjustment

- The MDS used to calculate the CMI is currently frozen based on the 10/1/2022 – 3/31/2023 MDS Submission.
- NYS DOH engaged Myers & Stauffer to revise the CMI measurement to accommodate PDPM based MDS Submissions.
- Targeted completion date is (was) Fall 2025.
- Open Questions:
  - All PDPM components? Or select ones?
  - How will CMI be weighted?
  - Phase in for new methodology?
  - Downward pressure on facilities with the highest CMI?

Indirect Component

6	Statewide Indirect Price	57.18	57.18	57.18	57.18
7	WEF Adjustment (Schedule 2)	1.0240	1.0240	1.0240	1.0240
8	WEF Adjusted Indirect Price	58.55	58.55	58.55	58.55

The Indirect Component reimburses ABC Facility for fiscal & administrative services, plant, grounds, security, laundry, housekeeping, dietary, medical records

- Taking the Statewide indirect Price
- Multiplying by the WEF Adjustment, which is based on 2007 costs and is not changed nor trended for inflation.

Statewide Indirect Price

INDIRECT COMPONENT			
RATE YEAR	TRANSITION YEAR	< 300 BEDS	> 300 BEDS	> 300 BED DIFFERENCE
2015	Year 4	56.66	63.93	7.27
2016	Year 5	56.92	64.23	7.31
2017 & Beyond	Year 6	57.18	64.52	7.34
Transportation Adjustment	Transition Completed	57.18	64.52	7.34

Statewide Pricing was introduced on 1/1/2012. As part of the conversion from cost based rates to a pricing system:

- Statewide Indirect Prices were transitioned in from 2012 – 2017 in conjunction with the transition adjustment (line 11).

Per Diem Add-Ons (Line 10)

		MDS *
Dementia CA, BA, PA, PB	$ 8.00	Section I4200
Traumatic Brain Injury (TBI)	$ 36.00	Section I5500
Bariatric (BMI)	$ 17.00	Section K0200

Each resident who meets the MDS criteria will result in the add-on being calculated into the Medicaid Rate.

* Changes currently frozen due to MDS/CMI freeze

Per Diem Add-Ons (Line 10)

Bariatric Add On	
Total BMI Patient Count	10
Rate Add On	17.00
Days in Year	365
Add On Total	62050
Medicaid Days	28286
Per Diem Amount	2.19

- In this example, ABC Facility has 13 residents who met the BMI Criteria. This resulted in $2.85 added to the overall Medicaid Rate.

Statutory Adjustments

12	Quality Adjustment (Schedule 5)			
13	Misc. Per Diem Adjustments	3.33	3.30	3.33	3.30
14	Adj Per PHL Section 2808(25)(C)	-0.57	-0.57	-0.57	-0.57
15	Adjustment to Cap Case Mix 5.0%				

The Medicaid Rate includes several items which are included based upon Department of Health regulations and/or initiatives:

- Quality Adjustment: Rate add-on or recoupment based on NHQI quintile. This line has not yet been used.
- Misc. Per Diem Adjustments: See next slide

Statutory Adjustments

- Misc. Per Diem Adjustments
  - 1.5% across the board investment per diem
  - 1% across the board investment per diem eff. 4/1/2022
  - 7.5% across the board investment per diem eff. 4/1/2023
  - Minimum Wage Adjustment
    - Eligible facilities based on survey submission
  - 2% penalty per diem
    - Based on NHQI scoring
  - Other Misc. Adjustments
    - Few facilities will have this.

Statutory Adjustments

12 Quality Adjustment (Schedule 5)				
13 Misc. Per Diem Adjustments	3.33	3.30	3.33	3.30
14 Adj Per PHL Section 2808(25)(C)	-0.57	-0.57	-0.57	-0.57
15 Adjustment to Cap Case Mix 5.0%				

The Medicaid Rate includes several items which are included based upon Department of Health regulations and/or initiatives (continued):

- Adj. Per PHL Section 2808(25)(c): This adjustment was tied to the a change in the reimbursement of Medicaid bed holds.
- Adjustment to Cap Case Mix 5.0%: Prior to the 7/1/2019 Medicaid Rates, increases or decreases were capped at 5% pending OMIG audit.

Rebasing

In recent years, there has been a push to “Rebase” the rates.

- Rebasing will likely update the WEF.
- Statewide prices and Non-Comp rates could also be updated.
- Without additional Medicaid funds, this will reallocate existing Medicaid dollars.
  - Facilities would be split between “Winners” and “Losers” similar to when DOH implemented Statewide Pricing in 2012.

MINIMUM DIRECT CARE SPENDING PROVISIONS "70/40/5" RULE

70/40/5 Rule: Determining Thresholds

- ABC Nursing Home is a 120 bed facility with no specialty units or services.
- Revenue on Schedule 7 totals $12,667,954:
- Capital per Diem is $11.46 and Assessment Per Diem is $13.45

Schedule 7 - Analysis of Net Patient Revenue & Total Operating Revenue		RHCF	Revenue - Other	Total
		0463	0160	0161
Analysis of Total Operating Revenue				
Medicaid Net Revenue				
A. Social Services	011	7,042,732		7,042,732
B. Managed Care Provider	025			
C. Other Services	012		347,494	347,494
TOTAL MEDICAID NET REVENUE	001	7,042,732	347,494	7,390,226
Medicare Net Revenue				
A. Part A - All Income	002	2,848,281		2,848,281
B Part B - Income	003	269,325		269,325
C. Part B - Final Settlement	004			
D. Managed Care Provider	026			
TOTAL MEDICARE NET REVENUE	013	3,117,606		3,117,606
Private Patient Revenue	005	322,205		322,205
Other Net Patient Revenue	006	1,836,356		1,836,356
TOTAL NET PATIENT REVENUE	010	12,318,899	347,494	12,666,393
All Other Operating Revenue*	015		1,561	1,561
TOTAL OPERATING REVENUE	020	12,318,899	349,055	12,667,954

70/40/5 Rule: Determining Thresholds

- Testing thresholds based on Revenue:

	Original Methodology	Revised Base Scenario	Revised w/Agency Compliance
Testing Thresholds			
Revenue Reported (Sch 7)	$ 12,667,954	$ 12,667,954	$ 12,667,954
Less: Carve Outs			
Capital Per Diem	$ -	$ 315,150	$ 315,150
Assessment Per Diem	$ -	$ 369,875	$ 369,875
Non-Medicaid Revenue	$ -	$ -	$ 5,276,167
Testing Threshold	$ 12,667,954	$ 11,982,929	$ 6,706,762
70% Threshold	$ 8,867,568	$ 8,388,050	$ 4,694,733
40% Threshold	$ 5,067,182	$ 4,793,172	$ 2,682,705

Note: Revised scenarios based on A7328 demonstration project signed into law in December 2023.

70/40/5 Rule

- For 2024 Year End:
  - Non Medicaid revenue eliminated from "70%" and "40%" calculations if RN, LPN, and CNA agency staff is 9% or less per PBJ filings
  - 50% reduction of penalties if RN, LPN, and CNA agency staff is 30% lower in its 2024 Aggregate PBJ filing versus 2023 Aggregate PBJ filing.
  - 25% reduction of penalties if RN, LPN, and CNA agency staff is 20% lower in its 2024 Aggregate PBJ filing versus 2023 Aggregate PBJ filing.

70/40/5 Rule

- For 2025 Year End:
  - Non Medicaid revenue eliminated from "70%" and "40%" calculations if RN, LPN, and CNA agency staff is 8% or less per PBJ filings
  - 50% reduction of penalties if RN, LPN, and CNA agency staff is 30% lower in its 2025 Aggregate PBJ filing versus 2024 Aggregate PBJ filing.
  - 25% reduction of penalties if RN, LPN, and CNA agency staff is 20% lower in its 2025 Aggregate PBJ filing versus 2024 Aggregate PBJ filing.

70/40/5 Rule

- For 2026 Year End:
  - Non Medicaid revenue eliminated from "70%" and "40%" calculations if RN, LPN, and CNA agency staff is 8% or less per PBJ filings
  - 50% reduction of penalties if RN, LPN, and CNA agency staff is 30% lower in its 2026 Aggregate PBJ filing versus 2025 Aggregate PBJ filing.
  - 25% reduction of penalties if RN, LPN, and CNA agency staff is 20% lower in its 2026 Aggregate PBJ filing versus 2025 Aggregate PBJ filing.

70/40/5 Rule

- Based on the 2024 Q2 PBJ Filings:
  - 601 SNFs included in CMS PBJ Public Use File
  - NY SNFs Average 12.20% Agency Staff
  - 388 (64.56%) reported less than 10% Agency Nursing Staff
    - Within these 301 facilities, they reported 5,161 days (18.64%) where they did not comply with any of the minimum staffing requirements.
  - 113 (18.80%) reported more than 20% Agency Nursing Staff
    - Within these 180 facilities, they reported 3,068 days (18.53%) where they did not comply with any of the minimum staffing requirements.
  - In perspective, all 601 facilities reported 8,658 days (15.94%) where they did not comply with any of the minimum staffing requirements.

70/40/5 Rule: Example

- XYZ Nursing Home is a 200 bed facility with an adult day health care program
- Facility is CMS 4 Star Rated with 4.21 Nursing Hours per Day.
- Revenue on Schedule 7 totals $34,563,198

Testing Thresholds

Revenue Reported (Sch 7)			$	34,563,198	**(3)**
Medicaid Capital Rate 1/1/2022	$	26.36			
Medicaid Days (Part I-3, 0620/99)		42,655			
Less: Capital Exclusion				(1,124,386)	
Cash Receipts Assessment (If on Sch 7)				-	
Grant funding from fed gov. for COVID-19				-	
Medicaid Revenue Reported (Sch 7)	$	17,239,822			
Demontration project (<10% agency)	**No**			-	
Adjusted Revenue			$	33,438,812	**(3)**

70/40/5 Rule: Example

- Testing thresholds:

Adjusted Revenue	$	33,438,812	**(3)**
70% Threshold	$	23,407,168	**(1)**
40% Threshold	$	13,375,525	**(2)**
Expenses Reported (Exh H)	$	33,557,590	**(4)**
Operating Revenue Threshold for 5% Allowable Profit	$	35,577,269	

- 70% Direct Care Threshold Test

Direct Care (70%)			
Total Reported Expenses (Exh H)	$	33,557,590	
Less: Exh H Col 40 - Rent & Deprec.	$	(3,359,925)	
Plus: Admin Rent & Deprec.	$	13,856	
Plus: Fiscal Rent & Deprec.	$	54,837	
Less: Sch 9, Line 023 (Real Estate Taxes)	$	(401,927)	
Less: Exh H - Line 04 (Fiscal)	$	(731,590)	
Less: Exh H - Line 05 (Admin)	$	(4,296,389)	
Less: Exh H - Line 08 (Security)	$	(157,068)	
Less: Exh H - Line 19 (Med Records)	$	(135,524)	
Total Direct Care Expenses	$	24,543,860	
Threshold (70% of Revenue)	$	23,407,168	**(1)**
PASS/FAIL		**PASS**	
Potential Liability	$	-	

70/40/5 Rule: Example

- 40% Direct Care Threshold Test

Resident Facing Care (40%)			
Program Service - Salary (Exh H)	$	5,028,647	
Program Service - Benefits (Exh H)	$	2,407,655	
Program Service - Fees (Exh H)	$	5,065,077	
15% Reduction for Fees (RN,LPN,Aide)	$	(759,762)	
Program Service PCS (Exh H)	$	269,073	
15% Reduction for PCS (RN,LPN,Aide)	$	(40,361)	
Ancillary - Salary (Exh H)	$	946,216	
Ancillary - Benefits (Exh H)	$	146,864	
Ancillary - Fees (Exh H)	$	857,704	
Ancillary PCS (Exh H)	$	890,740	
Total Resident Facing Expense	$	14,811,853	
Threshold (40% of Revenue)	$	13,375,525	**(2)**
PASS/FAIL		**PASS**	
Potential Liability	$	-	

70/40/5 Rule: Example

- 5% Profit Margin Threshold Test

Profit Margin (5%) Analysis - Based on expenses (per PHL 2828)			
Operating Expenses	$	33,557,590	**(4)**
Non-Operating Expenses	$	325,523	
Subtotal	$	33,883,113	
Allowable Margin (based on PHL)		105%	
Operating Revenue Threshold	$	35,577,269	
Operating Revenue Actual	$	34,563,198	**(3)**
PASS/FAIL		**PASS**	
Potential Liability	$	-	

70/40/5 Rule: Example

- In this example, XYZ Nursing Home was in compliance with all 3 minimum spending requirements.
- What if XYZ Nursing Home failed one or more of the minimum spending requirements?
- Lets examine the possibilities…

70/40/5 Rule: Example

- 70% Direct Care Threshold Test

Direct Care (70%)			
Total Reported Expenses (Exh H)	$	31,557,590	
Less: Exh H Col 40 - Rent & Deprec.	$	(3,359,925)	
Plus: Admin Rent & Deprec.	$	13,856	
Plus: Fiscal Rent & Deprec.	$	54,837	
Less: Sch 9, Line 023 (Real Estate Taxes)	$	(401,927)	
Less: Exh H - Line 04 (Fiscal)	$	(731,590)	
Less: Exh H - Line 05 (Admin)	$	(4,296,389)	
Less: Exh H - Line 08 (Security)	$	(157,068)	
Less: Exh H - Line 19 (Med Records)	$	(135,524)	
Total Direct Care Expenses	$	22,543,860	
Threshold (70% of Revenue)	$	23,407,168	**(1)**
PASS/FAIL		**FAIL**	
Potential Liability	$	(863,308)	

- What are this facility's reporting options?

70/40/5 Rule: Example

Reporting Strategies for 70% Threshold Failure

- Review accounts grouped to Exh. H, Lines 4 (Fiscal), 5 (Admin) 8 (Security) and 19 (Medical Records).
  - Are any expenses misposted to the wrong account?
  - For example: Office supplies posted to Line 5 (Admin) but used by Admissions (Line 21)
- Functional Benefit Allocation
  - For example: allocate union benefit expense to union departments
- Additional Expense Allocations

70/40/5 Rule: Example

Reporting Strategies for 70% Threshold Failure

- Lower 70% threshold by reducing revenues.
  - For Example: Allowance on Private Pay Days or Accrual of potential Medicaid Liabilities.
- ***Residential Health Care Facility Accounting and Reporting Manual*** *(RHCF ARM)* governs how this reporting should be reported on RHCF-4.
  - Reference to 10 NYCRR 86-2.3 and 414.13
- RHCF ARM includes methodology on how to determine and document the basis for cost allocations.
- Included in this manual is the “2 week time study” method.

It will be noted that many of the items listed are not referenced to a single cost center, but to the "using" or "appropriate" cost center (these are indicated by the letters a through h as listed below). These are items commonly used in more than one cost center, whose cost must be recorded directly or by interdepartmental transfer in the using cost center.

(a) Using Cost Center

(b) Appropriate Nursing Cost Center

(c) Appropriate Educational Cost Center

(d) Appropriate Food Services Cost Center

(e) Appropriate Cost Center

(f) Cost Center to which employee is assigned

(g) Appropriate Balance Sheet Account

(h) Appropriate Natural Classification

70/40/5 Rule: Example

Reporting Strategies for 70% Threshold Failure

- Marketing expense related to admissions activity may be allocated to Admissions.
- Marketing expense related to new hires may be allocated to the hiring department.
- Copiers, Postage Machines, and Office Supplies should be charged to the department utilizing the items.
- Software Expense for EMR, GL, Time & Attendance, etc. should be charged to the utilizing departments.
- Cell Phones should be allocated to departments based on actual usage.
- Allocate paper shredding and record retention costs by utilizing department.

70/40/5 Rule: Example

Reporting Strategies for 70% Threshold Failure

- Cable TV and Internet Services should be grouped with either utilities (which can be grouped in plant) or activities depending on who is using those services
- Oxygen and Oxygen Concentrators may be grouped into Respiratory Therapy
- Sales tax allocated by department using the 835 Natural Class (i.e. 6020.835)

70/40/5 Rule: Example

- 40% Direct Care Threshold Test

Resident Facing Care (40%)			
Program Service - Salary (Exh H)	$	4,028,647	
Program Service - Benefits (Exh H)	$	1,907,655	
Program Service - Fees (Exh H)	$	4,565,077	
15% Reduction for Fees (RN,LPN,Aide)	$	(684,762)	
Program Service PCS (Exh H)	$	269,073	
15% Reduction for PCS (RN,LPN,Aide)	$	(40,361)	
Ancillary - Salary (Exh H)	$	946,216	
Ancillary - Benefits (Exh H)	$	146,864	
Ancillary - Fees (Exh H)	$	857,704	
Ancillary PCS (Exh H)	$	890,740	
Total Resident Facing Expense	$	12,886,853	
Threshold (40% of Revenue)	$	13,375,525	**(2)**
PASS/FAIL		**FAIL**	
Potential Liability	$	(488,672)	

- What are this facility's reporting options?

70/40/5 Rule: Example

Reporting Strategies for 40% Threshold Failure

- Review salary accounts groupings to determine if resident facing care costs are being posted to a different department.
  - For Example: Are RNs being recorded on Line 13 (Nursing Admin) when they provide resident facing care services?
- Lower 40% threshold by reducing revenues.
  - For Example: Allowance on Private Pay Days or Accrual of potential Medicaid Liabilities.

70/40/5 Rule: Example

Reporting Strategies for 40% Threshold Failure

- Review Job Descriptions and Functions to ensure they accurately reflect the job being performed.
- Perform time studies to properly allocate employee's salaries who may work in different departments.
  - For example, if a RN Supervisor also performs functions which would normally be handled by an on-unit RN or LPN. Be sure to include that detail in all job description documentation.
- Ensure payroll reporting (including payroll dollars, hours worked, and hours paid) properly reflect job descriptions.
  - In the previous example, the portion of the RN Supervisor's job spent on RN/LPN functions may be allocated to program services nursing.

70/40/5 Rule: Example

Reporting Strategies for 40% Threshold Failure

- Direct allocation of workers compensation costs based on policy terms.
- Union benefit expense allocated to departments which have union employees (and non-union benefit expense allocated to departments which have non-union employees).
- Allocate other employee related costs, such as parties, gifts, and payroll processing fees to each utilizing department based on number of employees or similar metric.

70/40/5 Rule: Example

- 5% Profit Margin Threshold Test

Profit Margin (5%) Analysis - Based on expenses (per PHL 2828)			
Operating Expenses	$	31,557,590	**(4)**
Non-Operating Expenses	$	325,523	
Subtotal	$	31,883,113	
Allowable Margin (based on PHL)		105%	
Operating Revenue Threshold	$	33,477,269	
Operating Revenue Actual	$	34,563,198	**(3)**
PASS/FAIL		**FAIL**	
Potential Liability	$	1,085,929	

- What are this facility's reporting options?

70/40/5 Rule: Example

Reporting Strategies for 5% Threshold Failure

- Separate out non-operating revenues and expenses so they are reported separately on Exhibit E
  - For Example: Pass Thru Entity Tax (PTET), Intergovernmental Transfer (IGT), etc.
- Review potential expense accruals.
- Review potential revenue adjustments.

70/40/5 Rule: Example

IMPORTANT

- **Ensure all data is consistently reported across all reports (especially payroll data).**
  - This includes CMS PBJ, RHCF Medicaid Cost Report, Medicare Cost Reporting, Workers Compensation reporting, etc.
- All adjustments need to be included on both the final audited financial and the facility's General Ledger.
- Documentation supporting all changes should be retained as part of the facility's books and records.

Open Questions: Overall Issues

- NYS Department of Health has left many open questions regarding how this program will be administered.
- These open questions have the potential to materially change how a facility would comply with this requirement.
- Measurement of Non-Compliance
  - For multiple instances of non-compliance, is it the highest of the recoupment amounts? Or the aggregate of all recoupments?
- Disbursement of 70/40/5 recoupments.
  - Since the funds are disbursed via the NHQI, facilities will receive proceeds regardless of how they performed under the 70/40/5 program.
  - Any proceeds are then (assumedly) subject to next year's 70/40/5 threshold calculations (a revolving door of revenue?).

Open Questions: Overall Issues

- Confirmation of how the state plans to calculate 70/40/5 compliance.
- Detail on the waiver application process & evaluation criteria
- Detail on criteria for hardship applications
- Detail on how and when these submissions will be audited by DOH
- Clarification on how excess revenue owed to DOH will be assessed?
- Facilities who are CMS 4 or 5 Star Rated and which also have met or exceeded the minimum staffing requirements could still be subject to remittance of excess revenue under the provisions of 70/40/5. Isn't is counterintuitive to the intentions of both the minimum staffing requirements and 70/40/5?

Open Questions: Cost Reports

- The Public Health Law, State Register, and Regulations specifically cites lines of RHCF-4 Exhibit H as allowable costs, but then seeks to eliminate items required to be reported within those departments.
  - For example, Real Estate Taxes (presumably disallowed per regulations) are reported on Exhibit H, Line 6 (Plant Operations & Maintenance). However, on Exhibit H, Real Estate Taxes are reported net with allowable expenses such as Utilities.
  - Is DOH allowed to carve out such expenses not readily determinable by utilizing Exhibit H? And, if so, what would be their method of determining the value of such embedded expenses?

Open Questions: Other Issues

- Many items are yet to be addressed by DOH.
  - How are providers to determine and measure compliance if so many items are essentially TBD?
- Payment of actual and/or recording of estimated (accrual) “40” and “70” shortfalls may cause facilities to fail financial covenants of their lenders.
- For 2022, the budget authorizes a pro rata methodology to calculate minimum spending standards for resident facing staff and direct resident care.
  - DOH has not shared this methodology as of yet

MINIMUM STAFFING REQUIREMENTS

NYS Minimum Staffing Requirements

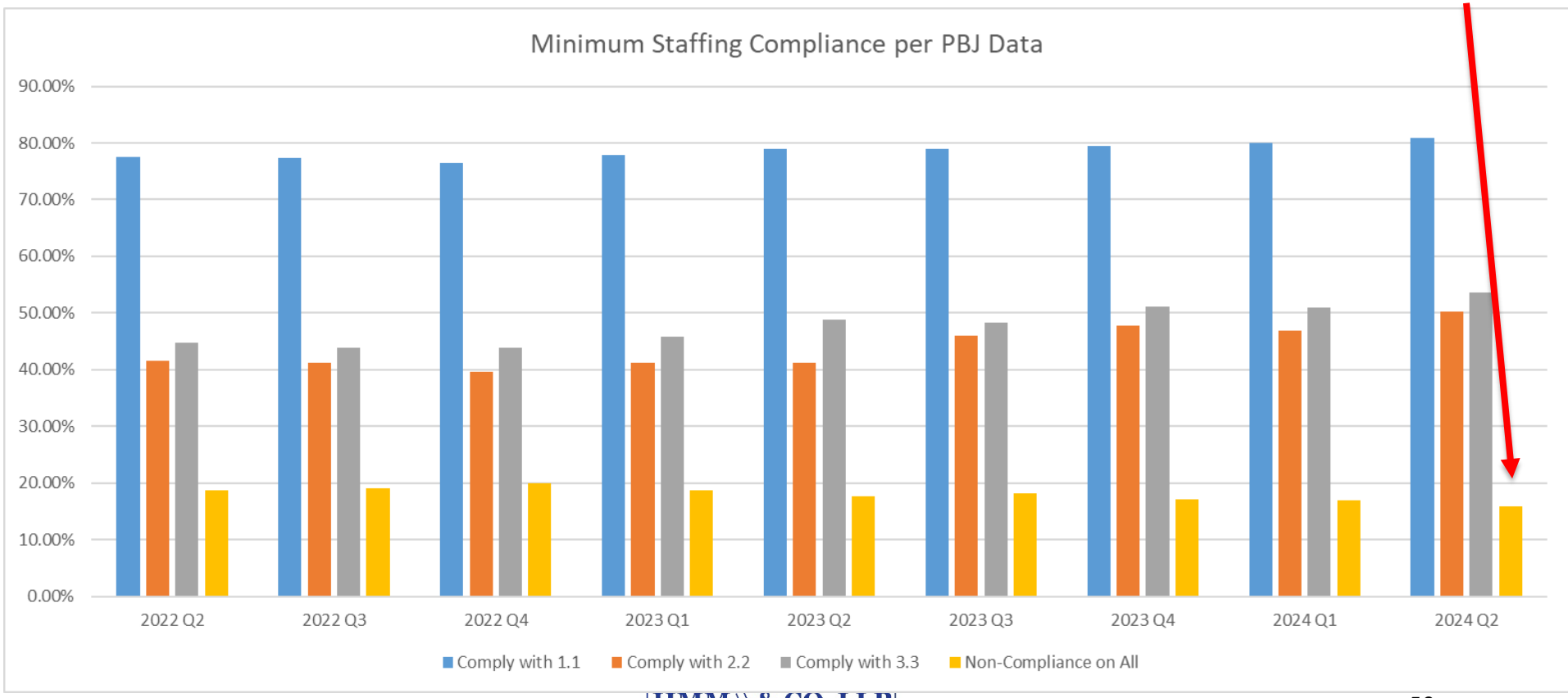
Where we currently stand

- 599 NY SNF Facilities in CMS Payroll Based Journals (PBJ) Public Use Dataset
- HMM evaluated daily PBJ submissions for compliance with
  - Licensed Nursing Hours per Day (1.1)
  - Certified Nursing Aide Hours per Day (2.2)
  - Total Resident Facing Nursing Hours per Day (3.5)
- CMS has released PBJ data through 2024 Q2.

NYS Minimum Staffing Requirements

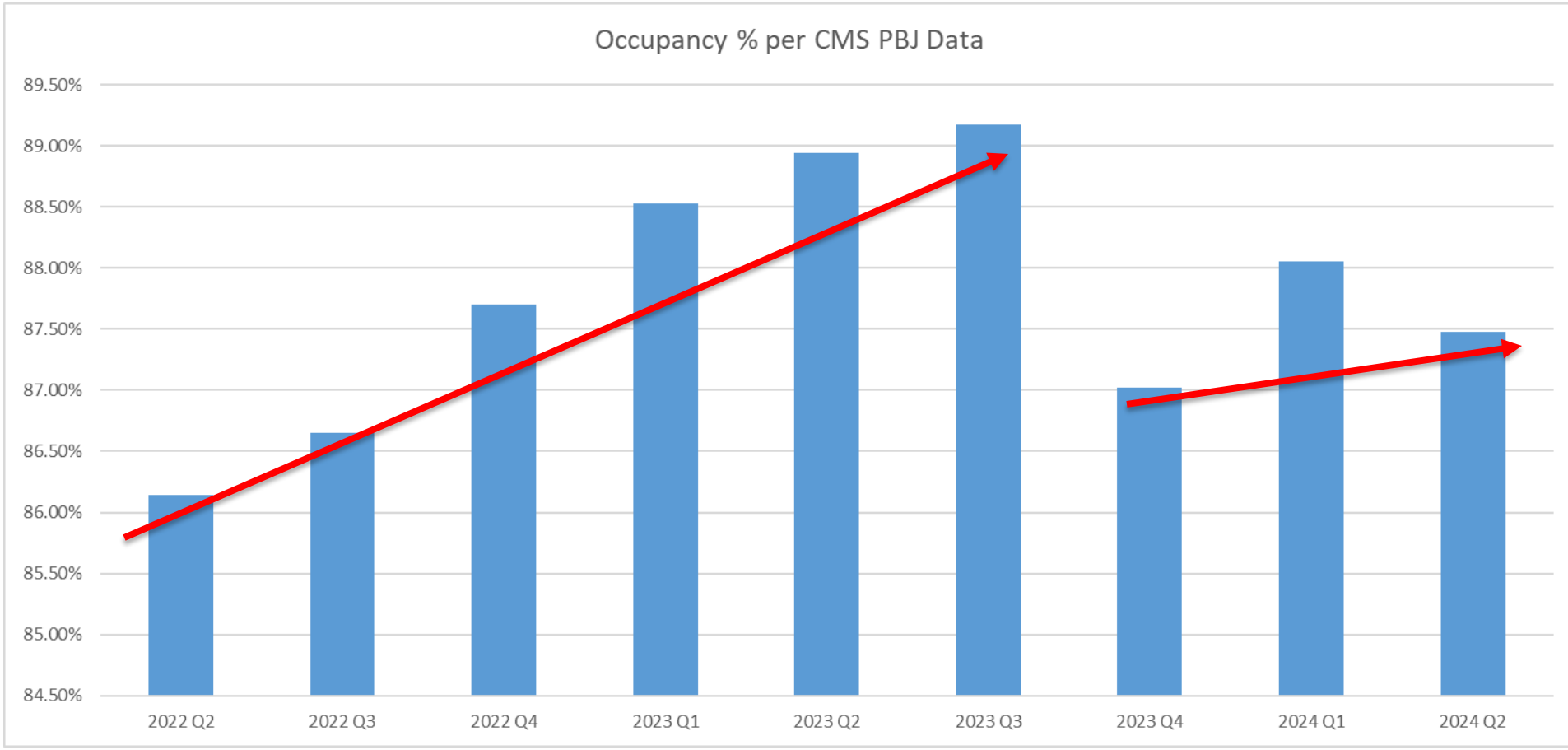
Where we currently stand:

16% of resident days did not comply with all 3 metrics



NYS Minimum Staffing Requirements

Where we currently stand:



NYS Minimum Staffing Requirements

- NYS Law mandates use of CMS PBJ Data to evaluate facility compliance.
- Assessments for noncompliance began effective April 1, 2022.
- NYS Department of Health is authorized to waive penalties for factors such as:
  - Declared Disaster Emergencies
  - Frequency of Non-Compliance
  - Regional Labor Shortages

NYS Minimum Staffing Requirements

- Action Steps
  - Review PBJ Submission data for accuracy
  - Reconcile quarterly PBJ reports to annual cost reports (RHCF and Medicare).
  - Gather and maintain documentation for all staff classifications and allocations.
  - Work with CPAs and Cost Reporting Consultants to ensure audited financial statements and all cost reports reflect proper staff groupings.

NYS Minimum Staffing Requirements

- Action Steps
  - Calculate and Review facility staffing ratios on an interim basis.
  - "Audit" job functions and ensure staff responsibilities match the reporting classifications.
    - The *Residential Health Care Facility Accounting and Reporting Manual* allow facilities to utilize a 2 week time study as a basis for cost allocations.
    - Job descriptions should match functional responsibilities. Consult with your labor attorney if additional clarification is required.

REGULATORY ITEMS

Beneficial Ownership Information

- Passed into law in 2021 with an effective date of January 1, 2024.
- Several court challenges filed, which delayed effective date.
- Current filing deadline per FINCEN is March 21, 2025.
- Trump administration announced intention to modify enforcement of BOI filing requirement.
- All entities are recommended to speak with legal counsel to determine specific implications.

Important New Reporting Requirement for U.S. Businesses

Starting January 1, 2024, a significant number of businesses will be required to comply with the Corporate Transparency Act ("CTA") which requires the disclosure of beneficial ownership information ("BOI") of certain entities from people who own or control a company.

The CTA is not part of the tax code. Instead, it is a part of the Back Secrecy Act, a set of federal laws that require record-keeping and report filing on certain types of financial transactions. Under the CTA, BOI reports will not be filed with the IRS, but with the Financial Crimes Enforcement Network (FinCEN), another agency of the Department of Treasury.

Why: The intent of the BOI reporting requirement is to help U.S. laws enforcement combat tax fraud, money laundering, the financing of terrorism and other illicit activity.

Who: In general, the Act applies to U.S. formed corporations and limited liability companies along with certain foreign-owned entities doing business in the States. Many sole practitioners, small businesses and middle-market businesses will be required to file ownership reports.

What: The report requires companies to provide information on any individual who, directly or indirectly, exercises "substantial control" over a reporting company or owns or controls at least 25% of the ownership interests of a reporting company. An individual has substantial control of a reporting company if they direct, determine or exercise substantial influence over important decisions of the reporting company – this includes senior officers of the company, regardless of formal title or if they have no ownership interest.

When: For existing entities created/registered before January 1, 2024, the deadline for reporting is January 1, 2025. New entities created after December 31, 2023 must file within 30 days of initial registration of the business. There is a proposal for new entities created in 2024 to extend the 30-day timeframe to 90 days. Penalties for willfully not complying with the BOI reporting requirements can result in a criminal and civil penalties of $500 per day and up to $10,000 with up to 2 years in jail.

Next Steps: We encourage you to consider consulting with legal counsel if you have questions regarding the applicability of the CTA's reporting requirements and issues surrounding the collection of relevant ownership information.

Medicare Mandatory Off Cycle Revalidation

- CMS is requiring all Skilled Nursing Facilities to complete “Mandatory Off Cycle Revalidation”.
- CMS released Form CMS-855A to facilitate this process.
- Filing is done via the PECOS system.
- This filing will include additional details about their ownership and operations beyond their standard revalidation process.
- Submission deadline for revalidation is May 1, 2025.

From: HMM, CPAs LLP
Sent: Monday, October 28, 2024 12:07PM
To: Owners/Administrators/Controllers
Subject: Medicare Mandatory Off-Cycle Revalidation

Medicare Mandatory Off Cycle Revalidation

EXECUTIVE SUMMARY

CMS recently announced that all skilled nursing facility providers will receive off-cycle provider enrollment revalidation notices from their Medicare Administrative Contractor (MAC) to collect additional data on ownership, managerial, and related party information not previously required. **All providers will be required to take action once the revalidation letter is received.**

WHAT YOU NEED TO KNOW

- Be on the lookout for a letter from your MAC from October through December 2024 regarding a mandatory off-cycle revalidation. Approximately one-third of SNFs will receive these notices each month.
- Providers will have 90 days from the date of the letter to respond and submit the newly required information into the **Medicare Provider Enrollment, Chain, and Ownership System (PECOS)** (https://pecos.cms.hhs.gov/pecos/login.do#headingLv1**)** system to keep their provider enrollment status active.
- The requested information is quite complex and affects every SNF, regardless of size or ownership characteristics.
- SNF providers no longer report in Sections 5 and 6 of the provider enrollment form, but in a new SNF-specific Appendix.
- In addition to SNF revalidation timeline discussed above, the new Form CMS-855A must be used for all of the following provider enrollment transactions effective October 1, 2024.
  - a. Initial Enrollment
  - b. Revalidations
  - c. Reactivations
  - D. CHOW

WHAT YOU NEED TO DO

- Review the new **Form CMS-855A** (www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms855a.pdf) and the new **GUIDANCE FOR SNF ATTACHMENT ON FROM CMS-855A** (https://www.cms.gov/files/document/guidance-snf-attachment-855a.pdf).
- CMS suggests providers seek counsel from an attorney to help interpret the new SNF reporting requirements.
- Begin compiling the new information that will be required to be reported ASAP.

Dropped Services Review

- NYS Office of the Medicaid Inspector General (OMIG) is reviewing RHCF submissions for “Dropped Services”.
- The “Dropped Service” review compares the facility’s Non-Comp Medicaid Rate to the expenses reported on RHCF-4, Exhibit H.
- Any reimbursed service which does not have expense reported is deemed to be dropped and is subject to recoupment.
- Non-Comp Medicaid Rates aren’t subject to traditional OMIG Audits (but are included as part of OMIG Property Audits via the Dropped Services Questionnaire).

Executive Compensation

- Executive Order 38 limits on executive compensation repealed by Governor Hochul in 2021.
- Facilities are still required to comply with Direct Care Spending (70/40) requirements.
  - Executive Compensation likely not part of 70% or 40% measurements unless job documentation supports functions included in those measurements.
- Excessive executive compensation could be deemed to be a violation of the withdrawal of equity provisions.
- Executive Compensation subject to examination by federal and state authorities, including the NY Attorney General's office.

Dropped Services Review

2021/2022 MEDICAID RATE REVIEW Approved as of Nov. 30, 2021

DIRECT PRICE

7/2021 Case Mix	Medicaid Only	1,580 2
7/2021 Case Mix	Total All Payers	1,42 80

Add-On: Dementia, TBI, BMI

	Number of Patients		
1/2021 Dementia	0	@	8.00
1/2021 TBI	0	@	36.00
1/2021 BMI	3	@	17.00

INDIRECT PRICE: Predetermined by DOH

Non-Comparable Cost –		**2007 RHCF-4**	**2020 RHCF-4**	
17	Medical Director	12,996	22,500	
20	Utilization Review	139,275	130,418	
31	Laboratory Services		40,058	DROP SERVICE
35	Inhalation Therapy	31,450		←
37	Dental	30,000	20,185	
44	Medical Staff			
106	Utilities	364,816	354,355	
242	Pharmacy	41,864	41,864	
	Total	620,401	609,380	
	Total Days	44,259	44,259	
	Per Diem	14.02	13.77	

HMM & CO., LLP
AUDIT | TAX | CONSULTING

Dropped Services Review

DROPPED SERVICES

As part of our audit of the 01/01/16 through 12/31/19 Medicaid rates for [redacted] we must confirm whether ancillary and physicians costs included in the base period (2007) were still paid for by the provider in the rate periods referenced above. Various facilities have contracted with third party vendors to provide services and supplies to nursing home patients. The third party vendors then bill the Medicaid program directly for those services. This may result in a duplication of reimbursement if such service was included in the provider's rate (through the trending of base period costs).

Below is a list of various services and/or supplies. Please indicate whether these services/supplies were included in the base period costs and whether the facility was still paying for these services in each of the applicable rate periods.

SERVICE OR SUPPLY	INCLUDED IN BASE PERIOD? YES/NO	$ AMT	PAID FOR BY FACILITY IN THE APPLICABLE RATE PERIOD? (ANSWER YES OR NO ON LEFT AND GIVE AMOUNT SPENT DURING YEAR ON RIGHT) 2016	2017	2018	2019	2020	EFFECTIVE DATE
LABORATORY SVCS								
EKG								
EEG								
RADIOLOGY								
INHALATION THER.								
PODIATRY								
DENTAL								
PSYCHIATRIC								
PHYSICAL THERAPY								
OCCUP. THERAPY								
SPEECH/HEAR. THER								
PHARMACY								
OTHER:								

OMIG Capital Audits

- Typically occur every few years and cover multiple cost/rate years
- Data requests can be lengthy, burdensome and without much notice
- Have historically taken several months to several years to complete
- Can be done using sampling or full scope

OMIG Capital Audits

- OMIG Audit Timeline
  - OMIG delivers audit notice and request list
  - Provider fulfills auditor requests
  - Follow-up / additional information exchange / discussions
  - Exit conference summary (ECS) / additional information exchange / discussions

OMIG Capital Audits

- OMIG Audit Timeline
  - Exit conference – typically via telephone/virtual - a few weeks after ECS is shared
  - Draft audit report – provider has 30 days to respond (or not respond)
  - Final audit report
  - Provider pays in full or EMEDNY recoups
  - Hearing request – provider has 60 days to request

OMIG Capital Audits

- Typical Items of Interest
  - Depreciation of assets (fixed, movable)
  - Televisions (Common areas vs. resident rooms)
  - Telephones are k/o'd (included in operating expenses)
  - Assets not yet placed into service
  - Routine maintenance, repairs
  - Mortgage/Bond related items (interest, amortization, insurance)

OMIG Capital Audits

- Typical Items of Interest
  - Approved Project Cost (APC) / Over-mortgaging %
  - Building rent (for those grandfathered in)
  - Equipment rent (but not supplies, maintenance fees)
  - Real estate taxes
  - Property insurance vs business interruption insurance; auto insurance non-patient care
  - Sales tax
  - Return of equity

OMIG Capital Audits

- Preparing for an OMIG Audit
  - Maintenance of sufficient and relevant documentation
    - Lease agreements
    - Invoices
    - Proof of payment
    - Accounting ledgers and reconciliations
  - Proper recording of expenses
  - Have a written capitalization policy and follow it
  - If ongoing CON project is CIP, do not depreciate (keep those invoices separate from day 1 of the project)
  - Ensure proper DOH approval for projects/financing, as applicable

OMIG Capital Audits

- Preparing for an OMIG Audit
  - Following cost reporting guidance
  - Prompt review of issued rates vs expectations (Attestations, Appeals)
  - Prompt review/response to ECS, Draft report
    - Request OMIG's work papers for any questioned items
    - Were proper 'from' rates used?
    - Was all relevant documentation furnished
    - Early and open discussions with auditors
  - Note: OMIG does not process appeals and we rarely see them make positive adjustments

Withdrawal of Equity / Asset Transfer

- In Excess 3% Prior Years Revenues

- Must Request Permission from ***DEPARTMENT OF HEALTH (D.O.H.)***

↓

60 Days PRIOR to Withdrawal

Withdrawal of Equity / Asset Transfer

- 3% of revenue on the most recently submitted RHCF-4 Schedule 7
- Submit request 60 days PRIOR to transaction
  - DOH forms
  - Recent financial data
  - Projected cash flow
  - Any other relevant information

Withdrawal of Equity / Asset Transfer

- Possible Outcomes:
  - Receive approval letter and adhere to prescribed approval
  - Request for additional information/clarification
  - Denial (quality of care, poor financial condition)
- No approval in hindsight
- Penalties – repayment + 10%

Thank You

Questions?

Thank You

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